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Original research article

Referring clients to mental health centres after discharge from a psychiatric hospital

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Abstract
The study focuses on the use of follow-up social services by psychiatric patients following their discharge from a psychiatric hospital. The content solely addresses the issue of client referrals to mental health centres ("MHCs") in the Moravian-Silesian Region after discharge from the Psychiatric Hospital in Opava.

The research aims to determine why follow-up social services are underused by individuals discharged from a psychiatric hospital, which factors primarily lead to the unsuccessful follow-up of the patient to an MHC after hospitalisation in a mental health facility, and the main reasons for rehospitalisation of persons with mental health challenges from a community MHC back into a psychiatric hospital. The study is based primarily on information from the internal patient database at the Psychiatric Hospital in Opava for 2023, and on field research in MHCs in the Moravian-Silesian Region – in which interviews with MHC staff and questionnaire surveys with clients of these organisations were conducted.

The research survey findings identify gaps in the referring of clients to the MHC, which may include, for example, a client's failure to be within a target group, inadequate health condition, a client's lack of cooperation with the referred MHC, or lack of support of the client's family in the process of service referral. The capacity of mental health centres and regional differences in the availability of these services are also important constraints.

Keywords: Mental health centres; Multi-disciplinarity; Psychiatric hospital; Rehospitalisation; Social service referral

Introduction

The issue of follow-up care for patients with mental health challenges after discharge from a psychiatric hospital (PH) has become quite topical in the Czech Republic. Psychiatric care reform is a key step towards the modernisation of psychiatric services, inspired by psychiatric care in Western European countries. The transformation process involves not only psychiatric hospitals, which have been associated with the Czech psychiatric care reform since 2013 (Lidinská and Petr, 2017), but also other organisations that offer their services to psychiatric patients or clients as follow-up care. Mental health centres ("MHCs") have become the main instruments of psychiatric care reform in the Czech Republic. Since 2017, these have been operating as community centres that provide multidisciplinary care, including diagnosis, treatment, and crisis intervention, as well as fostering social inclusion. MHCs link health and social services and are an innovative approach aiming to facilitate the transition of patients after discharge from a psychiatric hospital to their home environment. Thus they are an important instrument for deinstitutionalisation of mental health care, aiming to prevent readmission, reduce the length of stay in psychiatric hospitals, and integrate people with mental illness back into the community at large (A short guide to psychiatric care reform, 2017).

MHCs work with an array of other services, such as psychiatric outpatient clinics, general practitioners, specialist doctors, inpatient facilities, follow-up social services, public guardians, and state and local authorities. They also play an indispensable role in regional working groups aimed at building and coordinating a network of services for people with mental illness. This broad collaboration of MHCs ensures comprehensive care for patients/clients with mental illness, including crisis intervention, community-based therapy, reduced relapse rates, and psychiatric hospital admissions. Another benefit of an MHC is supporting patients/clients in securing stable housing and sustainable employment. MHC services are provided free of charge – health care is covered by public health insurance, while social services are financed by the European Social Fund, through the Operational Programme Employment, the state budget of the Czech Republic and regional budgets. An MHC is not intended to replace the Integrated Rescue System (IRS) or home care services. According to the Alliance of Mental Health Centers (2025), there are 37 MHCs in the Czech Republic. Their distribution is uneven, which not only limits

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access to these services in selected regions but may also reduce the efficiency of care and the availability of MHC services.

The MHC target group includes individuals with Serious Mental Illness (SMI), with a diagnostic spectrum of F2 and F3 diagnoses (possibly F42, F60.0, F60.1, F60.3, F6.5, F60.6, F61, F62), a condition lasting longer than two years, a functional impairment of below 60 according to the Global Assessment of Functioning ("GAF") scale, and a need for early intervention (Ministry of Health of the Czech Republic, 2021).

MHCs are not explicitly established as a separate legal entity in Czech legislation; their functioning is based on the legal framework of health and social services, on the border of which they also function. MHCs link health and social services in line with the legislation in force, originally Act No. 372/2011 Coll., on Health Services, and Act No. 108/2006 Coll., on Social Services. Both statutes have recently been amended by Act No. 240/2024 Coll. and Act No. 164/2024 Coll. The changes concern the regulation and development of MHCs in the Czech Republic.

Despite the fact that the transformation of psychiatric care has been underway for more than 10 years, it still faces a number of obstacles, such as limited capacity of MHCs, regional differences in the availability of services, and/or the need to ensure the continuity of health and social care (Winkler et al., 2013).

In relation to the above, the submitted paper focuses on how follow-up social services –specifically MHC – are currently used after discharge from a psychiatric hospital. The research aims to analyse the main barriers and gaps in the current process of establishing MHC services after discharge from PH Opava, identify the main reasons for rehospitalisation of persons with mental illness from an MHC back to PH Opava, and analyse the key factors leading to the failure to connect the client with the MHC after the end of hospitalisation in PH Opava.

