Country Profile "**Czech Republic**"

Suicide and Suicide Prevention: Key Facts and National Priorities

Author(s):	Lead author: *Alexandr Kasal* Co-authors: *Roksana Táborská, Laura Juríková, Eva Tušková*
Version:	1.0
Date:	17. 05. 2023

Contents

This report arises from the Joint Action on Implementation of Best Practices in the area of Mental Health, which has received funding from the European Union through the European Health and Digital Executive Agency (HaDEA) of the European Commission, in the framework of the Health Programme 2014-2020, GRANT NUMBER 101035969 — JA-02-2020. The content of this report represents the views of the author only and is his/her sole responsibility; it cannot be considered to reflect the views of the European Commission and/or the HaDEA or any other body of the European Union. The European Commission and the Agency do not accept any responsibility for use that may be made of the information it contains.

Introduction

The EU-Co-funded "Joint Action on Implementation of Best Practices in the area of Mental Health", short **JA ImpleMENTAL**, has a duration of 3 years, lasting from October 2021 to September 2024. Detailed information can be found at the project's website JA ImpleMENTAL ja-implemental.eu. It aims to promote and improve mental health structures, services, capacity and outcomes in participating countries in 2 specific areas:

- mental health reform (promoting community health services) and
- suicide prevention.

Two national best practices - mental health reform in Belgium and the Austrian suicide prevention programme SUPRA - serve as best practice examples. Selected components of these should be prioritised and implemented over the course of the JA in 14 i.e. 17 participating EU-countries. JA ImpleMENTAL comprises 6 Work Packages (WPs), 4 horizontal WPS and one for each best practice. **WP6 on suicide prevention** aims to support improvement in knowledge and quality of suicide prevention services. Defined elements of SUPRA should be transferred and pilot implemented at national/regional level, suicide prevention strategies in participating countries developed i.e. revised.

The present country profile is one of the major deliverables of the JA, presenting national priorities for suicide prevention embedded in contextually relevant facts. It summarizes results of the national Situation- and Needs Assessment (SANA), recommendations and prioritized measures for suicide prevention. It includes challenges and opportunities as well as outlining next steps necessary to scale-up i.e. promote national/regional suicide prevention activities. The country profile is a basis for strategy formulation, for decision-making and a declaration of commitment to suicide prevention.

1 Context

1.1 Country, Health and Social System

The Czech Republic is a unitary parliamentary republic. The country is landlocked in Central Europe. Its capital and largest city is Prague with 1.3 million inhabitants. The country is bordered by Poland to the north, Germany to the west, Austria to the south and Slovakia to the east. The Czech Republic includes the historical territories of Bohemia and Moravia and a small part of Silesia. Measured by gross domestic product (GDP) per capita, it ranks among the group of high-income countries.

The Czech health insurance system is based on universal coverage and a universal accessibility of health care. The system is financed via mandatory, wage-based health insurance contributions, general taxation and out-of-pocket payments. The care is provided by state, regional or municipal as well as

private health care providers. The Czech social security scheme comprises sickness insurance, pension insurance, state social support benefits and social care.

As well as other (not only) European countries, Czechia went through the Covid-19 pandemics at the beginning of the 20s. A general closure (incl. closing of the country borders, closure of services, restaurants and bars as well as schools and restriction of face to face contact) was in place during the pandemics. In 2022, Russia unleashed a war in Ukraine that led to an economic crisis as well as to an increasing number of refugees seeking asylum in the Czech Republic (one of the highest per capita number of refugees among EU member states).

Table 1: Population structure: 2021, expressed as number of persons, by age and sex (1)

	Sex		
Age group	**male**	**female**	**Total**
<18	1 034 482	984 127	2 018 609
18 - 64	3 331 170	3 193 676	6 524 846
65+	909 451	1 248 871	2 158 322
Total	**5 275 103**	**5 426 674**	**10 701 777**

The population structure according to age and sex is described in Table 1. Healthy life expectancy at birth is 73.1 (75.3 for females and 70.9 for males), and 13.6 at age 65 (2). A total of 10.7% of the population is at risk of poverty and social exclusion (3). Income inequality, expressed as the Gini coefficient, is 24.8% (4), and total healthcare expenditure relative to GDP is 9.41**%** (5).

