Depression scorecard: Lithuania

This report is based on a user guide and template that were produced by The Health Policy Partnership as part of the Words to Actions initiative. The user guide and template were initiated and funded by Janssen Pharmaceutica NV. No experts involved in the original depression scorecard work, other than The Health Policy Partnership, were paid for their time. This report for Lithuania was produced by INK agency with funding from Janssen Pharmaceutica NV.

About this scorecard

The depression scorecard is a tool that aims to support the assessment of national-level performance in key aspects of policy, delivery and care for people with depression. The framework that underpins the scorecard was developed based on an international literature review and consultation with an expert advisory group.

The idea for the depression scorecard came from collaborative discussions between The Health Policy Partnership and Janssen Pharmaceutica NV as part of the Words to Actions initiative. For full details about the Words to Actions initiative, please see wordstoaction.eu/about.

The scorecard framework was developed and applied initially by The Health Policy Partnership, in collaboration with experts, to four countries: Belgium, France, Italy and Romania, with findings summarized in individual scorecard reports. National-level findings were developed based on in-depth literature review and interviews with leading national experts in depression.

The scorecard framework has now been made publicly available for advocates to use in their own countries, following the template and instructions provided in an accompanying user guide.

This scorecard report is based on that framework to assess depression care in Lithuania.

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Janssen Pharmaceutica NV and The Health Policy Partnership have not been involved in the research and drafting of this depression scorecard report and are not responsible for its content.

Funding disclaimer

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No experts involved in the original depression scorecard work for Belgium, France, Italy, and Romania, other than The Health Policy Partnership, were paid for their time. The same is true for experts involved in developing the scorecards in Slovakia, Czech Republic, Hungary, Slovenia, Croatia, Serbia, Bulgaria, Estonia, Latvia, and Lithuania.

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Depression: why it matters

Depression is the most common mental health condition affecting people today according to the World Health Organisation (WHO). Globally, it is estimated that 5.0% of adults suffer from depression. It is a leading cause of disability worldwide and is a major contributor to the overall global burden of disease. Approximately 280 million people are affected by depression worldwide.[1]

According to the Organisation for Economic Co-operation and Development (OECD), the number of cases of depression increased because of COVID-19 pandemic. The impact of the pandemic on mental health has been huge. The available data shows that in most countries, levels of anxiety and depression have more than doubled since the crisis began.[2]

Depression is a devastating disease. Those who live with the condition can experience a loss of interest in almost all activities and it has a profound impact on many aspects of their lives. Depression is the leading cause of suicide,[3] contributing to up to 60% of all suicides worldwide.[4] The impact of depression is made even harder to bear by the significant stigma surrounding the condition, and mental illness generally. Stigma associated with depression may exacerbate suffering and prevent people from seeking and receiving quality care for their illness.[3,5]

Depression is the main contributor to mental health problems in Europe and is one of the most common reasons for long-term sick leave and disability.[3]

2.8%
of people in Lithuania aged over 15 are diagnosed with depression (2021)[6,7]

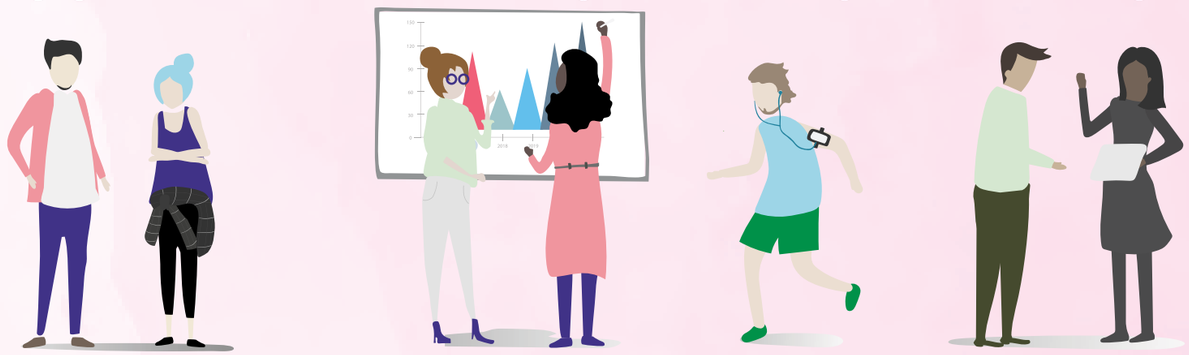
5,7 %
of Lithuania's overall health expenditures is spent on mental health (2020)[12]

