



Depression scorecard: **Latvia**

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Contents

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.

Author and contributor details

The research and drafting of this depression scorecard report were led by Vineta Zikmane and Kristiana Kelase-Pilege, Project Managers from VA Communications. We are also grateful to the following national experts who provided valuable insights on the situation in Latvia:

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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 Latvia.

Funding disclaimer

As mentioned above, this report is based on the guidelines and examples developed by The Health Policy Partnership as part of the Words to Actions initiative. The development of the guidelines and examples was initiated and financed by Janssen Pharmaceutica NV.

The Belgian, French, Italian and Romanian experts involved in the initial depression evaluation report, aside from The Health Policy Partnership, did not receive payment for their time. The same is true for experts involved in developing the scorecards in Latvia, Slovakia, Czech Republic, Hungary, Slovenia, Croatia, Serbia, Bulgaria, Estonia and Lithuania.

Depression: why it matters

4

Depression scorecard for Latvia

5

About this scorecard

8

Summary scorecard for Latvia

10

Joined-up and comprehensive depression services

12

Data to drive improvements in depression care

15

Engaging and empowering people with depression

16

Harnessing technology to improve access to care

20

Conclusion and recommendations

24

References

26

Depression: why it matters

Depression is a widespread illness worldwide, suffered by 3.8% of the population or 280 million people. Most likely to live with depression are adults (5%) and seniors over the age of 60 (5.7%).¹ In Europe, depression is even more common; in 2019, 7.2% of Europeans were diagnosed with chronic depression.² Depression is not, as is often thought, merely mood fluctuations and a short-term emotional reaction to difficulties in daily life. It is a serious psychological illness that can impact all

14.6 %
of people in Latvia aged between 15 and 64 are living with depression¹¹

€55.48 million was withheld from Latvia's GDP just due to the deaths by suicide for 2020⁸

In 2019 in Latvia, financing for mental healthcare was **€56.2 million**, which was 0.6% of the total state budget⁹

aspects of a person's life: lowering performance at work, disrupting education, and affecting personal relationships, sometimes even leading people to purposeful self harm or suicide.¹ As depression is widespread worldwide, it has been researched extensively, and various medications and treatment methods have been developed for the illness. However, in most countries there are still various barriers to the successful diagnosis, treatment and prevention of depression, linked with both bureaucratic decisions and prejudice within society. This all not only delays the correct diagnosis and treatment of depression, worsening the general health of society, but also has a direct impact on the economy of each country

In 2019, **18.1 per 100,000 inhabitants in Latvia died from suicide or self-harm.**⁹ Estimates show that depression may have caused up to 80 % of these deaths⁶

15.88 psychiatrists per 100,000 inhabitants in Latvia (2019).⁷

In 2019, **4.9%** of Latvia's health spending on mental health¹⁰



Depression scorecard for Latvia

Depression is a commonly-found illness in Latvia. The most recent official figures published by the Centre for Disease Prevention and Control of Latvia (CDPC) in 2016 show that around 7 % of the public aged between 15 and 64 suffer from depression.³ Meanwhile, in 2017, research by the Psychiatry and Narcology Department of Riga Stradiņš University on the spread of depression and the use of healthcare services within a 12 month period among the Latvian public showed that 7.9 % of those aged between 15 and 64 suffered from clinically significant depression within the 12 month period, while 7.7 % suffered from symptoms of depression. This means that a total of 14.6 % — around 270,205 — of Latvia's inhabitants suffer from depression.¹¹ However, as industry experts assert, Latvia maintains a high level of undiagnosed depression, as there are still high levels of prejudice around mental health in Latvian society.^{12,13}

Unfortunately, undiagnosed and untreated mental illnesses, particularly depression, are a significant risk factor for suicide. Information from the Latvian Psychiatric Association shows that around 300 people die by suicide every year, and around 80 % of these cases are linked with untreated depression.⁶ Latvia is still among the countries with the highest rates of suicide in the European Union (for example, according to Eurostat, Latvia had the 6th worst suicide rates in the European Union in 2019).¹⁴

