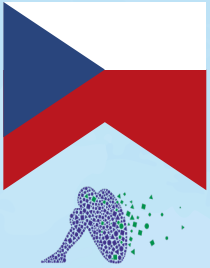

Depression scorecard: Czech Republic

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 Czech Republic was produced by Garmedis 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 summarised 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 Czech Republic.

Author and contributor details

The research and drafting of this depression scorecard report were led by Ondřej Hušek, Garmedis.

We are also grateful to the following national experts who provided valuable insights on the situation in Czech republic:

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- Marie Salomonová MSci., Co-founder and CEO Nevypusť duši

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.

Due to the ongoing reform of mental health care in Czech republic, only two experts were able to take part in the creation of this scorecard. The Czech depression scorecard findings will be updated as soon as the reform is completed.

Funding disclaimer

As mentioned above, 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 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, Lithuania.

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

11.4

per 100,000 inhabitants in Czech Republic died from suicide or self-harm;[13] global estimates indicate depression may have contributed to up to 60% of these deaths[14]

11.2

psychiatrists per 100,000 inhabitants in Czech Republic[15]

5.2%

of people in Czech Republic are living with depression[12]

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]

€544 million

cost of mental health (direct and indirect) annually in Czech Republic[16]

4.8%

of Czech Republic's health spending on mental health[17]

4.9%

cost of mental health to Czech Republic's GDP (direct and indirect expenditure)[17]

Depression scorecard for Czech Republic

In the Czech Republic, approximately 100,000 people seek medical help due to depression each year.[18] Chronic depression affects about 4% of the country's population.

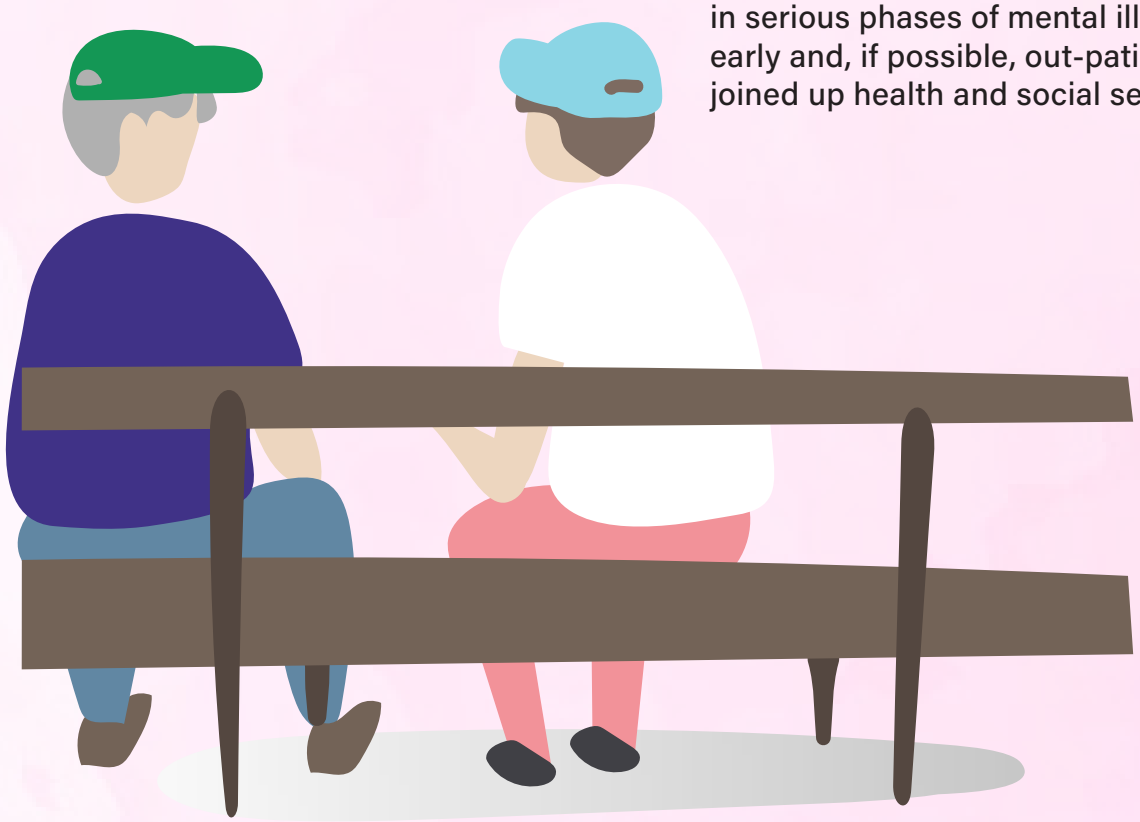
Suicide is the second most common cause of death in the Czech Republic for people between the ages of 15 and 24. More than 1,300 end their own life every year and 90% of all suicides are associated with some type of mental illness.

