Depression scorecard: Hungary

Experts and organisations listed as authors and contributors participated in the study, led by Ideas & Solutions.
The authors had full editorial control over the content. The study was initiated and supported by Janssen. The content of this study is not treatment or therapy specific.

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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 aim of this research is to assess the current level of performance in key areas of healthcare services for people with depression in Hungary. The framework that underpins this scorecard report was developed based on an international literature review and consultation with an expert advisory group.

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

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

The scorecard framework has now been made publicly available for advocates to use in their own countries, following the template and instructions provided in an accompanying user guide. The methodology used in this research will be published on www.Depressioncare.eu and on The Health Policy Partnership website.

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

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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 applies to experts involved in the work on the scorecard reports in Slovakia, the Czech Republic, Hungary, Slovenia, Croatia, Serbia, Bulgaria, Estonia, Latvia and Lithuania.

The experts involved in the development of the depression indicator system for Hungary, with the exception of the experts from Ideas and Solutions, were not remunerated for their work.

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Depression: why it matters

Unipolar depression is one of the most significant problem in psychiatry and medicine because of its prevalence and its individual and social importance.[1]

The symptoms of unipolar major depression are characteristic, causing the patient considerable suffering: loss of the ability to feel pleasure, loss of motivation for all activities, sleep disturbance, loss of appetite, feelings of worthlessness and guilt, frequent suicidal thoughts and attempts, and often accompanied by a number of physical symptoms. The patient is no longer able to carry out normal activities, or only to a very limited extent.

Unipolar major depression is one of the most common psychiatric illnesses, with nearly 200,000 patients in Hungary each month, less than half of whom are on medical (pharmacotherapy) treatment.[2]

Untreated depression can result in a downward spiral; at the 'end' of the spiral, the patient may experience reduced productivity, long-term unemployment, disability, inability to care for themselves, or even suicide. International and national research suggests that 65-87% of suicides are committed by persons with untreated depression at the time of suicide, and 15-19% of untreated major depressive patients die by suicide.[3-6]

Major (unipolar) depressive disorder (MDD) is predicted by the WHO to be the leading cause of loss of disability-adjusted life years (DALYs) worldwide by 2030. [7] Economic studies have now also shown that the societal burden of depression is greater than the combined total cost of hypertension, asthma, rheumatoid arthritis and osteoporosis.[8]

Major depression is a disease that often directly threatens not only quality of life but also life itself, with a direct and indirect economic burden in Hungary of up to HUF 360 billion per year.[2]

In Hungary, **15 %** of the adult population has experienced at least one major depressive episode, and 2.6 % experience major depressive symptoms every month (1998).[9]

€4.53 billion cost of mental health (direct and indirect) annually in Hungary (2018). [12]

17.5 per 100,000 inhabitants (1,706 people in total) in Hungary died from suicide or self-harm in 2020.[10]

The social burden caused by major depression in Hungary is much more significant than the direct costs of treating depression: the estimated annual indirect health care costs of treating major depression are HUF 334 billion and the annual direct health care costs of treating major depression are HUF 26 billion; the indirect and direct burden is approximately equivalent to the total annual retail pharma budget of Hungary, estimated at **HUF 360 billion per year** (2021).[2]

There are **11.9 psychiatrists** per 100,000 inhabitants in Hungary (2021).[11]

3.1% cost of mental health to Hungary's GDP (direct and indirect expenditure) (2018). [12]

7% of people in Hungary [aged over 15] are living with depression (2021).[1]

Depression scorecard for HUNGARY

In the WHO European Region, depression accounts for the largest share of the burden of mental illness – around 26% of the total in the European Union. Mental health conditions nowadays account for 21.1% of work disability, with depression being the second most prevalent, after stress. [13,14] Common consequences of untreated major depression and affective disorder include long-term disability, early disability, unemployment, secondary alcohol/drug abuse and dependence, smoking, increased somatic morbidity and mortality, and a markedly increased risk of suicide. [2,15]

In Hungary, the affected patient population can reach 600-700 000 patients per year, and there are nearly 200,000 major depression patients in any given month, less than half of whom are on medicinal treatment.[2]

The disease is generally under-diagnosed and under-treated, with diagnosis often delayed by years. In addition, the COVID-19 epidemic has led to a significant increase of depressive and anxiety symptoms and completed suicides in Hungary in 2020.[16]

Moreover, while the fight against mental disorders, including depression received increasing attention in outpatient and inpatient psychiatric care, education, and health programmes after the early 1990s, depression and psychiatric disorders seem to have lost their public health priority among health policy makers by now. It is scientifically demonstrated, that the most important factors behind the 65% decrease of suicide rates in Hungary between 1985-2020 were the improved access to psychiatry care and to effective treatments, therefore policy makers should keep mental health, patient care in the strategic focus.[10]

In general, the lay public and national policy makers are not or only partially informed about the socio-economic burden of major depression. The increasing prevalence and burden of mental disorders require a modern prevention and care system and integrated care organisation in Hungary.

A systemic approach to the treatment of patients with major depressive disorder should be emphasised: in addition to the traditional pharmacological and non-pharmacological therapies, integrated care should focus on disease awareness, prevention and education, thereby reducing stigma, further developing and expanding the capacity in both primary and specialist care, as well as facilitating interprofessional communication and patient follow-up.