1.2 Mental Health System

The mental health care in the Czech Republic is **financed and secured by both the health and the social care system** (see above).

Czechia has a **stand-alone policy for mental health.** The *National Action Plan on Mental Health (2020-2030)* was accepted by the government in January 2020 in order to fulfil the *Mental Health Care Reform Strategy* which was accepted already in 2013, but will end in 2023. The action plan should eliminate some of the implementation deficits detected in the previous stage of the reform and react to the current development in the field. The implementation of the action plan should be secured by the Governmental Council on Mental Health. Activities should be covered massively by the European Structural and Investment Funds. The main goals of the action plan are: to facilitate the shift of ca 30% of long-term mental health patients from mental health hospitals to community care, to further develop a sufficient net of community care (incl. health and social care), to ensure adequate housing for these patients and to introduce a system of collaboration between the health and the social sector as well as strengthen the role of municipalities in this process.

The **total government expenditure on mental health care** (as % of total public health expenditure) in 2015 was 4.00%, in total these are 501.6 million Euros (6). This is almost the same share as in 2006 (4.14 %) (7), which represents only two-fifths of the recommended volume of funding from the total health budget (8). This amount of funding is also several percent lower compared to Western European countries (9). Government **social support** available for persons with severe mental health conditions includes income, housing, employment, education, social care and legal support (10). The **Share of people reporting unmet mental health care needs due to financial reasons** in 2014 was 1.1% (11).

The data about the **proportion of involuntary admissions** to the number of total admissions to psychiatric wards/units of general hospital specifically are not collected in the Czech Republic. Estimated share of involuntary admissions based on expert opinion and anecdotal evidence from several reports is 33%-66%. Data on the **follow-up care of people discharged from hospitalisation due to mental health** conditions is currently not reported.

The **community-based mental health outpatient facilities** were developed based on the Mental Health Care Reform Strategy (2013-2023). In September 2022 there were approx. 30 centres (that means cca 1 per 350 000 inhab.). The centres are run by non-governmental organisations (NGOs) or mental health hospitals. According to the standard of care, the centres provide care of a multidisciplinary team consisting of healthcare and social care specialists (psychiatrists, clinical psychologists, nurses, psychiatric nurses and social workers). The main goal is to increase the effectiveness of psychiatric care and, in particular, to improve the quality of life and reduce the stigmatisation of people with mental illness. A map of the current net of the community mental health centres is available here: https://www.google.com/maps/d/u/0/viewer?mid=1wUIw3an8hY_0pzoO5F1EAj4Rk_5mnas9&ll=49.844367309875885%2C15.361049149999982&z=8.

Table 2: Facilities, number of beds and hospital admissions related to mental health: 2020 (10)

Indicator at national level		number	rate per 100.000 adult/minor population
Mental health hospitals	Facilities	19	0.22
	Beds	8684	100
	Admissions	37873	436.17
Psychiatric wards/units in general hospitals	Wards/units	32	0.37
	Beds	1317	15.17
	Admissions	20499	236.08
Mental health inpatient facilities specifically for children and adolescents	Facilities	3	0.15
	Beds	210	10.40
	Admissions	1062	52.61

The focus of the ongoing reform is, among others, to shift emphasis from long-term hospitalisations towards shorter hospitalisations for acute states of mental illness and to provide long-term care in the community settings. Traditionally, acute care is provided in the psychiatric wards in general hospitals, the number of beds in these facilities is slowly increasing since 2018 as well as the number of beds for acute care in some of the mental health hospitals (in order to secure geographic accessibility of acute care). The capacity of long-term care is gradually decreasing as the reform of mental health care proceeds and more community mental health centres are in service.