Latvia spends less on healthcare than most European Union countries. When describing Latvia's healthcare profile, the Organisation for Economic Co-operation and Development (OECD) emphasises the fact that although public healthcare financing has increased slightly over the past few years, healthcare spending is still insufficient. In 2018, total spending on healthcare per person in Latvia was €936.20, one of the lowest figures in the European Union,¹⁵ and more than 30 % of patients cover their own healthcare costs, meaning

that, for 8 % of patients, healthcare becomes a catastrophic expense, bringing the household to the poverty line.¹⁵

One of the strengths of Latvian depression care is named by all experts as access to psychiatrists; people who experience mental health problems have extensive and fast access to specialists, with patients usually not having to wait longer than a week from making an appointment to seeing a specialist.^{12,13,16} However, the availability of specialists is linked with overworked doctors and the risk of burnout,^{16,17} as well as high administrative load,¹⁶ as a result of which the quality of care may suffer, as noticed by both healthcare specialists and patients.

Depression scorecard for Latvia

Over the past few years in Latvia, new clinical algorithms have been developed to recognise and treat depression, including for different risk groups, but plans and guidelines developed by professionals are not always implemented successfully when working with depression patients. Guideline development also lacks patient involvement, with documents being prepared by health industry professionals independent of patients, which means there is no feedback on depression treatment in Latvia, leading to an inability to make appropriate improvements in this field. There is also no indication that, when developing healthcare guidelines and plans in Latvia, data on depression patients and their experience is taken into account. Data of people with depression are collected in the official national register, but it only reflects a tiny part of the current situation. Data entry is voluntary, is not controlled, does not have a clear data usage system, and doesn't collect data on treatment outcomes.



About this scorecard

This scorecard was developed to highlight to policymakers where change is most needed to improve the management of depression in Latvia. 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 Latvia, 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.¹⁸



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.¹⁸ 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.¹⁸

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.¹⁹ 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.²⁰ 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'¹⁸

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.^{21,22} In addition, people with depression may find it helpful to use digital tools to connect with others and reduce feelings of isolation.²³



Summary scorecard for Latvia



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?

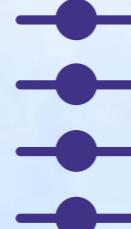


Is a range of therapeutic options reimbursed and available to people with depression, such as psychotherapy, counselling and cognitive behavioural therapy?



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 healthcare guidelines in Latvia are ready and available, but implementation is still mediocre

The public health guidelines developed by the Ministry of Health of the Republic of Latvia are the current mid-term policy planning document which sets out Latvian public health policy for 2021-2027. The document was created based on the Latvian National Development Plan for 2021-2027, where one of the goals includes strengthening public mental and emotional health, thus attempting to improve the life satisfaction of those living in Latvia and reducing suicide rates in the country.²⁴ The public health guidelines set out several indicators which would allow authorities to measure their success, for example, a reduction in those suffering from depression from 22.4% in 2020 to 20% in 2027.⁴ However, depression and the indicators, diagnostic and treatment plans for depression, are not set out in detail in Latvian healthcare planning documents, rather these issues are included in part in descriptions of various overall mental health improvement measures and goals. As experts emphasise, although various mental healthcare plans have been developed in the country, they are insufficient and lack financing and the involvement of responsible institutions in order to implement them, particularly when it comes to depression and suicide care. Meanwhile, for 2022, there is no mental health plan at all, as the entire healthcare system has been taken over by the COVID-19 pandemic.¹⁶ From a patient's perspective, too, the guidelines developed by the government are not of a sufficient quality, lacking an emphasis on a complex approach to treating depression and other mental illnesses.²⁵

The cooperation system between primary and secondary care specialists: disorganised, but improving