The Czech Republic lags far behind the EU average in terms of the number of psychiatrists per capita. The WHO recommends that countries should have at least 27 clinical psychiatrists paid by health insurance per 100,000 inhabitants. Germany has 49, Norway 73, the Netherlands 150 and even Poland has 16. The Czech Republic has only 7. Due to this lack of psychiatrists, but also a lack of psychologists, the waiting times to get an appointment are long and often lead to hospitalisation in cases of serious mental health conditions.

At the same time and despite certain efforts at awareness raising, mental illnesses are still often perceived as a taboo or a stigma. Patients are thus faced with overcoming a considerable barrier even before they seek professional help.

A key challenge remains the number of psychiatry professionals and the capacity of facilities that provide psychiatric care. Limited capacities result in long waiting times that can lead to a deterioration of patients' condition and when they eventually get to see a psychiatrist they may require more intense treatment that increases the burden on the healthcare system.

The mental healthcare situation in the Czech Republic is rather complicated. Psychiatrist numbers are far from sufficient. The structure of mental healthcare provision has been very slowly shifting from hospitalisation of patients in serious phases of mental illnesses to an early and, if possible, out-patient therapy with joined up health and social services.



Changes to the structure of psychiatric care have been addressed in several strategic papers.

The 2030 National Mental Health Action Plan[19] is the key document laying the foundation for further development of psychiatric care. This implementation document defines specific procedures needed to realise certain parts of the Strategic Reform of Psychiatric Care 2013–2023[20]. It is also one of the implementation documents of the 2030 Strategic Framework for the Czech Republic[21] and develops in more detail specific areas of the "2030 Health" strategic framework for healthcare development in the Czech Republic, including the implementation plan.

The healthcare ministry in partnership with the National Institute of Mental Health (NÚDZ) and the World Health Organisation (WHO) have developed a National Suicide Prevention Plan 2019–2030[22] aimed at reducing the number of suicides in the Czech Republic. It is the first strategic document dedicated to the prevention of self-harm and suicidal behaviour that provides concrete implementation procedures.

Partial results of the psychiatric care reform include the creation of a network of Mental Health Centres that specialise in providing integrated services to mental health patients and have the status of a local multidisciplinary care provider.

The aim of the psychiatric care reform is to change the structure of mental health services by deinstitutionalising therapy, i.e. moving the bulk of mental healthcare to the out-patient sector to ensure early diagnosis, relevant treatment available to patients in the early stages of mental illnesses and support with coping with mental health conditions in the home environment. Another aim is to alter the public's perception of mental illnesses and to remove the stigma that they carry. The reform also centres on a multidisciplinary approach and joining up of several services. The psychiatric care reform has been underway since 2013 but there are no concrete provisions ensuring its continued rollout.

About this scorecard

This scorecard was developed to highlight to policymakers where change is most needed to improve the management of depression in Czech Republic. 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 Czech Republic, 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.[23]

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.2 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.[23]

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.[24] 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.[25] 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.'[23]

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.[26,27] In addition, people with depression may find it helpful to use digital tools to connect with others and reduce feelings of isolation.[28]

Summary scorecard for Czech Republic

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?

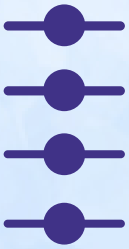
Is collaboration between primary care and mental health services supported and incentivised/ encouraged/facilitated?

