Depression scorecard: Slovakia

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 Slovakia was produced by Seesame with funding from Janssen Pharmaceutica NV.

About this scorecard report

The aim of this research is to assess the current level of performance in key areas of healthcare services for people with depression in Slovakia. The framework that underpins this scorecard report 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 more information about the Words to Actions initiative, please visit wordstoaction.eu/about. Janssen Pharmaceutica NV and The Health Policy Partnership were not involved in the research and the preparation of this scorecard report and bear no responsibility for its content.

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 summarised in individual scorecard reports. National-level findings were developed based on in-depth literature review and interviews with leading national experts on 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. The methodology used in this research will be published on www.Depressioncare.eu and on The Health Policy Partnership website.

This scorecard report is based on the same framework to assess depression care in Slovakia.

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Contents

Depression: why it matters

Depression is the most common mental health condition affecting people today, according to the World Health Organization (WHO).[1] It has far-reaching consequences and affects the life of people living with this illness, their families and the entire society. Depression is associated with a multitude of adverse impacts on people's lives, including their work performance, financial standing, chronic illnesses, worsened quality of life or a higher chance of death.[2,3]

A January 2022 WHO report estimates that around 1 billion people are living with mental health issues globally. Among this one billion, 5% of adults suffer from depression.[4] According to the WHO data, depression is the most common cause of suicide,[5] accounting for as much as 60% of suicide cases worldwide.[6] Social stigma associated with depression may increase the suffering of patients and prevent them from seeking a high-quality health care.[7-9] Depression causes a significant emotional burden for patients and their families, and also represents an economic burden on society. The total costs of mental ill-health are estimated at EUR 607 billion per year across the EU.[10]

In 2019, as much as 7.2% of people suffered from chronic depression in the EU, while the overall incidence of depression remains largely undocumented in many European countries. According to the OECD, almost 50% of severe depression disorders goes untreated.[11] Experts around the globe therefore call for improving access to treatment for people with depression, eliminating mental health related stigmas and reducing the global burden of depression.[4]

The term depression used throughout the Depression Scorecard: Slovakia covers depressive episode (International Classification of Diseases ICD-10 code: F32) and recurrent depressive disorder (F33).

3-3.5%

is an expert estimate of people living with depression in Slovakia.[12,13]

4.9

psychiatrists per 100,000 inhabitants in Slovakia. (2018)[12]

9 people

per 100,000 inhabitants of Slovakia died from suicide or self-harm.[14] Global estimates indicate depression may have contributed to up to 60% of these deaths (2020).[6]

EUR 2.1 billion or 2.4%

of Slovakia's GDP,[12] are the estimated costs of mental health (direct and indirect) annually in Slovakia (2019).[12]

3.1-3.3%

of Slovakia's total health expenditure is spent on mental health (2017).[12]

EUR 71.2

million are annual costs of health and social care for depressive disorders in Slovakia (2018).[15,16]

What is the situation in Slovakia?

According to the official statistics, 12% of people in Slovakia lived with mental health problems in 2019, while the depressive disorders are estimated to be affecting 3-3.5% of people in Slovakia.[12-13] Even though the share of people with depression in Slovakia is below the EU average (4.3%),[5] the statistics may be misleading as experts believe that many people suffering from depression may have never been included. In fact, as much as 67% of people showing depression symptoms are not treated in Slovakia. The underestimated statistics and patients' reluctance to seek treatment are partially caused by social stigma as well as by the lack of available health care services.[12]

The low number of psychiatrists in Slovakia is a sign of the seriously lacking quality treatment for people with depression. There are 306 psychiatrists in total in Slovakia, or 4.9 psychiatrists per 100,000 inhabitants,[12] as compared to the EU average of 17.[17]

The country also has a shortage of psychotherapists, which is largely due to systematic barriers.[12] Psychiatric offices are unevenly distributed through Slovakia, making the adequate treatment less accessible in some regions, while disproportionately overloaded in others. An average waiting period for a psychiatric examination reaches more than seven weeks in Slovakia.[18]

Some data about depression are collected at a national level, but they are either not collected systematically or only the very basic data are collected, for example, the prevalence of depression. Many statistical data are missing to conduct epidemiology studies necessary for research. The real incidence of mental disorders has yet not been documented in Slovakia.[12] A new epidemiology study which should also focus on depression is expected to be conducted soon under the Recovery and Resilience Plan.[20,21]

The total number of suicides follows a downward trend since 2008 in Slovakia. According to the most recent data, there were 9 deaths from suicide per 100,000 inhabitants in 2020.[14] However, these data, too, may be distorted by an inadequate or overcomplicated way of their reporting. The 2020 data show that 86 people diagnosed with depression attempted suicide. Such data, however, are only reported in the system if a person who makes a suicide attempt seeks medical care. In this case we speak about reported attempted suicides.