24 psychiatrists
per 100,000 inhabitants in Lithuania, compared with the EU average of 17 (2017)[10]

26.1 per 100,000
per 100,000 inhabitants in Lithuania died from suicide or self-harm[8] compared with a European average of 13 (2019).[9] Global estimates indicate depression may have contributed to up to 60% of these deaths[4]

0.99 billion
cost of mental health (direct and indirect) annually in Lithuania (2015)[11]

2.64%
cost of mental health to annual GDP (direct and indirect expenditure) compared with 4% in the EU overall (2015)[11]



Depression scorecard for Lithuania

Suicide is a serious problem in Lithuania. For many years, the suicide statistics in Lithuania are the highest across the EU. There are, however, positive trends and a consistent decrease in suicide rates was observed from 2010 to 2020, but it was still the highest reported in the EU.[13] The most significant positive improvement has taken place among men as a group, where the suicide rates are the highest.[8]

Although suicide is a major problem in Lithuania and it is recognized that depression increases the risk of suicide, no more detailed studies on the relationship between this health problem and the number of suicides in the country are available.

The prevalence of depression has been increasing in Lithuania – from 15 cases per 1,000 of the population in 2011 to 24 cases per 1,000 in 2019.[6] The only deviation was recorded in 2020 when a reduction in the number of depression cases was recorded. This deviation could not be attributed to the decrease in morbidity, but to the COVID-19 restrictions.

Despite the growing depression statistics, one of the biggest problems in Lithuania remains undiagnosed cases of depression. These are indirectly evidenced by the statistics on drug use. In 2017, Lithuanian residents consumed twice as much benzodiazepines as the average consumed across the OECD countries during 2016. At the same time, antidepressant consumption was several times lower than in other OECD countries.[14] Benzodiazepines prescribed by primary care specialists, are often used to relieve the symptoms of depression, while antidepressants are more frequently prescribed by mental health specialists. Since the services of mental health specialists are easily accessible in Lithuania, this situation could have resulted from the stigmatization of mental illnesses, including depression, which makes people avoid contacting mental health specialists.

From 2018 to 2020, the State Health Insurance Fund reimbursed healthcare institutions for depression treatment services in the amount of 15 million euros, on average each year (in 2020, less money was allocated to reimbursements, because due to the lockdown supply was restricted) which is approximately 1% of the total funds in the Compulsory Health Insurance Fund (a total of about 6% of the funds is allocated for the treatment of mental illness).[12]

About this scorecard

This scorecard was developed to highlight to policymakers where change is most needed to improve the management of depression in Lithuania. It is our hope that this document may galvanise policymakers to work in close partnership with all stakeholders to reverse the course of depression in Lithuania, taking a comprehensive and preventive approach to address depression in all its complexity.

It focuses on four key areas, identified as priorities for improvement:

1

Joined-up and comprehensive depression services

Integrated care – that is, a patient-centred system that supports the person with depression throughout their lifetime and with continuity across the health system – is essential to delivering adequate support and treatment. Integrating mental health services into wider health and social care services is convenient and can increase treatment rates, improve comprehensiveness of care, and reduce overall costs.[15]

2

Data to drive improvements in depression care

Collecting and analysing robust and up-to-date data on depression is essential for ensuring the right services are available for everyone who needs them. Monitoring patient outcomes helps to identify and inform good practice, and may give hope to service users that their mental health can improve.[15] Data on services can support clinicians, policymakers and people with depression to better understand what treatment options are available and accessible. More transparent data will also facilitate shared learning across all domains of depression care. New digital tools may have the potential to facilitate documentation for transparency and research purposes while retaining the anonymity of the user.[15]

3

Engaging and empowering people with depression

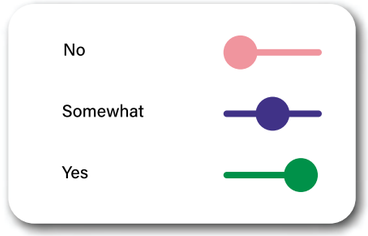
It is essential that people with depression – along with their families, friends and carers – are actively empowered to participate in depression care plans at all stages. Empowerment involves a person gaining information and control over their own life as well as their capacity to act on what they find important, which in turn will allow them to more optimally manage their depression.[16] Peer support, whereby a person who has previously experienced depression offers empathy and hope to others in the same position, can assist both people with depression and their peer supporter in their recovery.[17] Social systems, patient advocacy groups and other civil society organisations with access to underserved communities are critical in ensuring that mental health services reach everyone, including those who have 'slipped through the net.'[15]