Box 1. Most common barriers people face when seeking psychosocial help

Stigmatisation of mental illness and suicidal behaviour (including suicidal thoughts) among general population as well as among professionals providing psychosocial services

Low availability of services in some regions and financial barriers

Low availability of specific services (e.g. child psychiatry, psychotherapy)

Inadequate continuity and interconnectedness of mental health care

Structural stigmatisation: underfunding, non-functional setting of employment support system, a legislative barrier for the employment of peer workers in the health services

System incoherence: agreements depend on many ministries (barrier for collaboration)

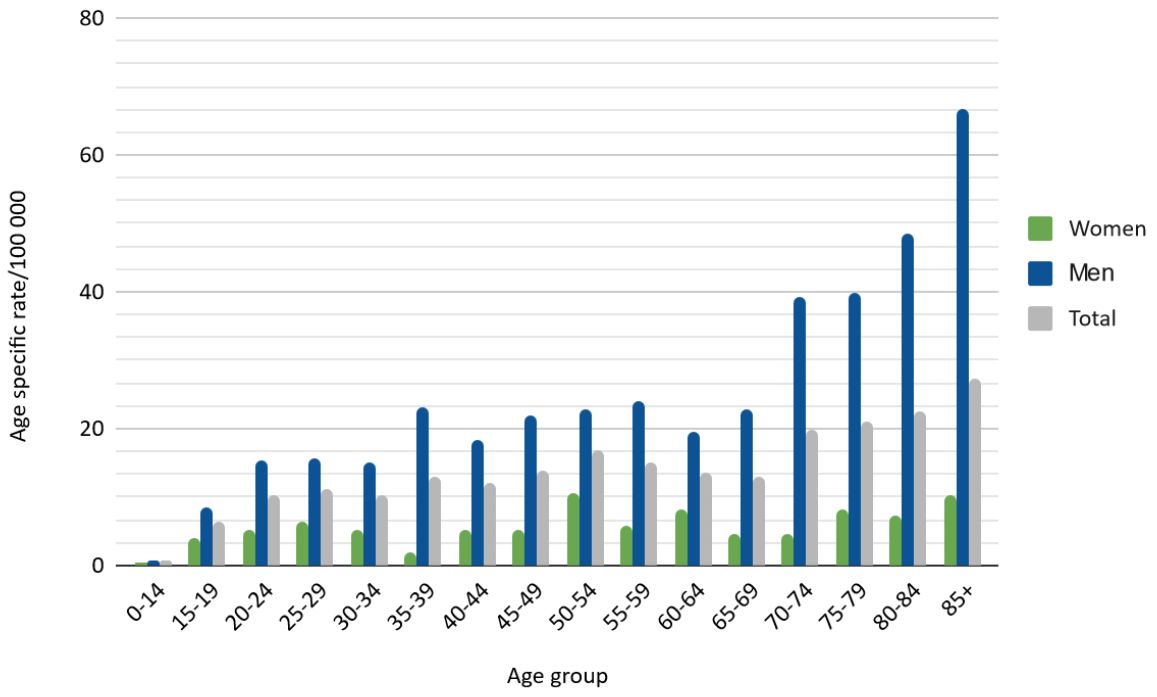
From the perspective of expert opinion of people with lived experience there is also a barrier in the insufficient involvement of people with experience in the creation and providing of psychosocial interventions. They describe that care is often not individualized and that the problem is keeping people with experience in the care system (health and social care) without much effort to make them competent. From their point of view, the full cover of care from health insurance at least for people with severe diagnosis is needed to achieve a recovery. There is a lack of awareness of who is a psychologist, who is a clinical psychologist, what to expect in treatment (often false information on the Internet).

2 Suicide and Suicide Prevention

2.1 Situation Analysis (SA)

Figure 1: Suicide rate: 2021, by age groups and sex (12; age specific rates calculated by authors)

The data are standardised according to the Czech standard population, not the European Standard Population, 2013.