Slovakia spends 3.1-3.3% of total health care expenditure on mental health treatment; this accounts for 0.2% of GDP (2017) whereas the OECD average is as much as 6-7%.[12]

Although Slovakia introduced the National Mental Health Programme as early as in 2004, it mentions depression only marginally.[22] An update to the programme is currently at a preparatory stage, but its precise wording or the scope of measures to tackle depression have remained unknown to the general public so far.[23] However, new concepts for psychiatric care for adults and for children have already been approved, laying down the basis for system-level changes in this field.[24-25]

Active cooperation between the healthcare and the social system is very limited today and a wider cross-ministerial cooperation on mental health issues has brought little success so far.[12] Changes in this setting are expected from the work of the cross-ministerial Council of the Slovak Government for Mental Health (Rada vlády SR pre duševné zdravie), established in 2021. The Recovery and Resilience Plan also pays relatively big attention to mental health issues.[23]

Even though the formal framework for the integration of health care for patients with depression already exists, its practical application is still insufficient.[20] Over 80% of patients with depression are treated by psychiatrists while general practitioners only treat less than 10% of cases.[26] Clinical psychologists are also considerably involved in diagnostic and treatment of patients with depression.

There are several patient organisations in Slovakia that provide support and assistance to people with depression and their family members, and are also partially involved in the planning of national mental health programmes.[22] Organisations specifically focused on mental health of selected groups of population, such as children and youth, workers, seniors or victims of violence, also function in Slovakia.[12]

Technology-based forms of support and assistance are also available in Slovakia, such as phone and email consultations and remote therapy sessions. Despite a certain shift in this area, psychiatrists still prefer face-to-face contacts.[12,27] E-prescription is also available to patients in Slovakia.[28]

About this report

This report was developed to highlight to relevant authorities policymakers where change is most needed to improve the management of depression in Slovakia. 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 Slovakia, 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.[29]

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.30 Data on services can support clinicians, policymakers, people with depression and their family members or carers 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.[30]

3

Engaging and empowering people with depression

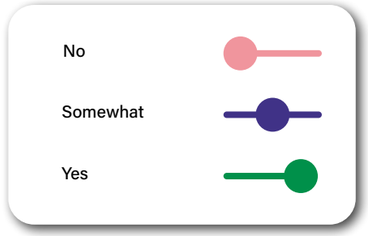
It is essential that people with depression – along with their families, friends and carers – are actively empowered to participate in depression care plans at all stages. Empowerment involves a person gaining information and control over their own life as well as their capacity to act on what they find important, which in turn will allow them to more optimally manage their depression.[30] 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.[31] Peer support may take various forms, from co-patient support groups or informal support through to official peer consultants whose role is specifically defined in the current Concept of Psychiatric Care (Koncepcia zdravotnej starostlivosti v odbore psychiatria). 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.'[30]

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.[32,33] In addition, people with depression may find it helpful to use digital tools to connect with others and reduce feelings of isolation.[34]

Summary scorecard for SLOVAKIA



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

Mental health becoming priority in healthcare system

The first National Mental Health Programme, prepared by the Ministry of Health of the Slovak Republic and adopted in 2004, is a strategic document responding to the system-level shortcomings and deficiencies in mental health care. The programme does not pay particular attention to specific diagnoses but depressive disorders are mentioned several times under major groups of diseases on which the proposed measures should focus.[22]

The current Slovak Government considers mental health one of the main priorities for the health care sector; therefore, the Ministry of Health set up the cross-ministerial and intersectoral Council of the Slovak Government for Mental Health in February 2021 to act as a permanent advisory body to the Slovak Government. Its key tasks include coordination and consultations in the area of mental health promotion and prevention. It also participates in the preparation of policies and strategies in this field. In addition, the Council is in charge of updating the National Mental Health Programme, with the update expected to be submitted for approval in 2022.[35,36] The full version of the updated programme has not been published so far, therefore it is yet impossible to determine to what extent it will deal with depressive disorders.