4

Harnessing technology to improve access to care

Digital platforms such as those which facilitate remote therapy sessions and online prescription requests, as well as other depression-focused software, smartphone applications and virtual platforms, can allow greater choices of treatment for people with depression while supporting them to take more control of self-managing their condition. While virtual sessions cannot replace in-person therapy, they may be a flexible option to support people with depression between regularly scheduled visits. Health and social services may also use digital tools to facilitate data collection and monitor care.[18,19] In addition, people with depression may find it helpful to use digital tools to connect with others and reduce feelings of isolation.[20]

Summary scorecard for Lithuania



Joined-up and comprehensive depression services

Is depression included in either the national health plan or a specific plan for mental health?

Is there a government lead on mental health, with cross-ministerial responsibility to support a 'mental health in all plans' approach?

Is collaboration between primary care and mental health services supported and incentivised/encouraged/facilitated?

Are there guidelines on depression care developed jointly by primary care and psychiatry?

Is a range of therapeutic options reimbursed and available to people with depression, such as psychotherapy, counselling and cognitive behavioural therapy?

Are depression services available and tailored for at-risk groups?

- Young people
- Older people
- People in the workplace
- Homeless people

Data to drive improvements in depression care

Are data on people with depression systematically collected by the health system?

Are data on mental health services being used for planning?

Are patient-reported outcomes being measured systematically?

Engaging and empowering people with depression

Do guidelines or care pathways for depression recognise the importance of patient empowerment?

Do guidelines on depression recognise the role of families and carers in making decisions on the planning and delivery of care?

Were patient and carer representatives involved in the most recent national plan or strategy covering depression?

Do carers have access to financial aid to help them support their loved ones with depression?

Is peer support recommended in depression care guidelines?

Are peer support roles reimbursed?

Are there national associations advocating for the rights of:

- people living with depression?
- carers of people living with depression?

Harnessing technology to improve access to care

Can patients access depression support remotely (via telephone or the internet) in addition to services delivered face-to-face?

Do professional societies or guidelines recommend the use of remote services alongside face-to-face services?

Is remote support for depression reimbursed?

Are people with depression able to use telephone or online platforms that allow them to renew their prescriptions from home?

Joined up and comprehensive depression services

In the government paper Lithuanian Health Strategy 2014–2025, depression is mentioned in the context of suicides and in the section describing the benefits of physical activity. The strategy recognizes that the mental health of the population is a challenge but does not specifically make any reference to depression. It only considers overall psychoemotional health.[21]

In Lithuania, the State Mental Health Centre, under the Ministry of Health for Lithuania, is engaged in reducing the country's incidence of mental illnesses and suicide rates and improving the mental health of the population as a whole.

According to the Law on Mental Healthcare of the Republic of Lithuania, the procedure for managing individual mental health issues is established by the Minister of Social Security and Labour (with the provision of mental healthcare services in social care institutions), and the Ministry of Justice and Ministry of the Interior (with the provision of mental health care services in correctional institutions and detention units).

Cooperation between primary care and mental health care institutions is ongoing. However, it could be more efficient. Coordination between institutions is hampered by the absence of a single e-health system. There are also problems in cooperation between social care and health care providers, because different funds pay for their services.

Primary care level specialists have sufficient competence to notice the signs of a mental health disorder, but rarely – mainly due to cultural reasons – are patients referred to mental health specialists. Sometimes, those who receive a referral to a higher level specialist do not actually go on to contact them.

Currently, there are national guidelines for the treatment of depression in Lithuania ("On the approval of the description of the procedure for the treatment of depression and mood (affective) disorders in outpatient setting using reimbursable medications"), but they have two main shortcomings:[22]

- the guidelines only cover the pharmacological treatment of depression reimbursed by the state;
- the guidelines require a thorough update.

The original document adopted in 2012 needs to be updated and expanded (only one, minimal revision, was carried out in 2018).[22]

Pharmacological treatment of depression in Lithuania is easy to access, most antidepressants available are fully reimbursed by the state, except the newest.

At the same time, the availability of non-pharmacological treatment for depression is significantly less. Psychotherapy services are rarely provided at healthcare institutions. Although psychotherapy in Lithuania is a state-reimbursed service, the rates for the services are so low that they do not cover the actual costs incurred by healthcare institutions. According to the current procedure, healthcare institutions cannot set higher service rates. As a result, many of them simply do not offer this service.

