Depression scorecard: Romania

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The Health Policy Partnership

About the depression scorecard project

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 scorecard framework has been applied initially 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.

This scorecard focuses on Romania.

Author and contributor details

The research and drafting of the depression scorecard were led by Catherine Whicher, Suzanne Wait, Pooja Krishnaswamy and Jody Tate of The Health Policy Partnership (HPP). We are grateful to the members of the Depression Scorecard Advisory Group, who volunteered their time to provide the guidance and feedback that shaped this work:

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- Claudia Dima, public health expert
- Amedeea Enache, Estuar Foundation
- Alexandru Paziuc, President of the Romanian Association of Social Psychiatry

Contents

Depression: why it matters

Depression is the most common mental health condition affecting people today.[1] The World Health Organization estimates that depression affects a staggering 4.3% of Europeans – 40 million people.[2] In light of the psychological effects of the COVID-19 pandemic, this number may now be even higher.[3]

Depression has a devastating impact on the lives of those affected, their families and societies more broadly. It is associated with numerous negative outcomes throughout a person's life, including poorer academic performance, reduced earnings, chronic illness, diminished quality of life and a higher chance of death.[4,5] It is the leading cause of suicide,[2] contributing to up to 60% of all suicides worldwide.[6] Up to 15% of people with untreated depression may die by suicide.[1] Stigma associated with depression may exacerbate suffering and prevent people from seeking and receiving quality care for their illness.[7-9] Depression also places a significant socioeconomic toll on European countries.

Only 3%

of health expenditure on mental health, compared with more than 5% in over 60% of European countries[15Δ]

1.5%

of people reported depression in previous 12 months, which is the lowest report rate among all European countries[10*]

10.4 per 100,000

inhabitants died from suicide or self-harm[11] compared with a European average of 12.9.[12‡] Global estimates indicate depression may have contributed to up to 60% of these deaths[6]

Romania has close to 12 psychiatrists

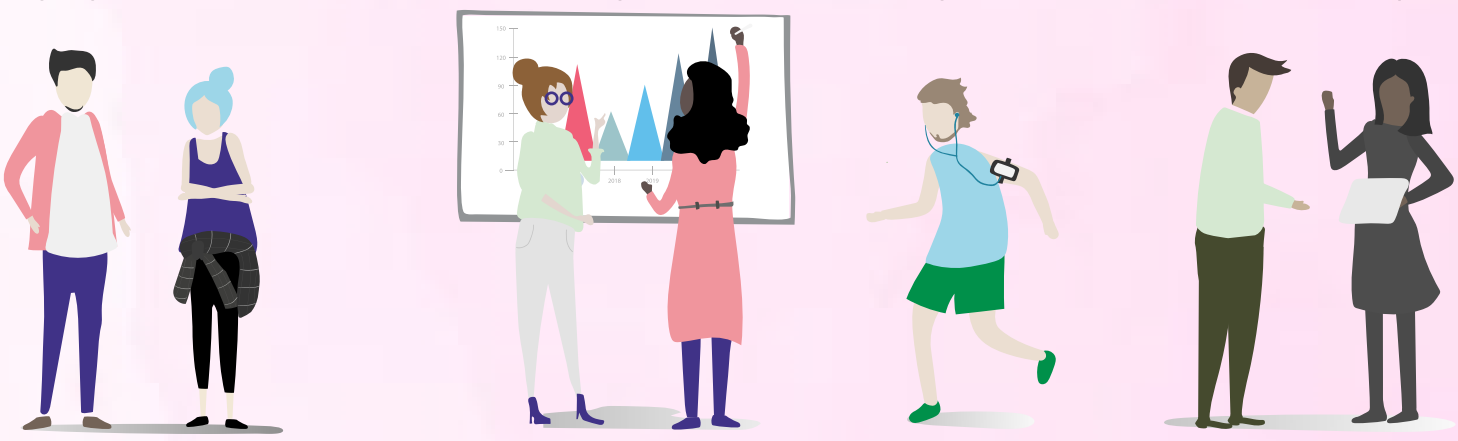
per 100,000 inhabitants, compared with the EU average of 17 per 100,000 inhabitants[13§]

€3.4 billion

cost of mental health (direct and indirect) annually[14¶]

2.12%

cost of mental health to annual GDP (direct and indirect expenditure) compared with 4% in the EU overall[14¶]