The theoretical background is based on the main principles of mental health care reform (Ministry of Health of the Czech Republic, 2020; Winkler et al., 2013), which aims to improve the overall approach to mental health treatment and the quality of life of patients with mental illness. The emphasis is on comprehensive and multidisciplinary care, which should be provided to individuals with mental illness on a continuous basis. Indeed, there are multiple problems in establishing social services after discharge from health care institutions, and these have been detailed by many authors. For example, in their study of interventions to improve the discharge of patients from acute inpatient to community care, Tyler et al. (2019) identify this transition period as a very vulnerable one, with many additional risks and potential anxieties. The experience of transition from hospital to community living is also described by O'Shea and Williams (2023), who emphasise the unmet psychosocial support needs during this period. In contrast, Hegedüs et al. (2020) evaluate the effectiveness of transitional interventions and the use of follow-up services after discharge from psychiatric inpatient care as positive. Priebe and Schmahl (2009) also identified a lack of regular communication and co-planning between the health and social care sectors. Thornicroft and Tansella (2010) point out that in many systems there is a lack of integration between health and social services. Patient information is often communicated incompletely or not at all. Priebe et al. (2005) also identified the lack of coordination of activities between hospitals and MHCs as a significant barrier represented by the low level of communication between inpatient facilities and community services. Pfeiffer (2014) also points to the lack of coordination between inpatient and community care, and indicates that a clear definition of responsibilities in the transition of patients to community services is often lacking. The study by Winkler et al. (2015), which maps psychiatric care reform in the Czech Republic, states that there is a lack of a uniform format for the information exchange between hospitals and community services. Gaps in data communication lead to problems in planning and implementing care in MHCs.

Probstová and Pěč (2014) also note the lack of integration between health and social care, indicating that practising social workers face problems in obtaining information because they have limited access to medical records. They identified that the lack of effective communication causes delays in the provision of follow-up care, which may have a negative impact on the patient. Also, Pfeiffer (2014) emphasises the need for a unified electronic system that links hospitals, MHCs, and other social services.

In terms of staff training, Probstová and Pěč (2014) recommend training health and social workers in effective communication and coordinated care. This should be implemented in regular training sessions focused on multidisciplinary collaboration.

Materials and methods

To achieve the above research objectives, a quantitative research strategy supplemented by qualitative interviews with MHC staff was used.

The quantitative research strategy included two separate phases. The first analysed data gathered from the Hippo information system operated by PH Opava. Written consent of the hospital director was obtained for data collection from the Hippo information system. The information from this system represented basic input data on 1,146 hospitalised persons in PH Opava, their gender, age, diagnoses, and the follow-up social services to which these patients were discharged after the end of hospitalization. The data were processed for patients 18+ from the Department of Psychosis Therapy for men and women and the Department of Acute Psychiatric Care, according to the SMI for 2023.

In the second phase of the quantitative research strategy, 45 MHC clients who entered this follow-up service after discharge from PH Opava were addressed. A short questionnaire survey was administered to the MHC respondents, focusing mainly on information that could not be retrieved from the Hippo information system. The questionnaire contained questions focused on the method of information about an offered follow-up social service, including a question on how long it took the person to enter the community social service. For the research, the current clients of three MHCs in the Moravian-Silesian Region to which the PH Opava refers its patients (at the time of the research, i.e., during 2024) were contacted.

The qualitative research strategy was designed for expert interviews, which were conducted with 9 staff of selected MHCs that PH Opava cooperates with. The communication partners were selected through intentional sampling via institutions. The interviews served to illustrate the current situation in the process of referring patients with mental illness to a particular social service after their discharge from PH Opava. The interviews were carried out in 2024, with 3 staff members from each MHCs being interviewed. Prior to the start of the interviews, data on the reasons for not admitting clients to their service in 2023 were collected from the MHCs.

Three different data collection techniques were applied in the presented research investigation. The Hippo information system and data from case files were used in secondary data analysis. This data was then recoded and analysed using the statistical software IBM SPSS Statistics, version 25.

As part of the quantitative research, a structured questionnaire survey was conducted among the clients of the selected MHCs. This contained a few closed and open-ended questions so that it could be easily understood by the target population. Identification questions are embedded at the beginning of the questionnaire, followed by substantive, polytomous questions, with the option of only marking a single response.

As part of the qualitative strategy, interviews with experts were conducted through a semi-structured interview designed in relation to the set objectives and theoretical framework of the research. The interview included open-ended questions to elicit the worker's personal experience with the process of referring patients with mental illness to this service after discharge from PH Opava. The interviews were recorded on a tape recorder and transcribed verbatim.