This situation has led to psychotherapy services moving into the private healthcare sector. This means that in order to receive non-pharmacological treatment for depression, you face a financial threshold that not many patients can afford.

The services provided for the treatment of systemic depression tailored for specific risk groups, are not provided in Lithuania. There have only been projects or initiatives implemented by some individual healthcare institutions.

In early 2022, the *Guidelines for Changes in Mental Health Services* were introduced in Lithuania. They provide for significant changes in mental healthcare provision and will solve the most pressing problems: access to non-pharmacological treatment for depression, peer support services, etc. However, it is not yet clear to what extent the changes that are intended will be implemented.[23]

Case study 1: Mental health centres

There is a patient-friendly system in Lithuania – mental health centres are accessible at the primary care level. Therefore, a patient can contact a mental health professional directly – without referral from a GP.

A total of 106 mental health centres of varying sizes operate in Lithuania, servicing a population of 2.8 million: these can be separate mental healthcare institutions, units in polyclinics, or other primary care institutions.[23]

Mental health centres employ a team consisting of a psychiatrist, a psychologist and a social worker.

It is relatively easy to get access to inpatient services: the patient can make contact directly, come with a doctor's referral, or arrive in an ambulance. There are waiting lists for these services but waiting time is short.

Data to drive improvements in depression care

The prime data concerning people experiencing depression are collected and some of them are accessible in the databases and statistical publications of the Institute of Hygiene.[6]

The main purpose of data collection is the allocation of funds for mental healthcare services. Some data are used for planning, but this is not done comprehensively.

Electronic healthcare systems potentially contain data that would allow for the adjustment and effectiveness of the treatment of depression, but due to the absence of analysis centres, this potential remains untapped.

Patients may also provide feedback on inpatient treatment services, but the feedback system is not tailored specifically for assessing the treatment of depression or the effectiveness of the treatment. Patient surveys provide general questions, so their replies cannot make a significant impact.

Case study 2: Access to medicines

The WHO has, on many occasions, noted that the expenditure for medicines for outpatient treatment in Lithuania is the most common reason why households incur unbearable costs in healthcare-related areas.[24]

The main list of reimbursable medicines in Lithuania, which includes medicines for specific diseases, is called the A list. Doctors use this list for prescribing treatment for patients.[25]

In response to the OECD and WHO recommendations, in April 2019, the reimbursement rate of all A list medicines, including those for the treatment of depression, was increased to 100%, making the pharmacological treatment of depression more accessible to the population.[26]

Engaging and empowering people with depression

There is still a lack of patient empowerment initiatives in Lithuania, including patient involvement in decision-making.

National guidelines for the treatment of depression in Lithuania only includes pharmacological treatment, so they do not mention the importance of patient empowerment or the importance of families and caring for patients with regard to decision-making, planning or the provision of services. As a result, the guidelines do not mention support groups and their activities are not reimbursed by the state.[22]

Although patients and their carers are involved in the debate regarding certain decisions, the real possibility to influence changes rather than just being heard by decision-making groups, remains problematic.

Carers of patients with depression can only receive financial support in cases of severe illness, where the person is registered as mentally disabled.

Both the rights of patients with depression, and their carers are represented in Lithuania by the Lithuanian Society for People with Mental Disabilities. This is an umbrella organization seeking to represent all persons with mental disabilities and their families.[27]

Depression is one of the many interests of this organization, but usually it deals with serious cases of depression that involve mental disability. Currently, there is neither a national nor a regional organization in Lithuania that exclusively represents the interests of people with depression and/or their families.