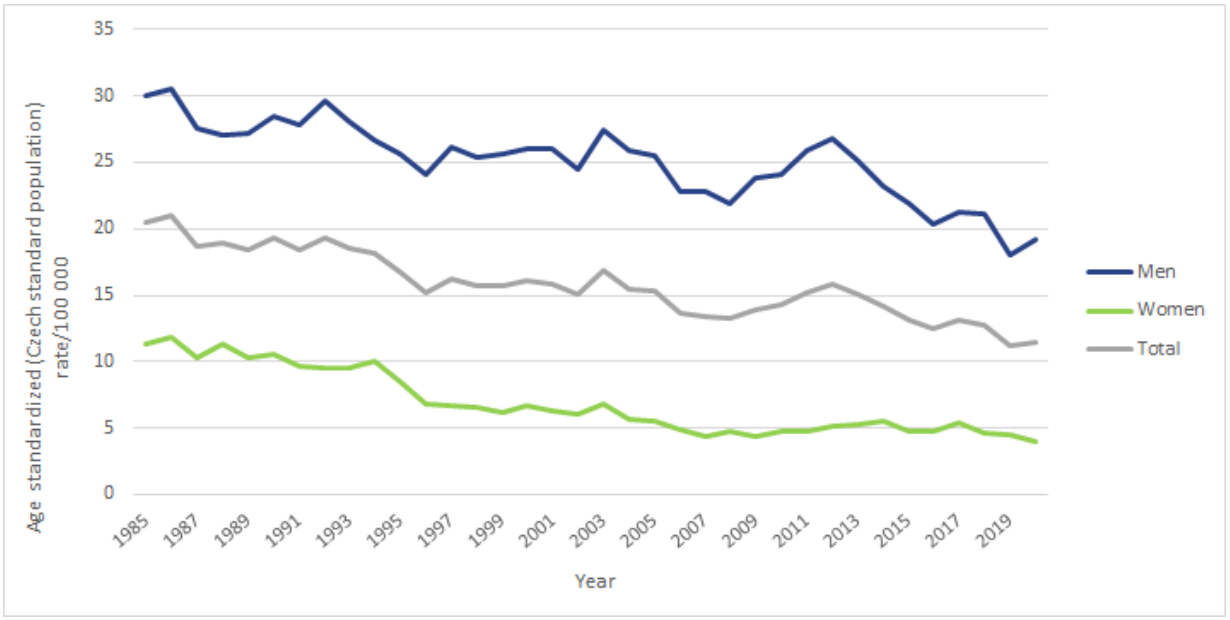


The suicide rates by age for both women and men follow the same trend with a flatter curve for women due to the lower intensity of the phenomenon. The trend is consistent between 2001-2010 and 2011-2020 for both sexes with the peak in suicide intensity at age 55-59, a small decrease at age 65-69 and a steady increase (and higher rates) in the older age groups. A slight change in the trend in suicide rates by age was observed between 2011-2020 among young people, with a significant increase in suicidality for males at 15-19 and 20-24 years of age, followed by stagnation in other age groups, and an increase among 35-39-year olds. The female suicide rate was increasing similarly for 15-19-year olds, stagnated or was declining for 20-year olds, and was increasing slightly for females in their late 30s. Comparing the 2001-2010 to the 2010-2020, there is a slight decrease in the overall number of suicides. Men have consistently

outnumbered women in the number of completed suicides over the years. Comparing the 2012 to the 2021, we can see a slight decrease in the number of suicides (from 1658 to 2021). Men are 4times more likely to die by suicide than women. (12)

Figure 2. Suicide rates between 1985-2020, by sex (17)

The data are standardised according to the Czech standard population, not the European Standard Population, 2013.



Every year the Czech Statistical Office (CZSO) provides data about deaths, including suicides, but there is no regular annual report. There were reports only up to 2003, afterwards, the data availability was scarce and insufficient.

Table 3: Most common methods of suicide: 2018, by age group and sex (13)

Sex/Age	0-19	20-39	40-59	60-79	80+
Women	1. hanging 2. poisoning 3. jumping or lying down in front of a moving object	1. hanging 2. jumping from height 3. poisoning	1. hanging 2. poisoning 3. jumping from height	1. hanging 2. jumping from height 3. poisoning	1. hanging 2. jumping from height 3. sharp object
Men	1. hanging 2. jumping or lying down in front of a moving object 3. jumping from height	1. hanging 2. jumping from height 3. jumping or lying down in front of a moving object	1. hanging 2. firearm 3. jumping from height	1. hanging 2. firearm 3. jumping from height	1. hanging 2. firearm 3. sharp object

Historically, hanging is the most common **method of ending one's own life** both among women and men in all age groups (for men 55.6% suicides happen by hanging, for women it is 34.7%). Among men, other frequent methods are firearms (16.6%), jumping from height (9.5%) and jumping or lying down in front of a moving object (6.3%). For women, it is jumping from height (24.4%), self-poisoning (19.7%) and jumping or lying down in front of a moving object (9.3%). The most suicides by jumping or lying down in front of a moving object happen on railways (Czechia has a dense railway network). Approx. half of the deaths by suicide happens at home, one fifth on a public place, nearly 10 % in a hospital. (13)