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

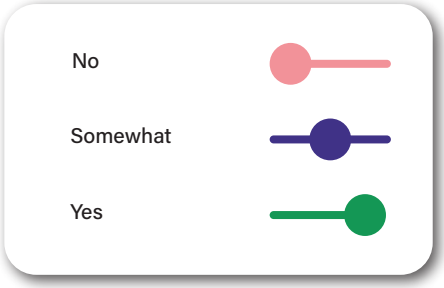


Data to drive improvements in depression care

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?

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

Is peer support recommended in depression care guidelines?

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

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

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

The mental healthcare system in the Czech Republic falls short of the comprehensive treatment concept in many respects including the treatment of depression and many other mental illnesses. The National Action Plan for Mental Health 2020–2030 provides a telling description of the state of mental healthcare in the country:

"To this day, the psychiatric care system in the Czech Republic relies heavily on large-scale in-patient psychiatric healthcare institutions where people suffering from severe mental conditions can remain hospitalised for very long time, sometimes for more than 20 years, which is clearly not cost efficient compared with community-based care, i.e. care provided in the patients' home environment.

Long-term hospitalisation is associated with a failure to meet the principles of the Convention on the Rights of Persons with Disabilities (WHO, 2018) but also with a higher risk of suicide after release from the hospital. The network of hospitals providing both acute and long-term treatment covers the country in a very uneven manner. The number of beds available in these facilities is inadequately low. Furthermore, this type of care is not integrated in general hospitals or connected to complementary somatic medicine services.

At the same time, the availability of psychotherapy is very limited. As for child mental health services, the out-patient care network is very sparse and plagued by long waiting times and a chronic lack of hospital beds. Pedopsychiatry wards in long-term treatment facilities for children and adolescents are very often designed for long-term care and do not admit acute cases.

Only a small number of in-patient facilities meet requirements necessary for accreditation for pre-attestation education, which creates another stumbling block in efforts to train new professions. Furthermore, child and adolescent patients are hospitalised in facilities located relatively far away from their homes, making it difficult for parents to visit their children and attend family therapy sessions.

This is an especially serious problem for parents of families with a lower socioeconomic status, i.e. precisely those families that are much more likely to experience mental illness. The vast majority of hospitals do not offer interdisciplinary care in their paediatric wards and some patients who clearly suffer from mental health issues are often released without any plans for follow-up care.

On the ministerial level, services for children and adolescents are the responsibility of a specialised ministry and collaboration with other departments on a more integrated approach has not been very efficient. Families are thus left to their own devices when searching for professional care and are often faced with communication barriers.

Community care is not sufficiently developed, especially in terms of prevention, rehabilitation and integration of people with mental health issues into regular society (including housing and employment). Community healthcare services for people with mental health issues are not integrated either into the healthcare system (such as primary care) or into social services and complementary services available on a regional level and rely primarily on the work of individual specialists offering only a narrow spectrum of services.

A multidisciplinary approach as the most efficient model for working with people with complex needs is found only in a portion of care services and multidisciplinary teams for mental health patients are currently testing this approach in pilot projects. The mental healthcare system lacks sufficient numbers of competent human resources, which stems from the structure and financing of care, the system of professional education and training as well as a lack of flexibility in terms of new approaches to working with human resources."[29]

The concept of joined-up care provided within the patient's usual environment is part of the psychiatric care reform initiated in 2013. So far, however, it has had only a limited impact on the services actually provided to patients.