All research strategies implemented as part of the presented investigation followed the 1964 Helsinki Declaration and its amendments and ethical principles that are in line with the American Psychological Association in research with human subjects (Campbell et al., 2010). All research data has been processed in accordance with Act No. 110/2019 Coll., on Processing of Personal Data. All personal data have been anonymised, informed consent was provided by communication partners, and measures were taken to ensure confidentiality of the information obtained.

As part of the quantitative questionnaire survey administered to MHC clients, a proposal was submitted to the Ethics Committee for Research of the Faculty of Social Studies, University of Ostrava, for approval to implement this research with a vulnerable target group (in this case, people with mental illness). The application for approval of this research was submitted to the Ethics Committee at its meeting on 15 March 2024, where it was subsequently approved under No.: OU-27269/20-2024.

Multiple analytical tools and statistical methods were used in the project. Univariate and bivariate data analysis was used to analyse data from the Hippo information system used in PH Opava, as well as to process data from a questionnaire survey among clients of selected MHCs. To test hypotheses, appropriate statistical tests were used depending on the input variables: the Pearson chi-square test of independence, the Mann–Whitney test, the two-sample *t*-test, and analysis of variance. The significance level for all tests was set at $\alpha = 0.05$. Analysis of qualitative data was conducted using thematic analysis by Braun and Clarke (2006). Following transcription of the interviews, we carried out open coding, identification and categorisation of codes into major themes using an inductive approach. The themes were further reviewed and interpreted with regard to their patterns of meaning, including a revision of the outputs with communication partners.

Results

A substantial part of the research consisted of an analysis of information on PH patients in Opava for 2023 from the Hippo information system. For these patients it was also investigated which social services these patients were linked to after discharge from PH Opava. Of the 1,146 patients who were hospitalised in PH Opava in 2023, 50.3% were men and 49.7% women. The patients' age in Opava ranged from 18 to 99 years. The average age of all patients in 2023 was 53.3 years; 75% of all patients were under 72 years of age in 2023, and 90% of all patients were under 82 years of age. A total of 45 patients died in 2023 in PH Opava. The patients were most frequently admitted to the open acute care ward (12.7%, 145 persons), the closed women's ward (8.6%, 99 persons), the geriatric psychiatry ward (admission 7.2%, 83 persons), and the inpatient ward (6.8%, 78 persons). The most frequent diagnoses in PH Opava were: F03 – unspecified dementia, suffered by a total of 30.2% (346 patients), and F200 – paranoid schizophrenia, suffered by a total of 29.1% (334 patients). Other diagnoses comprised less than 7% (Chart 1).

The Hippo database also tracks how long PH patients are hospitalised in Opava. From the beginning of their first hospitalisation until the end of 2023, this duration ranges from 1 day to 8,185 days, which corresponds to approx. 22.5 years of life. However, there is only one patient with such a long hospitalization period, most of the PH patients in Opava have been hospitalised for no longer than 1 year. The average number of days of total hospitalisation in Opava is 146 days, but most often patients stay there for one month. Exactly 50% of patients are hospitalised in the Opava hospital for up to two months, 75% of all patients are hospitalised for a maximum of 117 days, and 90% of all patients are hospitalised for a maximum of 274 days (Chart 2).

The collected data also raises the question of how many times in total a given PH patient is hospitalised in Opava. From the beginning of the first hospitalisation in PH Opava until the end of 2023, the minimum number of hospitalisations is 1×, but the maximum number of hospitalisations per person is 79×. On average, a PH patient in Opava was hospitalised 7× in total, but most often just once. Exactly 50% of patients were hospitalised 3× or less, 75% of all patients were hospitalised a maximum of 9× in their lifetime, and 90% of all patients were hospitalised a maximum of 19×. Only a small number of people have been hospitalized more than 22 times in PH Opava. During 2023, the majority of patients – 80.5% (922 persons) were hospitalized only once. The second most common number of hospital admission are two hospitalisations per year, i.e., 15% of patients in 2023 (172 persons) and three hospitalisations in 2023, i.e., a total of 2.8% of patients (32 persons). With each additional hospitalisation within one year, the number of patients significantly drops to a very small number of persons.

In the search for dependencies between the above-observed patient characteristics, a statistically significant dependency was verified at a 5% significance level (for all the above statistical tests, the significance level was set to Sig. = 0.000) between the gender and the patient diagnosis, whereby statistically significantly more women (206 persons) than men (140 persons) suffer from unspecified dementia in PH Opava, compared to paranoid schizophrenia, which is diagnosed statistically significantly more often in men (231 persons) than women (103 persons). It was also verified that the diagnosis was related to the patient's age. The mean age for unspecified dementia is 76.7, whereas for paranoid schizophrenia it is 40.