The main document that defines the attributes of the provision of mental health care services in the coming years, including a multidisciplinary approach to patients and their needs, is the Concept of Psychiatric Care which entered into force in 2022. The new concept has introduced several major changes – for example, it lays down the basis for the development of community care and defines the term 'peer consultant', their roles and competencies as part of a team working in a facility of community psychiatric care.[24]

Mental health is also addressed in the Recovery and Resilience Plan which responds to the consequences of the COVID-19 pandemic.[23]

Poor cross-ministerial cooperation on mental health in Slovakia

Active cooperation and connections between the health care system and the social care system are currently insufficient in Slovakia and the same is true for a wider cross-ministerial cooperation, as well. Changes in this setting are expected from the work of the trans-ministerial Council of the Slovak Government for Mental Health which was established in 2021.[35] It is gradually starting its work, but no major changes have yet been brought about in the sector. Patient organisations are largely dissatisfied with its functioning, as they, though being represented in the Council, do not in fact have many possibilities to influence its activities and direction.[37,38]

The lack of psychiatrists and insufficient engagement of general practitioners in providing care to patients with depression

According to the National Health Information Centre data, depression is predominantly treated in an outpatient setting in Slovakia (95% of interventions). The outpatient care also includes community care, which has not been established in Slovakia so far, even though experts call for its development. The community care is currently substituted for by day care centres to a certain extent, but their existing network needs to be expanded and their funding by health care insurance companies need to be improved. Experts also see a room for enhancing the quality of inpatient psychiatric care which today accounts for roughly 5% of treated psychiatric cases. The Concept of Humanising Institutional Psychiatric Care (Koncepcia humanizácie ústavnej psychiatrickej starostlivosti) was prepared for this purpose and published in March 2022.

The availability to health care services for people with depression has several substantial limitations in Slovakia. The total number of psychiatrists is far below the EU average, psychiatric offices are unevenly distributed across the country, and waiting periods for examination exceed seven weeks on average.18 Patients, therefore, must seek therapies outside of the public health care sector. However, such therapies are quite expensive and many patients cannot afford the necessary follow-up care.

More than 80% of patients with depression are treated by psychiatrists in Slovakia, while less than 10% of patients receive treatment by general practitioners.[26] However, it is very often general practitioners or specialists other than psychiatrists whom patients with depression contact in the first place.[39] General practitioners' extended knowledge of mental health issues and their greater engagement in the treatment of patients with mental health problems could, to some extent, compensate for the lack of psychiatrists and improve the access to, and availability of health care for patients with depression.

Experts also draw attention to the fact that while the provision of acute care is at a very high level, Slovakia considerably lags behind in the delivery of follow-up care. This is linked to the underdeveloped capacities in the community-based care, non-engagement of experts with a lower degree of qualification in the treatment, as well as the non-use of so-called peer consultants.

Slovakia faces a serious shortage of psychotherapists

The shortage of experts on psychotherapy represents a serious problem in the provision of necessary health care to people with depression. The psychotherapist profession as such does not officially exist in Slovakia; psychotherapy may only be provided by certified physicians and psychologists. The National Health Information Centre had 440 clinical psychologists in its official database in 2018, but the exact numbers on psychotherapy specialists are unavailable – the data on private therapists are particularly missing. This deficit is caused by system-level barriers, such as, for example, long and expensive training.

Groups most at-risk of depression have no sufficient support

The overall shortage of qualified doctors is also felt in the necessary medical specialisations. According to the official data, there were less than 60 paediatric psychiatrists in Slovakia in 2018 and only 29 of them provided outpatient care. The main cause is the low attractiveness of this specialisation, which considerably narrows other options for specialists in this field – child psychiatrists can treat children and adolescents only. In addition, there is now just one day care

centre specialised in paediatric psychiatry working in Slovakia.[12]

The need to increase the number of school psychologists has long been discussed in Slovakia. Since not all schools have the necessary funds for this purpose, only some of them are able to provide psychology services and consultations to their students. There are various non-profit organisations (e.g., Úsmev ako dar, Andreas, Deti na nete, IPčko, Linka detskej istoty, Liga za duševné zdravie) engaged in the prevention and support in mental health for children and young people that operate free hotlines and organise awareness-raising activities and campaigns.[12]

Slovakia has few geriatric psychiatry specialists; this specialisation cannot even be studied in Slovakia at the moment. The shortage of specialists is also linked with the low number of psychiatric departments for senior citizens and no day care centre for this at-risk group exists at all.[12]

Promoting and supporting mental health of employees is in the hand of employers, non-governmental organisations and educational institutions.[12] One of the reasons is the fact that employees are not included among the at-risk groups under the National Mental Health Programme.