Harnessing technology to improve access to care

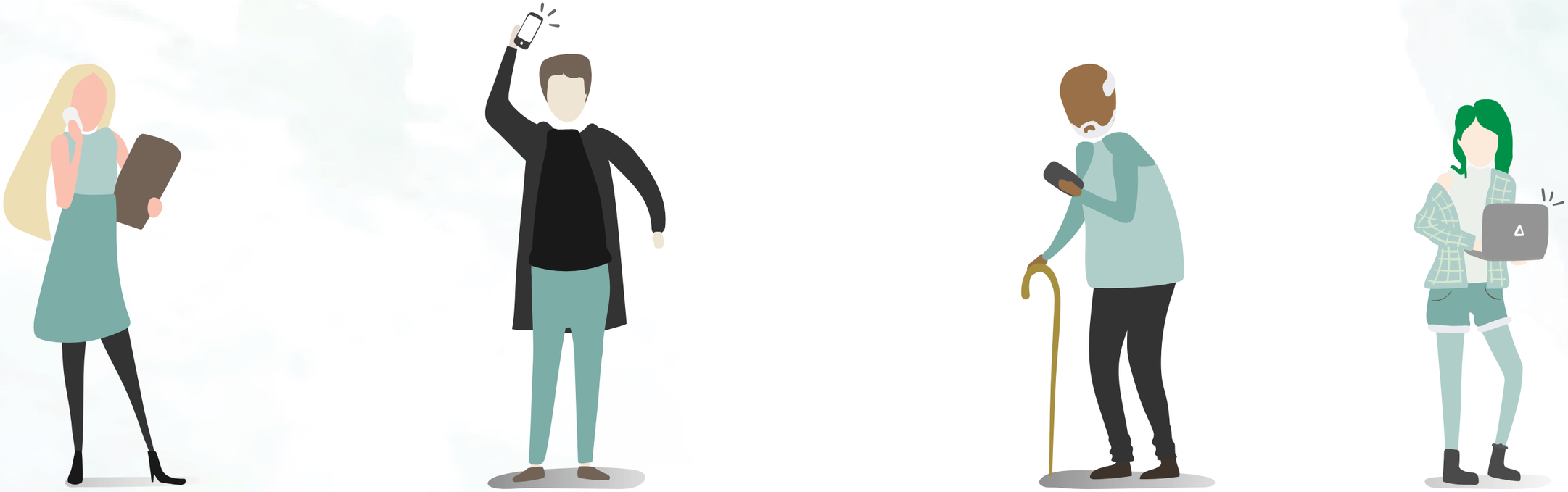
In order to improve services during the COVD-19 pandemic, patients had access to services over the telephone and the internet. The action plan to reduce the long-term negative effects of the Covid-19 pandemic on mental health envisages increasing the accessibility of these services.[28]

Patients with depression can receive initial outpatient mental healthcare services remotely, from a mental health specialist and also renew their prescriptions. This is the latest document (ministerial order), regulating the procedure and was valid from 10 November 2020.[29]

Remote mental healthcare services, including remote care for depressed people, are reimbursed – the reimbursement is the same as when consulting face-to-face.[29]

The provision of remote services is not mentioned in the current national guidelines for the treatment of depression in Lithuania, because the document was prepared before the launch of such services.[22]

Meanwhile, mental health professionals and associations are in favour of the further development of telemedicine, however, more consistent regulation is required if further steps are to be taken.



Conclusion and recommendations

There is a wide network of mental health centres in Lithuania. Services are provided to patients both directly and via referrals to medical specialists. Pharmacological treatment of depression is easy to access. However, it is far more difficult to get non-pharmacological treatment (psychotherapy or psychosocial rehabilitation services). Although these services are reimbursed, the rates charged for the services do not correspond to the actual costs. As a result, these services are very limited.

Prime statistics on depression are collected in Lithuania. The electronic healthcare information systems do have the potential to provide a deeper analysis of the issue. Currently, however, there are no analysis centres in Lithuania to process such information.

Because of the absence of a single electronic healthcare system, a patient's health data may not be available in all healthcare settings. This complicates the traceability of the patient's medical history, treatment, and whether the patient follows the treatment as prescribed.

Patients and their carers are involved in some decision-making related to mental health, but it is not clear to what extent this determines the decisions of policy-makers.

The COVID-19 pandemic motivated further regulation and provision of telemedicine services. At present, telemedicine services at the primary care level, are reimbursed at the same rate as direct face-to-face patient contact services. However, the development of telemedicine requires more consistent regulation, appropriate hardware and software.

The newly introduced *Guidelines for Changes in Mental Health Services* offer significant changes. These include the accessibility of non-pharmacological services, an orientation towards services for individual groups, development of community support services and mutual support groups.

Priority recommendations

Joined-up and comprehensive depression services

- to improve the accessibility of services for the non-pharmacological treatment of depression
- to develop tools for overcoming depression tailored to specific groups of people: young people, older people, etc.

Data to drive improvements in depression care

- using data from the electronic healthcare systems to improve planning and decision-making policy in the treatment of depression
- based on the data from electronic healthcare systems, evaluate the effectiveness of decisions related to the treatment of depression

Engaging and empowering people with depression

- to improve mechanisms that would involve patients and their representatives in the decision-making process
- to promote mutual support groups and other community-based services

Harnessing technology to improve access to care

- to maintain the positive telemedicine progress made during the COVID-19 pandemic
- to extend the regulatory framework for telemedicine to provide higher-level remote services
- to improve the technical capability to allow doctors to provide remote services

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