It was also verified that there is a statistically significant relationship between the gender and the total number of hospitalisation days in PH Opava in 2023. It was demonstrated that the duration of hospital admission was longer for men (190 days on average) than for women (100 days on average). It was also verified that the age of patients influenced the total number of days of hospitalisation in 2023. For one or two hospitalisations in 2023, the average age is 54 and 51 years

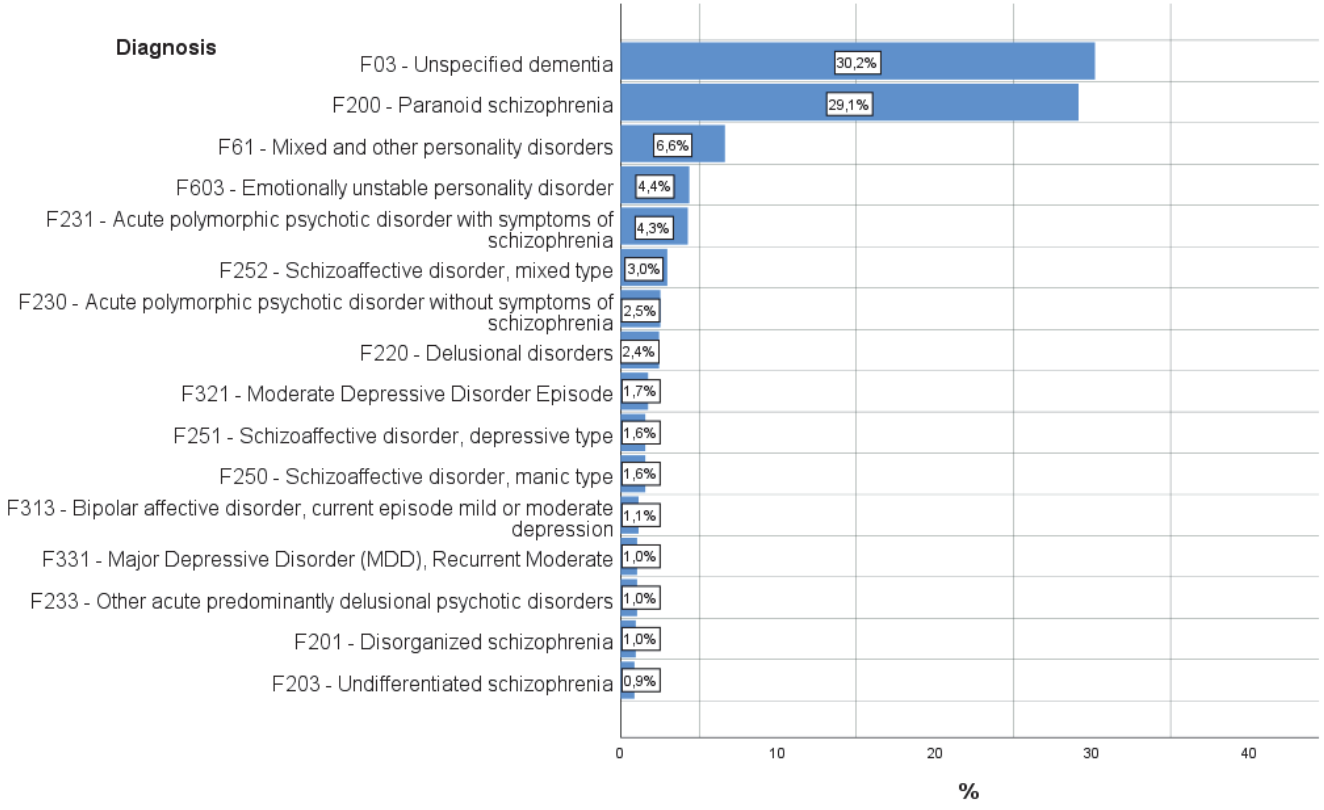

Chart 1. Diagnoses of PH patients in Opava in 2023 (in %)