*Data from 2014 ¶Data from 2015 §Data from 2018 ‡Data from 2017 ΔData from 2007

Depression in Romania

Mental health services in Romania have undergone successive reforms which have aimed to deinstitutionalise care and shift services into community-based settings.[16] While policies are in place to support this change, thorough implementation is yet to be fully realised.[17]

Depression is widespread in Romania. Data from 2014 indicate that 1.5% of the population aged 15 and over reported symptoms of depression in the previous 12 months.[10] The COVID-19 pandemic appears to have exacerbated this.[18]

Regional inequalities in access to mental health care are a significant issue, impacting the ability of people with depression to access appropriate care. There is wide variation in the distribution of both mental health hospital beds and mental health workforce between regions.[19] This is combined with widespread gaps in the availability of outpatient mental health services.[19]

Mental health services in Romania often fail to recognise the critical role of involving people with depression in decisions about their care.[20 21] Stigma and a lack of awareness of depression in the community present additional barriers, preventing people from seeking and continuing with their care.[22 23]

These barriers and challenges may stem, at least in part, from general under-resourcing of mental health services in Romania. Estimates from 2007, the most recent year for which data are available, suggest that only 3% of health expenditure is spent on mental health, which is lower than most other European countries.[15]

Assessing depression management: the scorecard

This scorecard was developed to highlight to policymakers where change is most needed to improve the management of depression in Romania. 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 Romania, taking a comprehensive and preventive approach to address it in all its complexity.

The scorecard 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.[24]

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.[24] 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.[24]

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.[25] 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.[26] 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.'[24]

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.[27] [28] In addition, people with depression may find it helpful to use digital tools to connect with others and reduce feelings of isolation.[29]

Summary scorecard for Romania

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

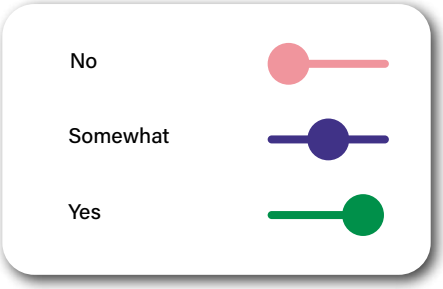



Data to drive improvements in depression care

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

Depression is inadequately integrated in national health and mental health policies and strategies

Romania's national mental health plan (2006, updated 2009) has been integrated into the national health strategy for 2014–2020, *Health for Prosperity*.[30] Although the strategy addresses mental health in general, it does not specifically refer to depression.

Policies to deinstitutionalise mental health services are yet to be fully implemented and there are significant gaps in the availability of services in the community

A process of mental health reform, which aims to deliver services in the community rather than in institutional settings, has been ongoing for a number of years. This shift has been slow and is not yet fully implemented.[16 17] While the number of institutional beds has reduced, the capacity in the community has not been strengthened to the same degree, leading to gaps in provision.[23]

Despite the intention to move towards community-based services for people with depression, in reality, there seems to be an emphasis on hospital care, while primary care and community care services are under-funded in comparison.[17]

Community services are available in some regions via mental health centres that support people with severe illnesses, but it seems that these services are few and inadequate to serve the needs of the population.[31] There are multiple reasons for this, but analysis from 2009 identified the main issues as: insufficient funding, low support and cooperation with local authorities, lack of cross-ministerial cooperation and coordination, and gaps in the available mental health workforce.[32] Mental health centres seem to have closed during the COVID-19 pandemic.[23]

People with mild mental illnesses tend to be supported by self-employed mental health professionals.[31] Primary care practitioners are usually also able to manage and monitor mild cases of depression after a patient is seen by a psychiatrist, although the level of coordination between the services is unclear.[23 33]

A lack of collaboration between primary and specialist services leaves people with depression facing gaps in care

Unlike in some other countries in the European Union (EU), guidelines for depression which involve primary care and psychiatric specialists are not available in Romania. A practice guide for primary care physicians to manage adults with depression was developed in 2009 and is endorsed by the Romanian National Society of Family Medicine (SNMF).[20]

Despite this, it has been noted by an expert interviewed for this scorecard that communication between primary and secondary care providers needs to be improved.[33] Furthermore, a review of the mental health care in Eastern European countries including Romania stated that cooperation and communication between healthcare providers treating patients with mental health conditions is inadequate.[34]

While policy and legislation supports cross-sectoral collaboration, implementation has been limited