The Latvian Mental Health Care Access Improvement Plan 2019-2020 developed by the Ministry of Health states that Latvia lacks an interdisciplinary approach in the mental health field.²⁶ Identified country-wide problems included fragmentary services and insufficient collaboration by institutions, bearing in mind that Latvia does not have mutually integrated social, healthcare and education services, and how they are offered and available depends on both the government's basic range of services and the financial options of local municipalities.²⁶ The disorganisation of the system is also highlighted by experts in the field, who at the same time state that the situation, although with inconsistencies, is gradually improving. In 2021, the Ministry of Health worked with psychiatrists to develop short algorithms for family doctors to help identify patients who need to be referred to a clinical psychologist for a consultation, and those who need to be referred to a psychiatrist or the hospital.¹⁶ These and other guidelines on recognising, treating and caring for those with depression in Latvia, which were developed with the involvement of family doctors, psychiatrists, psychologists and neurologists, are publicly available.²⁷ The guidelines, as experts agree, are a positive contribution towards improving collaboration between care specialists, because there are doctors who use and fulfil them in their practices,¹³ although in general there is still a lack of targeted, systematic work on improving collaboration between family doctors and psychiatrists in Latvia.

Access to treatment increasing; bigger problems outside of Riga

Overall, in Latvia, as specialists in the field agree, the field of depression treatment in Latvia is gradually improving, but there are still extensive opportunities for improvement. Latvia has outpatient facilities where depression patients with a doctor's referral can receive various therapy options, such as cognitive behavioural therapy; visual art, music, drama and dance-movement therapy; physiotherapy, occupational therapy and nutritionist's services. Waiting lists for these facilities can be up to a month long,¹² however, they are a good opportunity for patients to receive a wide spectrum of help in one place over the month-long course of treatment. Patient representatives state that people are willing to use these facilities,²⁵ but they are only available in the capital city and in some larger regional cities, so options for depression patients outside of Riga to access varied treatment is extremely limited.

One of the 2021 improvements in the mental healthcare field is the option for patients with a diagnosis by a family doctor to receive state-funded psychological consultations with a psychologist or psychotherapist (5-10 sessions).¹³ Previously, patients could only receive these free consultations through social services. Latvian legislation also stipulates that medication needed by patients with mental and behavioural diagnoses are partially compensated by government funding.²⁶ These can be prescribed by both primary and secondary care specialists, and the medicines have 75 % of the costs covered.²⁸ This amount of coverage has been in place since 2019, when long-awaited amendments in the field were passed, which at the same time expanded the range of diagnoses for which medication is compensated.²⁹ The 75 % compensation still leaves a significant payment on the part of the patient, which in some cases blocks access to therapy for the most disadvantaged patient groups. In comparison, the neighbouring countries of Lithuania and Estonia cover 100% of the costs of medication therapy for patients with moderately severe and severe depression. At the same time, Latvia has problems with covering new, innovative medication; unlike our neighbours, these are not covered in Latvia,¹² denying patients the chance to receive the best care.

Lack of mental healthcare adapted for risk groups

Overall, Latvia's mental health guidelines are general and do not include specific risk groups. Although 1 in 14 working-age Latvians suffer from depression (figures from 2017),³⁰ working-age people are not identified as a target group in Latvian mental healthcare planning documents: they do not have their own adapted depression care plan or treatment programme. The homeless are also not identified as a target group in Latvian mental health planning documents. Those without a home are able to receive psychologist consultations in day centres, such as the Riga Shelter Day Centre³¹ but no detailed depression care plan for homeless people has been developed, and they are not included in the healthcare plans for the next few years.

In some parts, seniors are named in Latvian healthcare planning documents as a target group, for example, in the mental healthcare access improvement plan. Here, one of the tasks was promoting mental health in, and developing and implementing a prevention programme for, specific target groups, including seniors.²⁶ As part of the Complex Health Promotion and Illness Prevention Measures programme, the website <https://esparveselibu.lv/> was developed, which contains information about health promotion and illness

prevention measures,³² but up until now, the content targeted at seniors has been largely linked with vaccination and the impact of dementia on quality of life for seniors. Equally, in the 2018-2020 period, the National Health Service commissioned clinical algorithms and patient gateways in various fields, including mental health, which involved documents on the diagnosis and treatment of depression in older patients.