According to the National Mental Health Programme, mental health care services need to be made available and affordable to the groups of population that are at risk of social exclusion, including the homeless people.[22] However, practical support and assistance to the homeless people with depression is limited. Some assistance is provided through prevention and support programmes for homeless people delivered by non-governmental organisations (e.g., Vagus, DePaul, Nota Bene, Odyseus, Prima).[12]

Due to their long-term discrimination and social exclusion, people from marginalised Roma communities (MRC) constitute a significantly large vulnerable group of population in Slovakia. The Roma from marginalised communities have a shorter average life expectancy, more often suffer from infectious and chronic diseases, face a greater psychosocial burden, and have a higher mortality rate. They have generally more restricted access to health care, therefore, they are not diagnosed with and treated for mental disorders at an early stage.[40] Children from the MRCs are more often diagnosed, albeit incorrectly, with light mental disabilities.

Data to drive improvements in depression care

Data are missing to give a real picture of depression prevalence in Slovakia

Systematic collection of medical data is provided by the National Health Information Centre (NHIC) in Slovakia. Among other things, the NHIC regularly publishes annual data on mental illnesses. The data are based on the reports about hospitalisations provided by hospitals and on the information about visits to outpatient specialists – psychiatrists.[41,42] Even though they provide quite an accurate picture of the treated and/or registered cases and patients, they give less information about the overall prevalence of mental illnesses in the Slovak population. This category of data thus remains distorted, according to experts, because many people with mental illnesses do not seek and/or do not receive specialist help.[12] It means that many important statistical data are missing for a systematic research and its application in practice in Slovakia. We may thus conclude that the actual prevalence of mental illnesses has not been documented in Slovakia so far.

The same problem also exists with respect to finding out the prevalence of depressive disorders. Only one epidemiology study focused on these disorders was conducted in Slovakia so far, in 2003.[19] The missing systematic collection of data is partially substituted by a European project entitled European Health Interview Survey (EHIS) which was conducted in Slovakia in 2006 and 2014 with the participation of the Statistical Office of the Slovak Republic.[43] In addition, several Slovak researchers implement projects that also involve surveys on depression. However, their results are often presented to a narrow group of specialists only, they are not widely available to the general public and, given their nature, cannot serve as a substitute for a national register and/or extensive systematic collection of data in terms of their complexity.

Focus on mental health has increased but patients' feedback and implementation of plans are missing

The most recent OECD analysis (2019) focused on mental health has emphasised the importance of measuring and assessing patients' health care experience. However, Slovakia was not included in this survey.[12] Just as the data on the prevalence on mental illnesses are not systematically collected in Slovakia, the outcomes of treatment and the quality of health care provided, which could be reported by patients themselves, are not measured, either.

One of the first recommendations made by the Council of the Slovak Government for Mental Health called for the implementation of a project to collect and process data on mental health which should also involve the establishment of a National Registry of Mental Illnesses.[44] Implementing this expert proposal would help better map and assess the actual situation in mental health and, among other things, contribute to meeting the objectives set under the current National Mental Health Programme, too. The implementation of a wider epidemiological study should also be funded from the Recovery and Resilience Plan.[23]

Engaging and empowering people with depression

People with depression have their place in decision-making on health care, but their engagement needs to be enhanced

The two existing framework documents – National Mental Health Programme and the Concept of Psychiatric Care – recognise the need to engage people with mental illnesses and their family members or carers in the planning, delivery and evaluation of health care.[22,24] However, the involvement of patients and/or patient organisations in the preparation of strategic documents and reform plans has so far been rather limited. Even though, formally, some patient organisations are invited to participate in inter-ministerial task groups that prepare strategic plans,[22,36] their actual impact is negligible when compared to other professional associations.

Family members or carers of people with depression also face a complicated situation. Slovakia does not currently have a system-level state financial mechanism in place to support people who provide care to patients with depression. Financial assistance is only available to carers of people with severe disabilities.[45]

Community care still in its infancy

The peer support scheme for patients with depression is not yet sufficiently developed in Slovakia. Although diagnostic and treatment guidelines mention community-based care as an ideal way to provide care to patients with depression, they do not offer any specific information about this form of support.[46,47] Sociotherapy clubs in which peer support roles can be engaged provide help mainly to people with substance addictions. Also, peer consultants are not entitled to any financial compensations for their services in Slovakia.