Box 2. Groups most vulnerable to suicide

People with mental illness (including abuse) and individuals with history of suicidal behavior

Youth

Elderly

Males

People with low socio-economic status

Minor populations (LGBT+, prisoners, roma population)

Among the **vulnerable populations** (summarized in the Box 2), older men have the highest suicide rates. Among young people aged 15–24 years, a suicide is the second leading cause of death (after accidents) (13). Another group with an increased suicide risk is children and adolescents (please see the statistics related to self-harm below), particularly children in institutional care. People with mental illness (especially those having a history of suicidal behaviour and those right after discharge from hospitalization for mental illness (14)) are also a vulnerable group. An increased suicidal risk probably occurs also in the non-heterosexual population, the prison population and ethnic minorities living in the Czech Republic. Those with low socio-economic status might be more vulnerable to suicide as well. Moreover, there are specific region disparities (e.g. availability of care, unemployment rates etc.) influencing above mentioned.

Table 4: Hospitalisation rate due to self-harm per 100 000: 2018, by age group and sex (15)

	0-19		20-39		40-59		60-79		80+	
	N	rate	N	rate	N	rate	N	rate	N	rate
Women	502	47.8	477	36.2	442	29.9	228	18	77	26.9
Men	189	17.2	500	35.9	386	25.1	144	13.7	31	21.5

On average, 3000 people are **hospitalised on a yearly basis for deliberate self-harm**, with slightly more females than males (56%). The highest hospitalisation rate is among boys and girls aged 15–19 years (60 and 150, respectively) and the most frequent way of self-harm is deliberate poisoning (84% of all hospitalizations for self-harm, followed by cutting with a sharp object or jumping from a height). (15) The Toxicological Information Centre (TIC) recorded 2607 cases of suicide attempts in 2018, 2256

(87%) cases were related to deliberate medication poisoning. Since 2008, the number of deliberate paracetamol poisonings has been increasing and is more prevalent in younger age groups, especially those aged 10–19 years. (16)

The Czech Republic has a **national action plan for suicide prevention** (https://www.reformapsychiatrie.cz/reforma/narodni-akcni-plan-prevence-sebevrazd-napps), which started in 2020 and lasts until 2030. It includes smart goals, delegated responsibilities and budget and regular monitoring.

In-person psychosocial/psychiatric crisis services (24/7) are available mostly in bigger cities. The **follow-up care after an emergency contact** (in both in- and outpatient services) is not standardised - the patient is referred to a mental health outpatient specialist, but it depends on availability of services and the will of the patient if the actual follow-up visit takes place. Regarding the **gatekeeper training**, there were several initiatives to train the general practitioners (GPs), but these were focused on the topic of mental illness in general. A few projects on gatekeeper training for teachers were also organised, but not in a systematic or standardised manner.

In the Czech Republic several **programs or services for the specific vulnerable groups** mentioned above exist, run mainly by NGOs, specifically: telephone helplines and online consultation services, crisis services and services providing care after discharge from hospitalisation for mental illness, community centres for vulnerable populations (LGBTQ+, people with mental illness, elderly, youth, men) and social services for those discharged from prison.

With reference to **postvention services** there are supportive/psychotherapeutic groups for bereaved, NGOs that work with individuals, families or schools. Unfortunately, their capacities are low and they are mainly established in the capital city. There is also an association that specialises in working with individuals (individual psychotherapy/counselling/guiding).

Regarding the **restriction of means of suicide** Czechia has standards on weapon security and constructional measures but no standards or norms for traffic and prescription practice regulation. Regarding **weapon security**, the procedure of getting a gun licence in Czechia is defined by law. The age limit is 18 (sports and hunting purposes) and 21 (collecting purposes, work purposes, life, health and property protection purposes). The licence is valid for 10 years, but the length might be reduced based on the health status of the applicant. A medical examination by GP (who might ask for further examination by other health care specialists, incl. clinical psychologist) is mandatory, while the specific health states (diagnoses) prohibiting getting the gun licence are defined by a specific bill. When using a weapon at work (e.g. in case of police) the weapon holder is examined once per 30 months. One also has to pass an expertise test secured by the Police of the Czech Republic. Regarding the **constructional measures**, there are some preventing a fall from height (e.g. at Nusle bridge).