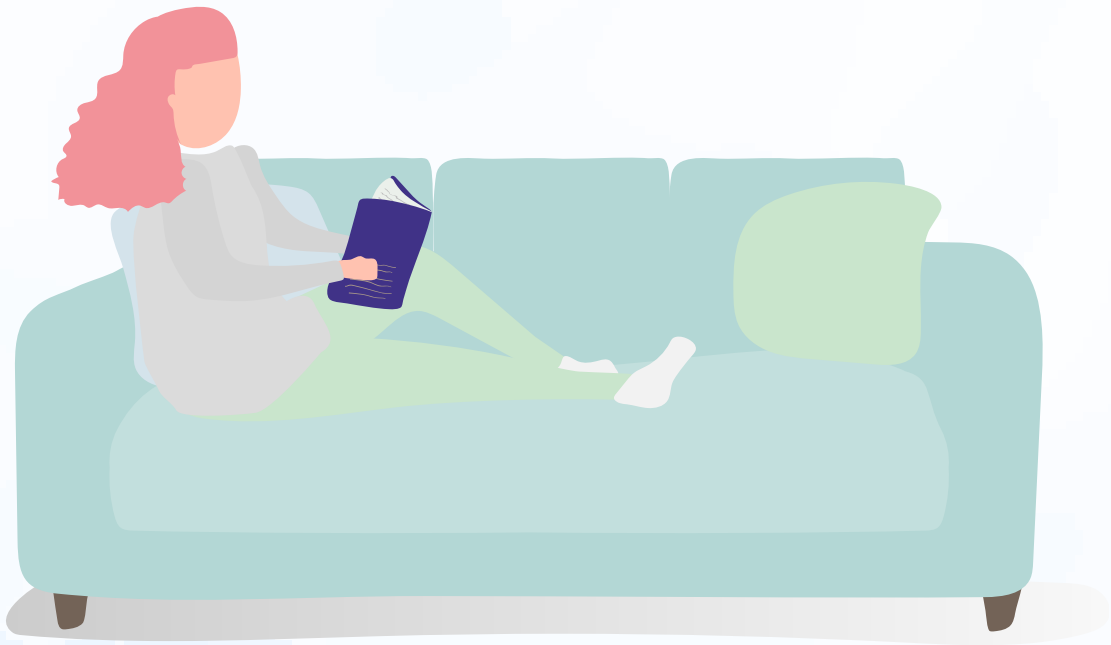
One of the outcomes of the psychiatric care reform in terms of complex services centred on patient needs is the creation of Mental Health Centres (see case study 1). A larger-scale change in mental healthcare has been hampered by human resource limitation (lack of both doctors and other healthcare professionals) and financial limitations. With a new government taking office after 2021 elections, it now unclear in what form or indeed whether at all the reform might continue.

Case study 1 – Mental Health Centres

A network of Mental Health Centres (CDZ) was set up as part of an ongoing reform of psychiatric care. Approximately 30 CDZs have so far opened in the Czech Republic. They represent a link between primary care, including out-patient psychiatric care, on the one hand and in-patient care, both acute and specialised, on the other.

The purpose of CDZs is to prevent and shorten hospitalisation and help patients integrate into regular life after long hospital stays. CDZ teams use a case management approach in their work. The teams consist of psychiatrists, psychologists, nurses, social workers and peer consultants.

In order to achieve their primary mission – maximum client integration and involvement in regular life activities and social environment, CDZs work with other local organisations dedicated to employment, education, housing and leisure.[30]



Data to drive improvements in depression care

Data on mental healthcare are systematically gathered and processed by the Institute of Health Information and Statistics of the Czech Republic (ÚZIS). Between 2013 and 2020, the Institute published a comprehensive annual report *Psychiatrická péče, zdravotnická statistika*[31] (*Psychiatric care, healthcare statistics*). Data on psychiatric care are also collected by insurance companies that make the information available for expert analyses. In addition to the ÚZIS, available data are also analysed by the National Institute of Mental Health (NÚDZ).[32] The NÚDZ also carries out its own research and generates own statistical data.

Information on the type and structure of care provided, the number of providers, their capacity and expenditure is, therefore, readily available.

Data on mental illness epidemiology are also easily available and have recently been published by, for example, the NÚDZ. These data indicate that there was a considerable, nearly threefold increase in depression cases in the general population during the covid pandemic.[33]

The economic and societal impacts of mental illnesses are an issue that deserves much more attention. Unfortunately, studies on this topic are only rarely published.[34] An analysis of the current economic and societal impacts could help drive the implementation of changes in the mental care system. A fundamental obstacle complicating an efficient analysis of such data is the split of services between the ministries of healthcare and social affairs and differences in the structure of data used by the two ministries (for example, calculating the true cost of healthcare services and connecting this cost to the real cost of related social services is very challenging and possible more or less only on the level of the individual).