There are dozens of nationwide mental health support organisations in Slovakia. Some of them provide help to people with the whole spectrum of mental health issues (e.g., Liga za duševné zdravie, No more stigma), others concentrate on selected risk groups.[12] However, these organisations often encounter a barrier in the form of insufficient funding which considerably limits their possibilities and the outreach – being non-profit organisations, they rely on the limited financial support from the state, grants and voluntary financial donations from the public.

Harnessing technology to improve access to care

Digital therapy options are available but limited

Digital tools and modern technologies are increasingly involved in the provision of health care. Their uptake has considerably increased in Slovakia in response to the COVID-19 pandemic, including with respect to mental health care, where regular face-to-face therapeutic sessions were largely limited. Nevertheless, traditional means still remain to be used to a large degree, such as, for instance, hotlines which mainly provide free consultations and advice.

These hotlines are usually operated by non-profit organisations; a state-sponsored hotline resumed its operation in 2021. The state expects that the relaunched hotline will make professional support accessible to a group of people who have not so far sought such support mainly due to a social stigma.[27] Thousands of consultations are provided through support hotlines each year.[12] Online therapeutic sessions with psychologists or psychotherapists are much less available.

The COVID-19 pandemic paved way to new treatment options

The existing National Mental Health Programme and diagnostic and treatment guidelines have long failed to respond to the need of providing remote health care services.[22,46,47] However, standing face-to-face with the COVID-19 pandemic, professional associations and the health ministry responded by amending methodology guidelines and procedures. In 2020, the Ministry of Health of the Slovak Republic published the Standard Procedure for the Provision of Psychiatric Care during the Pandemic, which expressly specifies that psychiatric patients who tested positive for COVID-19, but do not require hospitalisation for psychiatric indication should receive psychiatric treatment in their home setting with the use of telemedicine options – telepsychiatry and telepsychotherapy.[48]

The applicable standard diagnostic and therapeutic guideline on the comprehensive psychological management of adult patients with a depressive episode and recurrent depressive disorder, in force from July 2021, contains recommendations to use computer-based cognitive behavioural therapy (cCBT) in the first-line treatment of subclinical, mild to moderate depression.[49] The current rate of use of cCBT in practice is unknown, however.

E-prescriptions are fully available in Slovakia but technology potential remains underutilised

A relatively advanced technology solution is used for the renewal of drug prescriptions in Slovakia. Patients with mental illnesses (including depression) can request a renewed prescription by phone and collect their prescription drugs directly in a pharmacy (through the eZdravie platform).[28] Thanks to the available apps and health insurers' online platforms, patients get an overview of the received medical care and of prescribed medical drugs. These tools are user-friendly and secured by encryption.

Generally, however, the use of advanced technologies in the provision of health care to patients with mental health issues in Slovakia falls short of the possibilities and potential of today's technological development. Experience of other countries shows that their wider practical application could make the necessary therapeutic options available to a larger group of patients, decreasing the costs for patients, health care providers, as well as health insurance companies. Moreover, treatment would become more effective and the collected data could contribute to improved policy-making in the area of mental health and to an overall better setting of the system's functioning.

This is also recognised by a number of Slovak experts who have set up an initiative entitled Digital Interventions for Mental Health (Digitálne intervencie pre duševné zdravie). Its key goal is to develop, research and implement available digital interventions and prevention programmes for mental health.[50]

It seems, however, that even the implementation of the Recovery and Resilience Plan will not help Slovakia advance in this area, despite the fact that improvements in the provision of mental health care are one of its pillars. The problem is that digital transformation in this area is basically restricted to merely creating a central register of psychodiagnostic materials and digitalisation of registers of psychologists. There is no mention of the use of remote digital interventions or other therapeutic options using digital tools in the Recovery and Resilience Plan.[23]

Case study 1 - Electronic prescription

eRecept, an electronic prescription system, was introduced in Slovakia in 2018. E-prescriptions are equivalent to paper-based prescriptions, where the stamp and signature of the prescribing physician are replaced by an electronic card of a health care worker. Physicians prescribe drugs in their information system, while a check runs in the background to provide them with the information about potential drug interactions or duplicities.

A major benefit of the eRecept system is that patients can collect their prescribed drugs directly in a pharmacy without having to first see their doctor. The system was stabilised after some initial technical issues and physicians and patients got used to it quite quickly. The eRecept system proved especially successful during the pandemic. Many outpatient specialists worked under a restricted regime which, of course, affected the provision of mental healthcare as well, but patients had no problems with getting the prescriptions they needed.