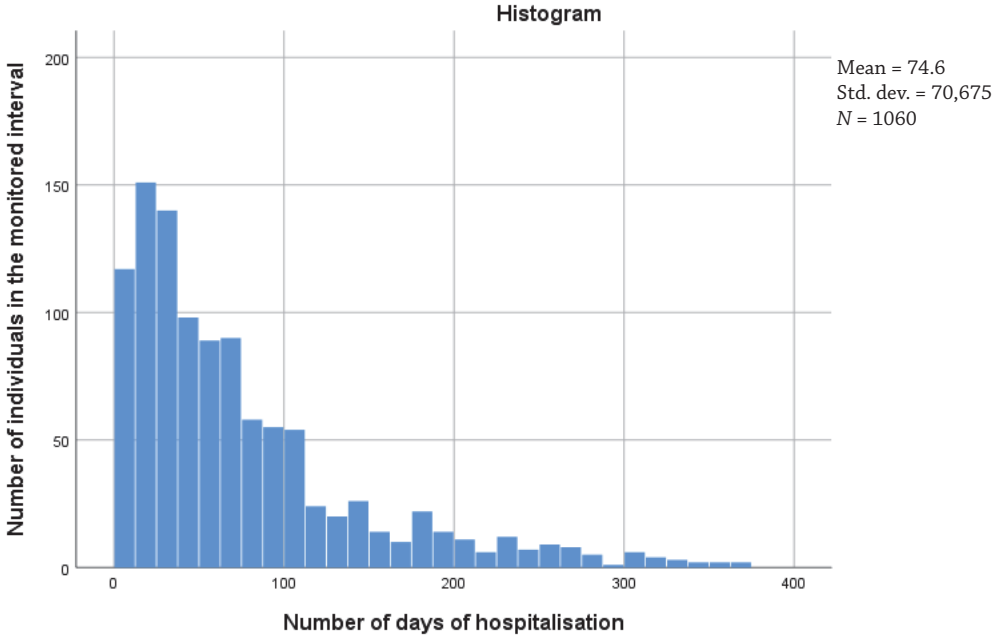

Chart 2. Number of days of total hospitalisation in PH Opava by the end of 2023 (the chart is limited to one year for clarity, which includes 92.5% of all patients)

respectively, whereas the average age of patients decreases as the number of hospitalisations increases. For example, in 2023, one person was hospitalized in PH Opava a maximum of 13 times. The age of this person was 19 years. For 4 to 5 hospitalisations per year in 2023, the average age was approx. 35. The total number of days of hospitalisation in 2023 was also dependent on the patient's diagnosis. It has been confirmed that the diagnosis that requires multiple hospitalisations is F316 – Bipolar affective disorder, currently mixed phase. This condition required an average of 3 hospitalisations per year. Two hospitalisations per year were required for F202, F209, F258, F317, F61, F201, F323, F319, F320, and F601. Other diagnoses do not require more frequent hospitalisations within one year.

In 2023, PH Opava referred more than half of its discharged patients (54.3%, 622 persons) to a total of 112 different social services and organisations, of which the three MHCs in the Moravian-Silesian Region and the Silesian Diakonia RÚT in a town of Nový Jičín were the most frequently represented (Chart 3). Almost half of the PH patients in Opava (45.7%, 524 persons) were not discharged in 2023, or were discharged without being referred to any further services.