Another area that would merit systematic data collection is service availability. However, shortcomings in this area are generally well known.

Data describing the state of healthcare, the capacity of healthcare facilities, the incidence of illnesses and desirable changes are, therefore, readily available. As for necessary changes, experts tend to be mostly in agreement thanks to efficient communication of the psychiatric care reform.

However, implementation of these changes in healthcare practice is not a priority for the ministry of healthcare and changes that are implemented are only of piecemeal nature.

Engaging and empowering people with depression

Psychiatric care currently treats patients mostly as consumers of care without any power to influence the management, control or administration of this care.[35] In fact, this approach to patients permeates the entire healthcare system in the Czech Republic in general. While ingrained processes are slowly changing situations where patients are involved in the decision-making on and provision of healthcare are still mostly exceptions and generally come about if the specific healthcare professional is willing to go beyond the framework of usual practices.

It is only recently that we can see a more active role of patient organisations that advocate for patients being more than mere recipients of services and becoming active participants in the setup and provision of these services. Patients have thus become members of advisory boards of certain institutions (e.g. insurance companies). The ministry of healthcare created its patient board[36] in 2017 and in recent years representatives of patient organisations have been invited to join several other of the ministry's advisory bodies. A number of organisations focusing on mental health participate in the activities of the ministry's patient board.[37] Thanks to this involvement, patients can bring forth suggestions based on their experience and propose changes to the system. They can also comment on proposed new measures including legislative changes.

Peer consultants as part of CDZ multidisciplinary teams

Peer consultant involvement in services provided within the Czech healthcare system is unusual. In the area of psychiatric care, peer consultants, i.e. people who have personal experience with mental illness and, at the same time, have the necessary qualifications (e.g. for social work), have been included in the multidisciplinary teams created in newly established Mental Health Centres.

Mental Health Centres use a case management approach in their work. Each patient is assigned a specific team member as his/her key case manager responsible for both direct care and coordination of other services. The case manager also seeks support from other team members if and when the situation and patient's needs require.

Within these teams, peer consultants use their own life story and experience with coping with mental illness.

Patient involvement remains an exception from the rule

However, small changes in the status of patients have had only limited impact. This is true both in terms of patient involvement indecision-making on the systemic level and in terms of patient involvement in care provision, e.g. in the form of peer consultation.

In the area of psychiatric care, this shortcoming has been explicitly laid out in conceptual and strategic documents created in relation with psychiatric care reform, including the National Action Plan for Mental Health and other documents.[38]

Case study 2 – Patient involvement in awareness raising and participation in riving changes in psychiatric care

The organisation Nevypusť duši[39] was created by people with personal experience with mental illness. Its activities focus mainly on education for selected groups of the public (pupils and students, teachers, employees). The organisation participates in projects targeting the general public including social network campaigns.

Thanks to its awareness raising and educational activities, members of the organisation were invited to participate in the psychiatric care reform and the Government Council on Mental Health.

The organisation's mission includes modernisation of mental health care, increasing prevention, early intervention, upholding patients' human rights and destigmatisation of mental illness. Nevypusť duši is also advocating for wider availability of services by increasing the number of graduates with relevant specialisations.

Harnessing technology to improve access to care

Technologies that could help improve access to healthcare are not being used in the Czech Republic. Telemedicine is not being actively implemented and still lack a conceptual framework. Standard procedures have not yet been defined for this form of healthcare service delivery and this type of services is not covered by public health insurance.

During the pandemic, various means of remote communication between doctors and patients were used on a temporary basis. This included general tools for online communication without adequate adaptation for the healthcare setting. In some medical fields (including psychiatry), such remotely provided healthcare services were reimbursed by insurance companies as a temporary measure during the pandemic. However, this practice has not been maintained after pandemic restrictions were lifted and no telemedicine standards have been defined.