³³These are intended to promote a unified approach by healthcare professionals and give support in decision making, thus providing patients with high-quality, safe healthcare services in as short a time as possible while avoiding unnecessary expenses.

A second risk group which has been under particular scrutiny in Latvia is young people aged 18 and under. In 2019, a state-funded programme for reducing depression and suicide was founded, as part of which adolescents aged between 11 and 18 with mood disorders are offered opportunities such as an initial consultation by a specialist for assessing their health condition, and the development of a personalised treatment plan.³⁴ Information on the programme, its availability and how to apply is available online, and young people can apply without the involvement of their parents.³⁵ However, in reality, a very small number of adolescents, living in a very specific region, receive this support, according to an expert.³⁶ The programme was initially developed to create freely-available support centres and psychotherapy options for young people with depression and suicidal thoughts, but in practice this does not currently work. Due to bureaucracy, administration and the type of government financing available, the programme, in practice, duplicates state-financed psychology consultations and out-patient services, which has led to extremely long waiting times of several months. The guidelines and mental health treatment opportunities for adolescents are also not integrated with educational institutions, which is where young people spend the most time.³⁶ Realistically, access to information about depression and treatments is very low for adolescents, because there is no source that they perceive to be well-known, trustworthy and able to compete with information found on social media.³⁶



Data to drive improvements in depression care

Data on people with depression is collected in the official Register, but this does not reflect reality

The Centre for Disease Prevention and Control of Latvia has created a Healthcare Statistics Database,³⁷ which has been integrated into the E-health information system since 2018 and is overseen by the National Health Service. It contains a register of patients with specific illnesses (hereafter: the Register), including data on mental health up to 2018. The Register includes diagnosed and current patients with mental illness, including depression.

The figures on the Register are collected based on information given by medical institutions using the E-Health system. However, all experts agree that the information currently in the Register is incomplete, because current Latvian legislation does not make entering data into the Register compulsory for all healthcare professionals, rather it is voluntary, and there are several groups who can submit information: state-funded institutions, private institutions, family doctor practices. Firstly, specialists from private institutions usually do not enter patient information into the Register, and this cannot be controlled. Bearing in mind the high number of patients who are treated in private institutions, including those who seek treatment periodically due to not always having funds for private healthcare, there is reason to believe that the Register shows less than half of the true situation. Secondly, the precision of diagnoses is in doubt: often, specialists register diagnoses that do not come with obligations, for example, by adding a less-severe diagnosis.^{16, 17}

The incompleteness of the Register is much criticised, both by patients and professionals, and discussions on its usefulness are taking place. For government institutions, it is certainly a convenient, unified source of information which helps in monitoring the situation and protecting society, for example, when used to prevent a driving licence or gun permit being issued to a person with severe mental health issues.¹² However, it would be necessary to educate society on the functions and use of the Register to reduce doubt and uncertainty, as well as to promote more active entry of patient data by specialists. Currently, specialists are not supported financially or motivated in any other way to input the data. This is one of the reasons why specialists in private institutions often avoid submitting information, as patients are not clear on why they should be included in the Register and what it means for them.¹²

Currently, data are not used in national processes to improve mental health treatment, lack of human resources and funding

Health services and care should be planned and developed based on qualitative data on patient numbers, length of treatment, outcomes, patient satisfaction, etc. It is also data that can provide insights into how effective the current system is and what needs to be improved. At present, patient reports on treatment outcomes and effectiveness are not systematically measured or formally collected at national level. In Latvia, guidelines should be developed for the evaluation of services in relation to the effectiveness of treatment. For example, the state currently invests a considerable amount in adolescent mental health care, but it is not clear whether even one adolescent has experienced a reduction in depression because of this investment. Collecting such data and prospectively forecasting future needs would certainly be valuable in the development of health policy planning documents.³⁶