Concerning the **collaboration with media**, there exist a media guide that also gives instruction and shows a good practice in suicide reporting but it is not a binding document.

In Czechia there is no regularly updated inventory on current projects on suicide prevention.

2.2 Needs Assessment (NA)

NA for Czechia consisted of the following steps: a) critically reviewing results of SA, b) critically reviewing available materials including research articles, reports, and policy documents, c) discussing with national advisory board and d) reflecting on funding opportunities.

Table 5: SWOT Analysis

Factor	Contents					
Strengths	Reliable data on suicide and self-harm	National Action Plan for Suicide Prevention 2020-2030	Established partnerships with key stakeholders	Established system of crisis services (telephone hotlines, crisis psychiatric care)		
Weaknesses	Data on suicide and self-harm for calendar year available only in July of the following year	No services for some of the vulnerable groups (e.g. those bereaved due to suicide)	A low awareness of the general public, negative attitudes even of professionals in the mental health field	Lack of human resources (especially in child and adolescent mental health care)		
Opportunities	JA ImpleMENTAL (networking with international experts in the field, providing training for Czech practitioners, advocating)	Awareness raising (topics of suicide and self-harm are attractive, yet shrouded in mystery; during pandemics there was an increased interest in the topic)	Untapped motivation and willingness to help of community of those who lost their loved-one due to suicide	New website on suicide and self-harm, which could be used in many ways - advocating for the topic, raising awareness etc.	Available funding for piloting of some of the activities included in the Action Plan	Key stakeholders are willing to collaborate
Threats	Stigmatisation of individuals with mental illness and of those who self-harm themselves or those with history of suicidal behaviour	Lack of funding for suicide prevention specifically and for provision of mental health care in general	Threat of a policy cycle (e.g. losing a support of key stakeholders)	Further reductions in human resources availability		

Table 5 summarises results of a SWOT analysis. In terms of **strengths and weaknesses**, some of suicide prevention activities in Czechia are anchored in the National Action Plan for Suicide Prevention 2020-2030 (NAPSP 2020-2030). During the phase of preparation and in the first two years of implementation, partnerships with important stakeholders were established. Planning and evaluation of NAPSP is based on reliable national data. Yearly data are, however, released only in the mid-year of the following year. Suicide prevention is historically provided by crisis services such as hotlines or crisis psychiatric care. Still, some of the vulnerable groups are not targeted by any service, for instance those bereaved by suicide. The Czech society has generally low awareness of the topics of suicide and self-harm, which cause many problems (e.g. self-stigmatisation, low help-seeking). Furthermore, Czechia is facing a lack of human resources especially in services delivering psychosocial help for children and adolescents.

JA ImpleMENTAL is a very important project in terms of **opportunities** as it provides several options to link with experts in the field. Newly established website on suicide and self-harm (www.sebevrazdy.cz) providing reliable and evidence-based information is a great way how to raise awareness. Finally,

funding is current available for piloting some of the activities listed in the NAPSP (e.g. piloting some services for those bereaved due to suicide).

However, there are several **threats**, which might close the open window of opportunity, lower the strengths or support the weaknesses. As Czechia is facing unprecedented inflation, financial resources can become scarce also for mental health care and other important services (social services, telephone helplines etc.). Furthermore, Czech psychiatrists are ageing and there is a risk of further decrease of their number. Also, the policy cycle is an ever-present threat as change in political representation can lead to lower support for specific topics. Finally, stigmatisation is another ever-present threat, which is not expected to disappear any soon.

3 Reflection on SANA results

In order to prevent self-harm and suicide among general population (above-average compared to EU) and specific vulnerable groups (see Box 2), it is necessary to:

- Implement activities included in NAPSP. Activities focused on raising awareness, increasing help-seeking and providing timely identification of individuals at risk should be prioritised.
- Training aimed at increasing practical skills and raising awareness among key professions (GPs, social workers, nurses, teachers etc.) should be implemented.
- Open windows of opportunities should be used (e.g. collaboration with national railway operator and piloting interventions on railway hotspots).
- Advocating for increasing capacities of currently lacking services (e.g. child psychiatry).
- Inform the formulation of the measures by the best available evidence (available data/consultations with stakeholders, international experiences) and monitor implementation.
- In all activities and at all stages, people with lived experience must be involved.