The only technological innovation that has been implemented over the past decade is the introduction of electronic prescription system. This tool is fully functional (doctors have

learnt how to issue electronic prescriptions, patients have gotten used to receiving electronic prescription and pharmacies have no problem issuing medications based on them). Patients thus no longer need to use prescriptions on paper.

The utility of such technologies in the area of mental health care is not apparent. Personal appointments are indispensable for psychiatric treatment and cannot be replaced by remote communication.

In the context of fundamental issues with care capacities, long waiting times and a service structure not suited for a modern approach with a maximum use of multidisciplinary care within the patient's community, harnessing technologies seems as a rather marginal matter.

Conclusion and recommendations

The Czech Republic is struggling serious issues both with the structure of services provided to mental health patients dominated by hospitalisation and with the overall capacity of the system where patients often need to wait for months before they can receive out-patient care. The problems are even deeper in child psychiatry. Similar capacity constraints also apply to psychologist, which only exacerbates the problem.

As part of the psychiatric care reform, the above issues have been adequately described and a pilot project was launched establishing Mental Health Centres that provide a comprehensive care with a multidisciplinary approach including the involvement of peer consultants. Furthermore, these centres provide services near patients' place of residence and in conjunction with other support services.

Psychiatric care is not sufficiently funded and no measures were adopted with view of increasing the system's capacity in the medium or long term and strengthening the position of mental health within the overall healthcare system.

Priority recommendations

Joined-up and comprehensive depression services:

- Increase the number and capacity of psychiatric out-patient services for children and adults
- Increase availability of modern treatment
- Put mental health on an equal footing as physical health

Data to drive improvements in depression care:

- Establish a connection between social and healthcare systems in order to monitor social care expenditure linked to healthcare expenditure and assess the benefits that medical interventions bring to the state's overall expenditure on patients

Engaging and empowering people with depression:

- Support deinstitutionalisation of metal health care (strengthen the out-patient sector)
- Support joined up health and social services
- Destigmatise mental illness

Harnessing technology to improve access to care:

- As new telemedicine technologies are introduced to other medical fields, make these tools available also in those areas of psychiatry that they may be suitable for

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31. Statistika vybraných oborů lékařské péče, ÚZIS. Available from: https://www.uzis.cz/index.php?pg=vystupy--statistika-vybranych-oboru-lekarske-pece--psychiatrie

32. See https://www.nudz.cz/vyzkumne-programy/resene-projekty/narodni-projekty/

33. WINKLER, P., MOHROVÁ, Z., MLADÁ, K., KUKLOVÁ, M., KÅGSTRÖM, A., MOHR, P., FORMÁNEK, T. Prevalence of current mental disorders before and during the second wave of COVID-19 pandemic: An analysis of repeated nationwide cross-sectional surveys. Journal of Psychiatric Research. 2021, 139(July), 167–171. ISSN 0022-3956. DOI: 10.1016/j.jpsychires.2021.05.032. IF 4.791

34. One of the few analyses on this topic is EHLER, E., BEDNAŘÍK, J., HÖSCHL, C., WINKLER, P., SUCHÝ, M. & PÁTÁ, M. 2013. Náklady na poruchy mozku v České republice. Cesk Slov Neurol, 76. However, this publication analyses data as of 2010.

35. National Action Plan for Mental Health 2020–2030, page 15. Available from: https://www.reformapsychiatrie.cz/reforma/ narodni-akcni-plan-pro-dusevni-zdravi-napdz

36. See https://pacientskeorganizace.mzcr.cz/index.php?pg=pacientska-rada--pacientska-rada-2021–2025

37. One of the organisations represented in the ministry's patient board is the Kolumbus association; a list of board members is available at https://pacientskeorganizace.mzcr.cz/res/file/dokumenty/seznam-clenu.pdf

38. See e.g. National Plan for Mental Health 2020–2030. Available from: https://www.reformapsychiatrie.cz/reforma/narodni-akcni-plan-pro-dusevni-zdravi-napdz

39. See https://nevypustdusi.cz/

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