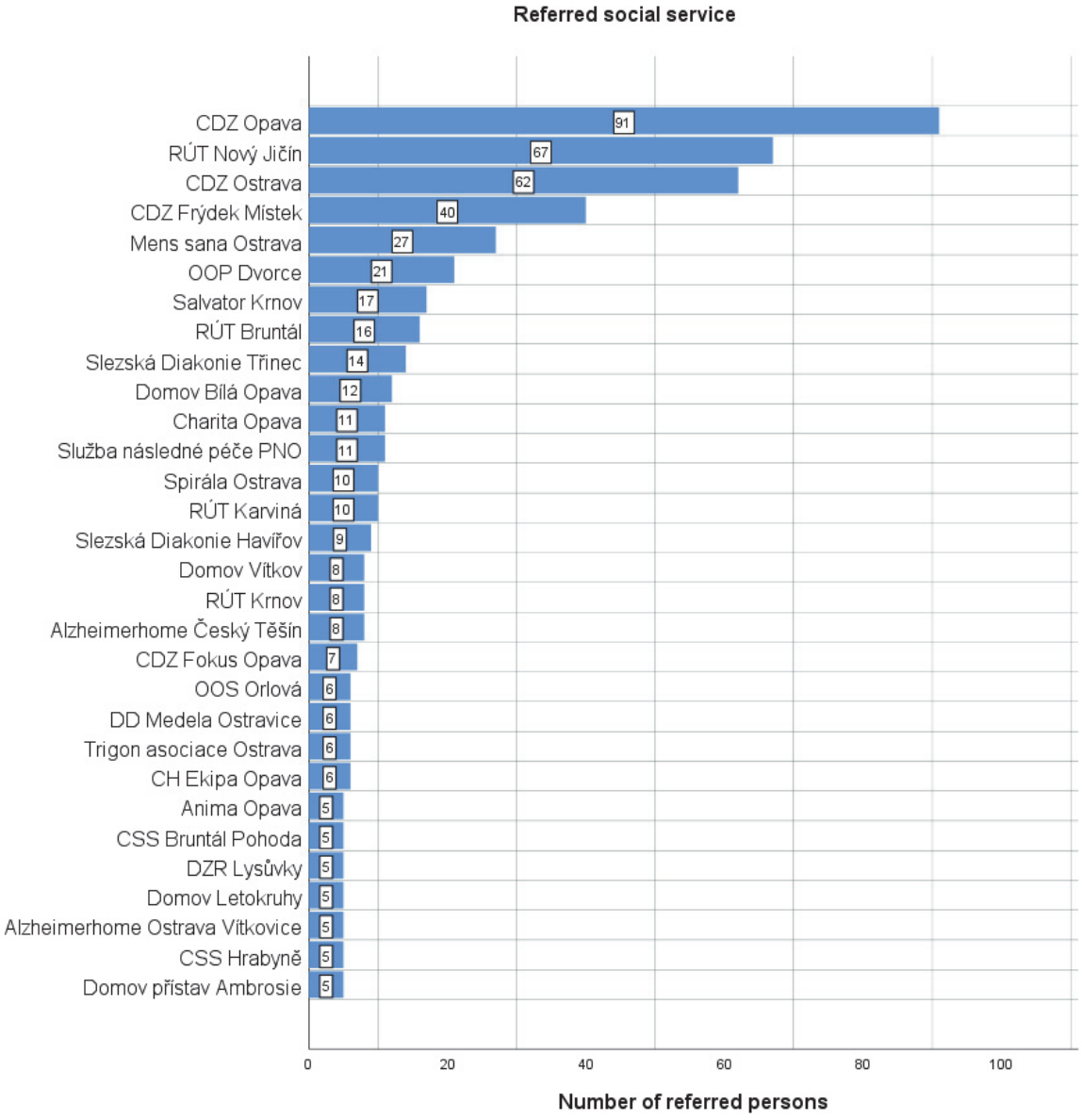

Chart 3. Referred social services after discharge from PH Opava in 2023 (number of referred persons)

Looking closely at the factors associated with service follow-up, the dependence on patient age was confirmed. However, the dependence on gender was not demonstrated. The average age at referral to older adult homes, hospices, Alzheimer centres, or long-term care facilities is approximately 80 years. The average age at referral to MHC is approximately 40 years, and to the Salvation Army and/or Renarkon community approximately 30 years.

If we focus on individual MHCs to which patients were referred from PH Opava in 2023, the importance of geographical proximity and service catchment area became apparent. In 2023, most patients were referred to the MHC in Opava (14.6% of patients, 91 persons), then to MHC in Ostrava (10% of patients, 62 persons), and finally to MHC Frýdek-Místek (6.4% of patients, 40 persons). Service referral involves approaching the patient to determine his/her interest in the service, contacting the MHC, and arranging the patient's first meeting with an MHC worker while the patient is still hospitalised. However, a follow-up survey in individual MHCs in the Moravian-Silesian Region found that only a very small percentage of those initially referred to an MHC service after discharge from hospital eventually used the service. In the MHC in Opava, it was found that of the 91 people who were previously referred from the PN in Opava, only 60 visited the service after discharge, and only 33 began to use the service (the success rate of referral is approx. 36%). Similar values were observed in MHC Frýdek-Místek, where out of 40 persons referred from PH Opava, only 15 visited an MHC after discharge, and only 8 of these actually started to use the service (the success rate of referral is 20%). Data on actual service use are not available for MHC Ostrava, but after discharge from PH Opava, 60 people out of 62 initially referred patients visited the MHC service. The most consistently listed reasons of MCHs for not accepting a client to a given MHC were the failure to qualify for a target group for which the MHC services are intended (this constitutes approx. 50% of the reasons), inadequate health condition of the potential service client (approx. 20% of the reasons), and service termination due to lack of cooperation with the client (approx. 20% of the reasons). Very rare reasons included a client from a non-catchment area (approx. 2% of the reasons), and/or a case where the client required services other than those the MHCs offer.

Based on this information, it was found that each MHC organisation has its own specific client file-recording method, including entering reasons for admission/non-admission into the client's records. This inconsistency neither allowed for a mutual comparison of the three MHCs in the Moravian-Silesian Region, nor for an overall unification of the results found in the specific MHC organisations. To supplement the results, a questionnaire survey was also administered to clients in each MHC, which helped to illustrate the referral process of MHC services after discharge from PH Opava.

A total of 45 MHC clients, approximately one-third from each organisation, participated in the survey. The respondents were half male (48.9%, 22 persons) and half female (51.1%, 23 persons), aged between 18 and 56. They utilised an MHC service most often for more than 1 year (42.2%, 19 persons), and usually once a week (37.8%, 17 persons), or once every 2 weeks (28.9%, 13 persons). A total of 79.5% of respondents (35 persons) reported using an MHC service for the first time, with only 8 persons having used it before. Almost all the clients were definitely satisfied with the MHC service (72.7%, 32 persons) or quite satisfied (20.5%, 9 persons). Most of all, clients appreciate the staff's interest, willingness, friendly approach to the client, support, or all of the above listed. The only downsides clients mentioned were not enough time for the service and its poor availability. Usually, MHC clients learned about the service from either PH Opava (40.9%, 18 persons) or from their psychiatrist (27.3%, 12 persons). Almost half of the clients (48.9%, 22 persons) were hesitant whether to enter the MHC service at all (most often for one month or for one week). However, a total of 62.3% (28 persons) of all clients surveyed had no idea what they would do after leaving MHC services, or whether they would continue with any other service.