Moves towards cross-sectoral collaboration in mental health can be traced back to legislation enacted in 2002, which called for the prevention of mental health conditions to be prioritised by a wide range of stakeholders. This includes a number of ministries (Health; Education; Research, Innovation and Digitisation; Labour and Social Protection; and Youth and Sport), in addition to the National Audiovisual Council of Romania, non-governmental organisations (NGOs) and professional associations.[16] Cross-ministerial collaboration is also a stated a priority within *Health for Prosperity* and the Child and Adolescent Mental Health Strategy 2014–2020.[35] After a slow start,[17 23 32 33] there does seem to be some movement in this area recently. A working group was established in the Romanian Parliament to update the mental health law. The group includes representation from NGOs and until recently was led by Senator Emanuel-Gabriel Botnariu.[35]

Cooperation between the health and social care sectors in Romania appears to be lacking, with both seeming to function almost independently of each other.[34]

There are few specific policies and programmes for many groups at risk of depression

Romania's national mental health plan aims to support service delivery for children and young people, as well as older individuals and 'traumatised people'.[30] Romania's Child and Adolescent Mental Health Strategy 2014–2020 further elaborates on the priorities for prevention and early diagnosis of mental health conditions specific to children and adolescents.[35] However, programmes to support early intervention and prevention of depression rarely reach implementation stage.[31]

Limited mental health services are available for older people, and those that do exist primarily focus on people with Alzheimer's disease. There seems to be a lack of information on the current provision of services for older people. In addition, there do not seem to be any policies or stated priorities which address the specific needs of other at-risk groups, such as people in the workplace who may struggle with depression alongside the stresses of their day-to-day work, or people who are homeless.

Depression care is reimbursed, although gaps remain

Although little information seems to be publicly available, Romania's social health insurance system, administered by the National Health Insurance House (NHIH),[17] is said to reimburse pharmacological therapy for depression in addition to psychiatric consultations and cognitive behavioural therapy, although the number of consultations covered is limited.[23] Other psychotherapies are not reimbursed.[23 36]

Data to drive improvements in depression care

Comprehensive data on depression are lacking

Health data are collected by the National Institute of Public Health (NIPH), though it does not appear that data on depression are collected systematically.[17] Data on people being treated in hospitals are reported monthly to the NHIH,[36] but data on people across all settings and in the community seem to be lacking.

The data which are collected appear fragmented. Health data are reported to NIPH by hospitals on discharge and periodically by family doctors.[23 33] However, experts interviewed for this scorecard state that some data are reported at a local level and some at a national level, with little coordination, meaning that data could be reported as duplicates.[33 37]

Data do not seem to be currently reported by specialist outpatient clinics or by private healthcare providers.[23 33] Romania also does not currently appear to be collecting or measuring patient-reported outcomes in depression or mental health.

Data do not seem to be regularly used for planning services

Though it is stated that data on health service utilisation are collected,[17] they do not appear to be publicly accessible. As a result of the fragmentation of data and the lack of feedback given to providers on the data they collect, it seems data are not widely used to inform changes in the delivery of services for people with depression.[17 23]

There do not seem to be any training programmes to support accurate and timely data collection and so methods of data collection and standardisation are likely inconsistent depending on the setting

Although public funds are allocated for healthcare data collection by the NIPH, there is no specific funding for data collection on depression.[33] According to one of the experts we have interviewed, the funding that is provided is insufficient and is mainly used for the payment of salaries for staff working in health statistics units. There is no funding allocation for data collection by family doctors.[33]

Engaging and empowering people with depression

People living with depression and their families are rarely involved in decisions on care, service planning or policymaking

Current clinical guidelines do not emphasise the involvement of people living with depression or their families in decisions affecting their care.[20] In general, traditional biological/biomedical approaches are often taken, with little consideration given to psychosocial components of a person's care.[34]

In addition, people living with depression and their families and carers do not appear to be involved in policymaking or the planning of services.[33 37] As reported by experts, they are not directly involved in any regulatory or reimbursement decisions, nor are their views sought for service delivery development.[6 23]

There is limited support for people living with depression and their carers

According to one expert, patient and carer support networks are in general unavailable for people with mental health conditions, including depression.[37] There also seems to be a lack of resources and centres that would provide information about depression care. It is unclear whether or not there is any formal financial support available for carers of people living with depression.[36]