However, at present, because the Register's data do not reflect the real situation and are incomplete, they are not used in the process of planning national mental health documents. Data are accumulated, the human resources needed to compile them are high, but there are few real benefits.¹²

Engaging and empowering people with depression

The involvement of patients and their families in treatment currently only occurs on a non-governmental level

The Public Health Guidelines for 2021 - 2027 developed by the Ministry of Health set a goal: to promote access to person-centred and integrated healthcare services, which requires efforts to "encourage awareness in patients and their family members of healthcare and patient rights, as well as to encourage the involvement of patients and their family members in treatment."⁴ However, there is nothing more specific in the document about the role of families and carers in depression treatment or decision making on treatment and planning. This problem is also mentioned by psychiatrists and representatives from patient organisations, who monitor this situation on a daily basis. Firstly, Latvia has several non-governmental organisations and societies that support people with mental illnesses, but there are none that operate on a country-wide scale. Secondly, when developing plans or creating a range of treatment options, there are no requirements from the government either for quality indicators or for the involvement of patients or organisations representing them,³⁶ thus there is no feedback for the government on depression treatment.¹⁷ On the other hand, a new healthcare policy is currently in development, and the Ministry of Health is discussing the opinions of service users, which shows that there is some movement towards listening to patients in care planning, but it is still not set as a compulsory requirement in guideline development.¹²

Equally, a distinct problem in Latvia is in organising support for patients' family members. They require special support, as they are largely left alone with the patient and their heavy illness, while medics are only involved periodically due to a lack of human resources,¹² but the government does not currently provide this in Latvia.

There is no systematic collaboration between patient organisations and medics in Latvia

Another field where Latvia is lacking an organised, systematic approach is in collaboration between organisations representing patients and medical specialists and institutions. There are no traditions or financing in this area, no specific collaboration model on a state level, and therefore the parties often have no knowledge of each other.¹³ Although, on a collaborative level, there are also good examples, such as, patient organisation representative participation in the competition committee for the role of head of the psychiatric hospital, still the level of collaboration from a modern Western perspective are fairly limited.¹²

On their part, psychiatrists state that they lack information on what patient organisations do, and there is no initiative to collaborate, although specialists would like to.¹³ Patient representatives also agree to the fact that one of the problems is a lack of information on what is happening on the other side.¹⁷ Equally, a problem preventing collaboration between organisations and psychiatry specialists is financing: if it was available, there would be options for collaboration, lectures and meetings for patients of depression and other mental illnesses.²⁵ We can conclude that, currently in Latvia, both patient organisations and psychiatrists are truly interested and willing to collaborate, but barriers include a lack of systemisation and information exchange, as well as the lack of financing from the government.

Medical personnel lack government representation

Similarly to patients, Latvia has no nationwide associations to represent the interest of those caring for patients. For their specific profession, the Mental Healthcare Nurses' Union of the Latvian Nurse Association aims to promote the development of specialised mental healthcare nurses in Latvia and provide as high a level of patient care as possible in the Republic of Latvia. Its main activities include ensuring the preparedness of its members and organising and implementing further education measures both within Latvia and abroad.³⁸ However, in Latvia there is no broader nationwide or regional association for representing the rights of all those caring for patients with depression.