Interviews with MHC staff illustrate and clarify information that is not available from the MHC's internal systems. Staff were asked 11 questions about the client referral process at PH Opava, which was described by all MHC staff as functional, efficient, and well set up. Contact with patients is often established during hospitalisation, where the situation mapping and communication between medical and social care staff takes place on an individual level. However, the participating MHC staff would like to see more awareness of MHCs and suggest, for example, training for the hospital staff.

The process of information exchange between MHCs and PH Opava was difficult at the beginning but is now perceived as smooth. Problems remain in the transfer of health care information; social workers cannot work with this directly, and thus they would welcome better cooperation with the hospital's health and social workers.

Regarding reasons for early termination of services, communication partners mainly agreed on poor cooperation with the client and failure to take medication, which can lead to hospital re-admissions and unwillingness to continue cooperation with the MHC. This reluctance is also evident on admission to the MHC, with approximately 20% of patients not attending the service at all after discharge from hospital despite initial contact with the MHC. They no longer answer the phone or attend their appointments after hospital discharge. Other reasons for non-attendance at MHCs may be lack of motivation and fear of participating in treatment, change of residence, lack of interest in MHC services, or problems with the patient's insight into their own illness. Often there are public transport phobias, which prevent clients from traveling to MHC. The involvement of peer workers in MHC could help during the follow-up process, when personal experience of the disease and cooperation with MHC can be passed on to the patient. Regular contact of peer workers and patients during hospitalisation in PH Opava would ensure sufficient provision of information about the service itself.

Regarding reasons for readmission to PH Opava, research participants agreed on the skipping of medication, deterioration of the patient's mental state, lack of insight into the illness, active substance abuse, stressful family situation, or loss of employment. The patients' failure to complete the treatment, early hospital discharge, lack of sheltered housing, and the existence of patients with a dual diagnosis (which is often associated with severe mental illness) were also listed. In searching for options that could prevent rehospitalisation, MHC staff agree that more residential services and available sheltered housing or other type of supported housing, such as aftercare, could help, but even then, a health care worker is missing on the team. Intrinsic motivation of clients, visits to self-help groups, and more family support are also important.

All interviewees had a clear idea of cases where a patient discharged from hospital would not be admitted to their service even if they were interested. The main reasons include failure to meet the target group criteria, substance abuse, aggressive behaviour, or lack of client cooperation.

According to the interviewed communication partners, communication between the staff involved in the treatment process at PH Opava, the establishment of a referral to an MHC service, and the correct setup of these work relationships is crucial for the successful establishment of cooperation with a client discharged from PH Opava. Also important is the space where the first communication takes place, in accordance with the patient's current state of health. Repeated visits to the hospital at different stages of the patient's illness contribute to this and help to develop a better understanding of the patient's needs. Family support and client motivation is also essential. Overall, however, all interviewees agree that poor communication and lack of awareness are factors that can complicate cooperation. Without good communication and the right relationship between the patient, family, and institutions, it is difficult to achieve a successful discharge and continuation of treatment.

Discussion

In the context of psychiatric care reform and the associated process of patient transition from psychiatric hospital to follow-up social services, there is a need to optimise the processes of referral and cooperation between institutions, even though the referral process of patients to MHC services during their hospitalisation is perceived as effective in this study. According to a study by O'Shea and Williams (2023), factors associated with positive experiences of transition from hospital to follow-up services include detailed planning, individualised care, and a gradual transition to follow-up services to alleviate concerns about safety, support, and coping with this stressful situation. Mutual communication and sharing of patient information is therefore an important factor for successful cooperation, which is in agreement with Probstová and Pěč (2014). Yet there is still room for improvement, particularly in terms of expanding awareness of MHC services among the broader public and healthcare staff. Priebe et al. (2005) also mention barriers or gaps in communication between hospitals and community services. MHC social workers face challenges in terms of accessing up-to-date patient information, which complicates the provision of effective care. This problem can be addressed by increasing coordination between health and social care facilities, for example, through digital platforms for data sharing and the establishment of regular feedback systems between institutions. The study by Winkler et al. (2015) confirms that there is no unified format for information transfer between hospitals and community services. Thornicroft (2010) mentions the lack of integration between health and social care services, with information often being passed on incompletely or not at all. Probstová and Pěč (2014) also reported that in practice social workers encountered problems in obtaining information because they have limited access to medical records.