Conclusion and recommendations

Acute health care available to patients with mental illnesses, including patients with depression of various grades, is currently functioning very well in Slovakia. However, there seems to be a problem with the provision of follow-up care and long-term patient management. The key reasons are capacities, funding but, most of all, the system as such.

Even though patients are entitled to therapeutic care covered from the public health insurance scheme, its actual provision encounters barriers in the form of limited personnel and financial capacities available in the system, while therapeutic options available outside the public health care system are expensive for patients. Patients must wait a long time for therapy and their treatment often comes late. The situation is further complicated by a social stigma that people with depression have to bear.

Moreover, Slovakia still does not have an established system of community centres and comprehensive – integrated care. Patients are also little involved in decision-making processes and peer support programmes. Yet the experience from other countries shows that exactly this kind of solution to the follow-up care proves to be working and effective in delivering the necessary assistance and support to people with depression. It is positive that this fact is recognised both by the representatives of patient organisations and health care providers. Both groups, therefore, seek adoption of necessary system-level changes in this area.

Several strategic documents were adopted in the recent months in response to the current state of affairs, and the cross-ministerial Council of the Slovak Government for Mental Health was established in order to help improve the functioning of the system. Despite the fact that changing the way health care is provided to people with mental health issues struggles with a number of problems, e.g., the lack of data, the start of change processes gives hope that the situation will improve in future.

Priority recommendations

Joined-up and comprehensive depression services:

- Slovakia has a long-lasting problem in the area of prevention and provision of follow-up care to people with depression. It is, therefore, necessary to expand integrated care services in the system, e.g., by developing community centres for patients. Community centres could also help with prevention and shortening the time of hospitalisations, or post-treatment of residual symptoms of depression. Their indisputable benefits also include better coordinated and comprehensive health and social care services, which the system is notably lacking today.
- The shortage of personnel in the system and related problems with availability of follow-up care could be addressed by easing qualification requirements and shortening the duration of professional training to provide therapy to people with lighter depression, systematic engagement of family members, relatives and friends, and by developing peer support.
- Prevention and assistance projects and programmes need to be implemented, focusing on at-risk groups such as young people, seniors and marginalised (vulnerable) groups of population. Such programmes are now virtually absent both at the national as well as community level.
- Slovakia could benefit from more intensive promotion of specialised awareness-raising campaigns to encourage people with depression to seek the necessary medical care, as well as campaigns to eliminate the social stigma associated with mental health issues.

Data to drive improvements in depression care:

- Slovakia has a long-lasting problem with health data. The country is missing patient registers, as well as systematic epidemiological studies. However, pressure is mounting both from within the health care system and among patients to improve the existing conditions. The announced preparation of a new epidemiological study on mental health under the Slovak Recovery and Resilience Plan is also good news in this respect.
- The lack of relevant data complicates the efforts to introduce system-level changes in mental health care. More intensive sharing and analysing of health insurers' data, results of expert studies and patients' feedback on the quality of life is needed. The aim is to better monitor and understand the real needs in the system and to respond more actively to the shortcomings in the treatment of depression.
- Slovakia could considerably benefit from the establishment of a central database, or an information hub, that will contain information about the available health services, as well as about comprehensive care options for patients with depression.

Engaging and empowering people with depression:

- Patients and/or patient organisations are today formally involved in projects aimed at reforming the existing system of mental health care. However, they only have limited possibilities to actively participate and shape the content and direction of such projects. Their engagement in defining the system-level changes could contribute to a more effective setting and higher quality of health care services.
- Standard medical guidelines on depression have recently been updated to respond to the latest therapeutic trends. However, they still do not cover good practices from a number of countries where specialists with lower qualification, people with depression, their carers and families are encouraged to actively engage in therapy. Future updates should cover this area, too.
- Slovakia currently has no scheme to provide financial and material support to carers and relatives who provide care to people with depression. It is desirable to make such support mechanisms a part of comprehensive system reforms.

Harnessing technology to improve access to care:

- No national or regional list of digital tools that health care providers can use exists in the Slovak health care system today. No special grant schemes are in place to coordinate or fund their implementation into practice. The current situation requires introducing standardised guidelines and professional training for working with digital tools, including the cyber and data security.
- Given the expected increase in the number of people with various grades of depression and the limited professional capacities, it is necessary that the number of digital tools continues growing. We must prepare for this in technical terms, as well as in terms of funding of online therapy options, professional consultations and multidisciplinary care.

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