As psychiatrists explain, medical personnel in Latvia currently face several problems: doctors are burning out, because although the Latvian Psychiatric Association has developed workload guidelines for doctors with suggestions on time to be devoted to first-time or returning patients, financing is currently fixed regardless of time worked;¹³ medical personnel are ageing, and younger professionals have no desire to work in the field due to high intensity,¹² leading to a lack of professionals including nurses in the field; and there is a lack of mutual psychological support among specialists, although this improved slightly due to the pandemic, as finally medical institutions now have access to psychologists to support their own specialists.¹²

Example: there is great interest in support groups for families

As *Gaismas Stars*, an organisation which represents patients, emphasises, the state or local municipalities offer no support services for the family members of mental illness patients. They quickly suffer from burnout from undertaking long-term care of people with severe chronic illnesses, thus experiencing long-term stress. Family members become desperate, and sometimes start taking medication and are forced to visit a psychiatrist as they cannot care for their own mental health. The organisation's experience shows that, among families, there is great enthusiasm and demand for support groups. Organising these rests solely on the shoulders of the organisation, and they implement projects, source financing and organise for family groups to meet with professionals like psychiatrists to help overcome burnout, depression and other problems. When support group projects come to an end, family members regularly show interest in the next group or even just meeting up as a group, so that they can talk to other people who are in a similar situation.²⁵ This clearly shows the need on a nationwide level for regular, accessible support for those caring for family members with, for example, depression or schizophrenia, to avoid them also developing health problems.



Harnessing technology to improve access to care

Options for remote consultations are developing, but in-person care is still irreplaceable

Over the past few years, options for receiving remote help have become increasingly extensive. A crisis and consultation centre Skalbes offers consultations and one-on-one psychologist and psychotherapist sessions to adults and children by phone.³⁹ Similarly, the National Health Service website offers information about specialists, the age of their patients, who they offer services to, what therapy methods they offer as part of psychological and/or psychotherapeutic help, and what remote platforms they operate on.³⁴ The National Health Service has released a test version of their website rindapiearsta.lv, which shows information about waiting times for a consultation with a psychiatrist, psychologist or other specialist.⁴⁰ There is no unified state-level digital tool offering digital consultations; each doctor or medical institution selects and implements the remote consultation platforms of their choice according to their opinions and options. Latvia also offers the Republic of Latvia E-Health system, which stipulates that, as of January 1st, 2018, prescriptions for state-compensated medication are only issued electronically. This can also be done after a remote appointment with the doctor in charge of treatment.⁴¹ In practice, the use of these tools has been spurred on by the pandemic. Before, doctors were cautious about issuing prescriptions remotely, but now, e-prescriptions are used almost exclusively.¹⁶ However, the E-Health system has potential for improvement, for example, giving doctors the opportunity to see the patient's full medical history, which is not currently possible.¹³

However, although remote appointments — calling a doctor, talking through a problem and receiving a digital prescription for medication — are a good alternative when in-person meetings are not possible,¹² both psychiatrists and patient representatives emphasise that they are not a replacement for in-person care. Remote care is most suitable for repeat visits and consultations, and should not become the norm in psychiatry, because evaluating a patient for the first time through a screen would be fairly imprecise;¹³ furthermore, this process lacks personal contact.¹⁷



Harnessing technology to improve access to care

Patient organisations encourage the expansion of remote help opportunities

In general, due to the COVID-19 pandemic, various remote tools are being increasingly offered in Latvia, including specialist medical consultations by phone and on various online platforms (for example, WhatsApp, Zoom etc.). Similarly, as of February 1st, 2021, Skalbes crisis and consultation centre's free 24-hour support phone line has been operating at expanded capacity. Thanks to support from the Ministry of Health, the centre hired specially trained crisis consultants who take calls all day and night, and the public can also sign up for free remote sessions with a psychologist.⁴⁴ Patient organisations indicate that at least some patients with depression and other mental illnesses like remote consultations and find them useful, because they can receive help without leaving home, their safe space. However, there is a lack of government involvement in this field. For example, requests for support with the creation of a list of contacts listing remote help options were denied citing the pandemic as a reason.¹⁷

Government documents state that there are plans to further remote consultations both for patients and specialists, and for professionals between themselves. The Public Health Guidelines for 2021 - 2027 developed by the Ministry of Health mentions the option for professionals to consult amongst themselves remotely; one of the aims, "on the improvement of mental healthcare, promoting early diagnosis, improving medication options and promoting better treatment results," a sub-goal aims to "implement methodical leadership in the mental healthcare field, particularly highlighting the role of family doctors, including by introducing remote consultations between the family doctor and psychiatrist on problems faced by the patient and prompt diagnosis of the illness."⁴