Success factors/facilitators

- JA ImpleMENTAL trainings and linking them with local experts and stakeholders in order to build bilateral collaborations
- Provide guidelines for professions which might get in the contact with vulnerable individuals and embed them in the existing institutional framework
- Actively reflecting needs of the patients
- Using opened windows of opportunity
- Actively involving key stakeholders and strengthening professional bonds with them
- Preferring evidence-based interventions with low costs and high adaptability to different contexts

Barriers

- Problematic social and healthcare frontier. Insufficient collaboration between the Ministry of Health and the Ministry of Labour and Social Affairs.
- Lack of interdisciplinary collaboration
- Lack of funding, lack of human resources
- Interventions with high costs, low adaptability, not reflecting patient needs
- Not reflecting the actual priorities of the system
- Not reflecting window of opportunities
- Policy cycle, stigmatisation, lack of human resources, lack of funding

Box 3. Prioritized measures for implementation according to the SUPRA columns

Coordination and organization (column 1)

- Revision of the existing strategy (National Action Plan for Suicide prevention 2020-2030)
- Work on becoming a reliable member of international suicide prevention networks (IASP, EAAD, WHO).

Support and treatment (column 2)

- Making postvention for railway personnel available analysing existing postventions systems in different railway companies, designing appropriate measures and piloting
- Piloting support groups for individuals bereaved by suicide (PRESEB project)
- Piloting multi level intervention for increasing continuity of care for high risk individuals (PRESEB project)
- **QUICK WIN:** Guidelines for teachers on suicidal behaviour in school setting

Restriction of means (column 3)

- Identifying and securing hotspots

Awareness raising and knowledge (column 4)

- Prepare and launching the website (+ social media accounts) providing accurate information for people in risk of suicides and their peers, incl. info on where to seek help
- Education of railway personnel
- Piloting series of trainings for different target groups e.g. school personnel, GPs, social workers, etc. (PRESEB project)
- **QUICK WIN:** Maintain the website sebevrazdy.cz and keep the social media accounts active
- **QUICK WIN:** Papageno prize (Responsible reports of suicide in the media)

Quality assurance and expertise (column 6)

- Prepare regular annual report on suicide and self-harm together with Institute for Health Information and Statistics and use it for awareness raising and advocation among national relevant stakeholders.

! **Quick wins** - easy to implement actions; not expensive, within the control of the team, have visible effects and an impact on high risk groups

4 Next steps

Next steps mentioned below are planned for years 2023 and 2024 and will facilitate preparation and implementation of some of the prioritized measures mentioned above in Box 2. Most of them are already initiated and collaboration with key partners and stakeholders are ongoing.

To prepare PRESEB project for call of Ministry of Labour and Social Affairs, while collaborating with key stakeholders. This project aims to pilot measures included in NAPSP:

- Support groups for those bereaved by suicide
- Piloting series of trainings for different target groups e.g. school personnel, GPs, social workers, etc.
- Piloting multi level intervention for increasing continuity of care for high risk individuals

To further collaborate with national railway operator in order to prepare interventions on railways.

To prepare regular annual report on suicide and self-harm together with Institute for Health Information and Statistics and use it for awareness raising and advocation among national relevant stakeholders.

To use social media and website www.sebevrazdy.cz (meaning *suicides* in Czech) for raising awareness and dissemination of information on where to seek help.

To work on becoming a reliable member of international suicide-pr. networks (IASP, EAAD, WHO).

To monitor mental health including the risk of suicidal behaviour of six-graders.