In general, Romania does not seem to adequately recognise the role of informal carers.[38] Although some financial support and leave allowance is available to carers of people with severe disabilities, this is limited and it is unclear if it includes depression.[38]

Although people with depression can provide highly effective peer support for others with the condition, there is no formal framework to develop peer supporter role in Romania.[23]

There are a handful of NGOs which aim to bridge the gaps in depression and mental health care for patients. Estuar Foundation seeks to improve the community and social care of people with a mental illness, including depression (see **Case study 1**).[39] They provide community-based day-care services as well as supported housing, and patient and carer support through counselling, re-integration services, mental health education and psychiatric care.[39] They are also involved in advocacy and lobbying work and provide training in mental health care. Liga Română pentru Sănătate Mintală is another NGO whose mission is to aid in the development of government policies and community services for people living with mental health conditions.[40]

Case study 1. Estuar user involvement advocacy training programme

In February 2021, the Estuar Foundation began a programme to train service users with mental health conditions to lead and empower others with similar conditions to be mental health advocates in the community. The foundation is running empowerment seminars, teaching participants the skills to become leaders and mental health activists within their own communities.

Harnessing technology to improve access to care

The COVID-19 pandemic has widened opportunities to remotely access psychiatric services

While the COVID-19 pandemic has created healthcare challenges unprecedented in recent decades, it has also created opportunities for the widescale use of digital health platforms in psychiatry for people living with depression in Romania.[41] In response to the pandemic, the Romanian government now reimburses remote telepsychiatry consultations delivered via smartphone or computer.[36 42] This is supported by the Romanian Association of Psychiatry and Psychotherapy, which called on service providers to urgently adopt online services using safe platforms.[43]

A lack of standards, guidelines or training on telepsychiatry means the services provided may vary widely

Telepsychiatry is being delivered through existing commercial digital platforms (such as Skype, WhatsApp or FaceTime) and by telephone.[44] The introduction of remote care has been a milestone in psychiatry for Romania, and while it has been formally included in the health insurance new framework contract,[42] limitations exist in its use. To overcome gaps in the delivery of this service, healthcare professionals need to be trained in offering telepsychiatry, including improving their overall technological skills.[36]

Conclusion and recommendations

Depression can be a debilitating condition. In Romania, people affected by depression often suffer in silence owing to high levels of stigma and a lack of awareness of the care options available. Because of this, it is likely that the number of individuals experiencing depression is underestimated. The COVID-19 pandemic has further cast a shadow on this population and may have exacerbated barriers to accessing help, and the effects may last long after the pandemic. However, it has also presented new opportunities for innovation in the remote delivery of depression care.

By improving care for people experiencing depression, we can alleviate the heavy burden that they, and their families and carers, are living with. Romania's performance across the four domains assessed in the scorecard demonstrates specific areas of focus for policymakers, healthcare professionals and patient organisations.

Priority recommendations

Joined-up and comprehensive depression services

- Invest in expanding the availability of community-based services for people with depression, to bridge the significant gaps which exist at this level.
- Amend reimbursement rules to remove the limits on the number of consultations healthcare professionals can provide per day. Appropriate resourcing should be put in place to ensure the services required by people with depression are available to them.
- Establish systems and incentives to improve communication and coordination between primary and specialist care, which is often lacking.
- Strengthen cross-ministerial collaboration for community mental health services to address the lack of involvement of those outside of the health system, such as the education or social services sectors. This should be accompanied by monitoring and quality assurance frameworks to track progress.

Data to drive improvements in depression care

- Ensure systematic data collection on epidemiology, care, treatment and patient outcomes for people experiencing depression by healthcare professionals who have been trained in data collection.
- When the data are available, they should be used to effectively plan and monitor services.

Engaging and empowering people with depression

- Update clinical guidelines on depression to ensure that people with depression and their carers are involved in decisions on care.
- Develop specific guidelines for primary care with input from primary care physicians, mental health specialists, and people with depression and their families.
- Address the lack of awareness of depression among people affected and their families by linking them with local associations or resource centres which can provide ongoing support.
- Pilot evidence-based peer-support networks to understand the role they could play in delivering care for people with depression.

Harnessing technology to improve access to care

- Identify a set of digital tools which can be used by healthcare providers to ensure consistency in their use across the country.
- Develop and implement standardised guidance and training for the use of digital tools in routine practice.

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