Additional funds from the state budget necessary for the introduction of remote consultations for patients

The Ministry of Health's informational report On the Necessary Measures for 2021 and Subsequent Years to Reduce the Long-Term Negative Impact on Public Mental Health of the COVID-19 Pandemic⁹ states that the government needs to offer additional compensation from the state budget to psychiatrists for remote consultations, including, if necessary, consultations with medical staff. This measure would require additional financing for 2021 of €318,435, while for 2022 and each subsequent year, it would require €347,384.

Example: unique virtual reality digital tool developed in Latvia

This year, a Ministry of Welfare pilot project is being developed in Latvia: virtual reality therapy for adolescents.⁴² The project is being implemented by the Adolescent and Youth Psychotherapy Centre.⁴³ It hopes to offer virtual reality therapy to teenagers who have committed crimes or who are victims of crime (giving priority to young people living outside of family care), thus improving the adolescents' mental health and reducing the risks of them committing a crime or becoming a victim of crime. The project uses a virtual room — a room in virtual reality — where, while wearing VR goggles, the patient almost feels as though they are in a real consultation room. This room is equipped with different tools for psychodiagnostics and for offering interventions for the improvement of psycho-emotional health and behavioural correction. This tool was developed to improve important emotional control skills in adolescents and young people, and it could encourage greater child and adolescent involvement in the therapy process, make it possible to experience situations which could not be experienced in real life, and automate the therapy process, providing the service for a greater number of young people.

Conclusion and recommendations

Although mental health is touched upon in its healthcare plans, Latvia unfortunately still lacks focus specifically on depression care and treatment, as well as on preventative steps for avoiding depression. The country's strengths regarding depression care are access to specialists and the development of varied guidelines by professionals in the field. However, in reality, due to the high number of patients suffering from depression and other mental illnesses, psychiatrists are overworked and burning out, while the guidelines are usually not implemented or carried out due to a lack of human resources and systematic work in this field. There is also a lack of data and inclusion of patients' experiences in the development of plans, so there is no feedback and no improvement in depression care in Latvia. There are also significant problems in the register of depression patients, in which data input is not compulsory for medical staff, meaning that official figures do not reflect the true extent of depression in Latvia. At the same time, patients associate being placed on the mental health register with potential problems in the future, for example, when attempting to gain a driving licence or certain jobs, meaning that patients tend to refuse state-funded help or turn to private medical institutions to avoid being placed on the register.

Priority recommendations

Joined-up and comprehensive depression services

- Encourage a wider use of the guidelines and clinical algorithms in practice, including by implementing a clear collaboration model between family doctors and secondary care specialists, in order to improve mental healthcare.
- Increase the government payment on compensated medication for depression treatment from 75 % to 100 %, and include new medications on the list of state-compensated medication.
- Increase access to wider mental health treatment options outside of Riga by creating integrated out-patient clinics.
- Develop a comprehensive mental health improvement plan for 2022 - 2025 with clearly-defined goals, as well as measurable indicators for categories important to patients and medical personnel, with adequate funding.

Data to drive improvements in depression care

- Evaluate the current data collection and aggregation system and its quality, and make improvements, including explaining the functions and use of the official government Register to the public.
- Develop service evaluation guidelines regarding treatment effectiveness, using data to analyse healthcare policy and make improvements.

Engaging and empowering people with depression

- Develop systematic collaboration between patient organisations and healthcare specialists, encouraging an exchange of information between all involved parties.
- Listen to the experiences of depression patients and carers and use this when developing guidelines for Latvia.

Harnessing technology to improve access to care

- Support the creation of a centralised, nationwide list of all options for receiving remote help.
- Make improvements to the E-Health system, giving doctors the ability to see the patient's medical history in full.

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