To revise the existing strategy (National Action Plan for Suicide prevention 2020-2030)

5 References

(1) Eurostat. *Population on 1 January by age and sex*. 2021a. Retrieved January 29, 2023, from https://ec.europa.eu/eurostat/databrowser/view/DEMO_PJAN__custom_2986693/default/table?lang=en

(2) Eurostat. *Healthy life expectancy based on self-perceived health*. 2020a. Retrieved January 29, 2023, from https://ec.europa.eu/eurostat/databrowser/view/hlth_silc_17/default/table?lang=en

(3) Eurostat. People at risk of poverty or social exclusion. 2021b. Retrieved January 30, 2023, from https://ec.europa.eu/eurostat/databrowser/view/sdg_01_10/default/table?lang=en

(4) Eurostat. Gini coefficient of equivalised disposable income - EU-SILC survey. 2021c. Retrieved January 30, 2023, from https://ec.europa.eu/eurostat/databrowser/view/ilc_di12/default/table?lang=en

(5) Eurostat. *Total health care expenditure*. 2020b. Retrieved January 29, 2023, from https://ec.europa.eu/eurostat/databrowser/view/tps00207/default/table?lang=en

(6) WHO. Mental Health Atlas Country Profile: Czech Republic. 2017. Retrieved January 29, 2023, from https://cdn.who.int/media/docs/default-source/mental-health/mental-health-atlas-2017-country-profiles/cze.pdf?sfvrsn=c2747763_1&download=true

(7) BROULIKOVA, Hana M.; DLOUHY, Martin; WINKLER, Petr. Expenditures on mental health care in the Czech Republic in 2015. *Psychiatric Quarterly*, 2020, 91.1: 113-125.

(8) PATEL, Vikram, et al. The Lancet Commission on global mental health and sustainable development. *The lancet*, 2018, 392.10157: 1553-1598

(9) KRUPCHANKA, Dzmitry; WINKLER, Petr. State of mental healthcare systems in Eastern Europe: do we really understand what is going on?. *BJPsych international*, 2016, 13.4: 96-99.

(10) WHO. Mental Health Atlas Country Profile: Czechia. 2020. Retrieved January 29, 2023, from https://www.who.int/publications/m/item/mental-health-atlas-cze-2020-country-profile

(11) OECD. Unmet needs for health care: Comparing approaches and results from international surveys. 2020. Retrieved January 28, 2023, from https://www.oecd.org/health/health-systems/Unmet-Needs-for-Health-Care-Brief-2020.pdf.

(12) CZSO. *Zemřelí podle seznamu příčin smrti, pohlaví a věku v ČR, v krajích a okresech - 2012-2021.* 2021. Retrieved January 29, 2023, from https://www.czso.cz/csu/czso/ceska-republika-podle-pohlavi-a-veku-20122021

(13) CZSO. *Zemřelí podle seznamu příčin smrti, pohlaví a věku v ČR, v krajích a okresech - 2009-2018.* 2019. Retrieved January 29, 2023, from https://www.czso.cz/csu/czso/zemreli-podle-seznamu-pricin-smrti-pohlavi-a-veku-v-cr-krajich-a-okresech-lv8io6up9t

(14) WINKLER, P., MLADÁ, K., CSÉMY, L., NECHANSKÁ, B., & HÖSCHL, C. Suicides following inpatient psychiatric hospitalization: a nationwide case control study. *Journal of affective disorders*, 2015, 184, 164-169.

(15) IHIS. Národní registr hospitalizovaných. 2019. Retrieved January 30, 2023, from https://www.uzis.cz/index.php?pg=registry-sber-dat--narodni-zdravotni-registry--narodni-registr-hospitalizovanych

(16) TIC. Toxicological Information Center. Department of Occupational Medicine. General University Hospital in Prague. Retrieved January 30, 2023, from https://www.vfn.cz/en/pacienti/kliniky-ustavy/klinika-pracovniho-lekarstvi/toxikologicke-informacni-stredisko/

(17) CZSO. *Sebevraždy v České republice – 2011-2020*. 2021. Retrieved January 30, 2023, from https://www.czso.cz/csu/czso/sebevrazdy-v-ceske-republice-2011-az-2020

6 Corresponding authors

ALEXANDR KASAL
Head of the working group on Suicide research and prevention
National Institute of Mental Health
Topolová 748, Klecany
Email: alexandr.kasal@nudz.cz
www.nudz.cz/en/

EVA TUŠKOVÁ
JA ImpleMENTAL project coordinator for Czechia
Ministry of Health of the Czech Republic
Palackého nám. 375, Prague 2
Email: eva.tuskova@mzcr.cz
www.mzcr.cz