Practitioners cite premature termination of treatment and insufficient capacity in sheltered housing as two of the most common reasons for rehospitalisation. According to Pipeková et al. (2014), sheltered housing, together with outreach services such as independent living support and personal assistance, are among the most modern forms of social services. Other limitations for establishing a service in MHCs include insufficient diagnoses of the potential client, and the catchment area of the service or its availability – which is also confirmed by Winkler et al. (2013). The interviews and data collected have shown that the provision of MHC services is also limited by the current legislation (Bulletin 8/2021), lack of the establishment of health-social demarcations in the legislation, or the different funding of the social and health services. Thornicroft (2011) notes that people with mental illness have lower social adaptation than people without the illness. They are therefore more dependent on their primary relationships and family support is a very strong factor – which is also noted in this research. Holá et al. (2021) also state that the involvement of family members in the care of people with mental illness is quite crucial. Emotional support and help from family members can significantly facilitate the transition to follow-up services, whereas family conflicts, disputes, or negative family attitudes toward institutional help can complicate the process. The role of the family's economic condition is also important and may influence the availability and motivation of patients leaving hospital care when deciding whether to enter MHC services.

The data also shows that the most common reason for not being accepted into MHC services is not qualifying within a target group. Primarily, MHCs are aimed at the SMI target group. However, one of the criteria for MHC care is also persons at risk of SMI. The health part of the MHC service is governed by Bulletin 8/2021; acceptance for the service is decided by a physician based on an initial examination. If a client does not meet the target group identified for MHCs support, he/she is not admitted to MHCs services and he/she is referred to other services in the region (Ministry of Health of the Czech Republic, 2021).

The primary limitations of this study are its focus on only one type of follow-up MHC service, which may limit the applicability of the results to other services or contexts. The research on MHC clients and interviews with MHC service staff were carried out on a limited scale, which does not allow for generalisation of the findings. Although the qualitative approach and methods used made it possible to understand the experiences of research participants, the possibility of alternative interpretations cannot be entirely ruled out. The temporal and spatial constraints of the study were also a significant limitation, as they did not allow for greater involvement of respondents in the research and may have influenced their views on the effectiveness of MHC services due to their uneven regional availability.

Conclusion

The paper aims to clarify the process of follow-up social services after discharge from health care facilities, specifically in PH Opava and MHCs in the Moravian-Silesian Region. The research was based on input data on patients of PH Opava, a questionnaire survey with clients of MHCs, and interviews with MHC staff. The intent of the text was to shed light on the main barriers and gaps in the process of linking clients to the service and to convey the direct experiences of both MHC staff and clients with this process.

The research revealed that only one third of clients who were referred to the MHC service during hospitalisation in PH Opava actually started to use the service. The main reasons for this low success rate in client referral can be divided into two parts: the motivation and interest of the clients themselves, and the capacity of MHCs to accept the client for their services. From the client (or potential client) perspective, it is mainly the client's low motivation and fear of entering the service, unwillingness or lack of interest in further cooperation with the already established MHC service, low family support, lack

of awareness of the seriousness of their illness, change of residence, or phobia related to commuting. From the MHCs perspective, it is mainly the failure to meet the target group for which the MHC services are intended, the inadequate health status of the potential client of the MHC service, and the termination of the service for non-cooperation with an already connected client.

When it comes to the perspective of clients who have already used an MHC service, the service is very well rated. Almost all the clients interviewed are very satisfied with the MHC service. They most value the interest and helpfulness of the staff, the client-friendly approach, and the support they receive from the organisation. The only thing that is not satisfactory is the lack of time for the service or its availability. Most clients learned about the MHC service from PH Opava or from their psychiatrist.

The problem of rehospitalizations from MHCs back to PH Opava is (from the MHCs staff perspective) mainly in the interruption of taking medication, in the deterioration of the patient's mental state, in the use of addictive substances or in stressful situations that occur with clients – both in the family and at work. The lack of sheltered housing and residential services for people with a psychiatric diagnosis is also a major problem.

Based on the research, several key measures for improving the system of care for people with mental illness can be identified. There is a need to improve patient awareness during hospitalisation and to strengthen inter-institutional communication. This may include regular training and education on follow-up care support options. Another important step is to expand sheltered housing capacity, the lack of which is among the barriers to discharging patients from health care facilities. Communication and cooperation between professionals from different fields in the concerned organisations should be promoted in order to better coordinate care, thus reducing the number of rehospitalisations. The survey also emphasised the inconsistent maintenance of records in different MHCs, which lack a shared information system. There is a division between health- and social-related parts of the data, without clear guidelines for keeping client records. Thus, information from individual MHCs cannot be compared with each other.

The research findings identify gaps and opportunities to improve care and support for the patient with mental illness in the process of establishing follow-up services after discharge from hospital. They can be used to provide effective support through informed and responsive interventions in both the health and social sector.

Role of individual authors

All authors contributed equally to the paper preparation, including the implementation of the research to which the paper refers. Their roles were identical, and included the development of theoretical concepts, writing of the paper, preparation, design, and conducting the research, as well as data analysis and writing of the paper.

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Ethical aspects and conflict of interest

The authors have no conflict of interest to declare.

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