About this scorecard

This Scorecard report was developed to highlight to policymakers where change is most needed to improve the management of depression in Hungary. 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 Hungary, 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.[17]

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.[17]

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.[17]

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.[18]
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.[19]

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.' [17]

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.[20,21]
In addition, people with depression may find it helpful to use digital tools to connect with others and reduce feelings of isolation.[22]

Summary scorecard for HUNGARY

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?

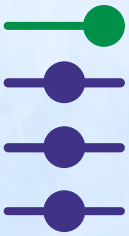
Is collaboration between primary care and mental health services supported and incentivised/ encouraged/facilitated?

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

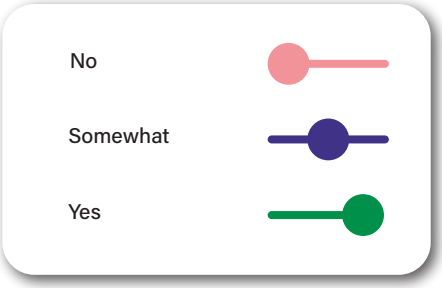


Data to drive improvements in depression care

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

One of the most pressing issues in the care of depression patients in Hungary is providing adequate funding for specialist care

In Hungary, patients with depression have access to a range of publicly funded health services (such as general psychiatric examinations, drug therapy, psychotherapy, counselling or cognitive behavioural therapy), but many patients have limited access to publicly funded specialist care due to lack of specialist and institutional capacity and insufficient funding (such as capacity limits and long waiting lists).

Psychotherapy would be another pillar of integrated care, alongside antidepressant pharmacotherapy: psychotherapy sessions are widely used and professionally acknowledged as a non-pharmacological treatment for major depression, and psychotherapy is often the best suited therapeutic alternative of non-pharmacological treatments.

The use of psychotherapeutic procedures/methods in Hungary is lower than the potential demand, based on professional experience and patient turnover data, as well as international comparison, largely due to underfunding. The total annual funding for psychotherapy in Hungary for major depression is less than HUF 150 million.[2,23]

The underfunding of domestic psychiatric care (particularly psychotherapy sessions) greatly reduces access to appropriate and modern care for patients in need, and contributes to the migration of physicians from the public healthcare system to the private sector. There is a need for the maintenance and increase of outpatient DRG points/values (outpatient DRG values). Psychotherapy DRG points/values revision must recognize the real cost of interventions, and the increased DRG rates can impact the number of psychiatrists leaving the public healthcare system for private healthcare sector.

Clarification of patient pathways and improvement of communication and collaboration between health care professionals will be required in Hungary

Patient pathways in depression care are far from the optimal, as a result many patients are lost or drop out from the health care system.

It is also a problem, that many patients with depression do not enter the health care system at all, due to the significant social stigma around the disease.

Patients visiting the physician with their symptoms face a number of challenges at primary care already: GPs have limited prescription power therefore treatment options at primary care level are limited, patients referred by GPs to psychiatry care, specialist often drop out of the system due to long waiting times or due to stigma. In specialist care - based on the experience of psychiatrists - the number of patient appointments are limited to 2-3 visits /year only, and as a consequence a significant proportion of patients drop out of care due to lack of continuous follow-up.

Non-optimal patient pathways also make it difficult to the follow up of patients; many patients get lost in the health care system and as a result their major depressive disorder will not be treated.

There is a need to improve communication between levels of care and between associate health care professionals (e.g.: requirement of regular consultation between regional Psychiatric Outpatient Units and primary care physicians), defining the actors and their competences, developing a more effective patient follow-up system than at present, and patients with depression should be preferably treated by psychiatrists (financial measures needed to support this preference), rather than neurologist and internists. Health care professionals providing occupational health services must be trained, and employees should receive health psychology support (screening at workplaces must be in focus).

The clinical guidelines and recommendations related to major depression have been updated in 2021 (*The Ministry of Human Resources' medical guideline on diagnostic and therapeutic guidelines for major (unipolar) depressive disorder*[1] *and Health Medical Guidelines - Diagnosis and Care of Mood Disorders in Children*)[24]; the medical guideline on the early detection, care and prevention of suicidal behaviour in adults is also up to date.

Preventive approaches need to be strengthened in Hungary

Research shows that nearly 50% of patients visiting their GP have a psychiatric symptom to treat, often associated with a somatic illness[25]. Major depression is recurrent in about 50% of cases and chronic in 20-30%, i.e., it persists for years or decades; early detection and treatment are also important to prevent complications.[26] Due to their prevalence and recurrence depressive disorders represent a major challenge both for psychiatry and primary care: depression and its frequent complications (e.g. suicide, suicide attempts, secondary alcoholism/drug abuse, etc.) lead to a significant burden on patients, carers and society level. [27]

Major depressive disorders can be treated effectively with medications and non-pharmacological treatments and suicidal thoughts can also be prevented.

General practitioners, besides psychiatrists, play an important role in identifying the risk of suicide. Appropriate coordination and professional cooperation between levels of care should also be promoted at policy level.

Furthermore, there are many examples, benchmarks in the prevention of depression and suicide in Hungary and internationally; presenting good practices and effective initiatives should be a priority of health policy in Hungary.

Data to drive improvements in depression care

Data regarding depression care are available in Hungary but not systematically evaluated

As a single payer (sick fund) in Hungary, the National Health Insurance Fund Administration (NEAK) is the central organisation responsible for health insurance tasks defined by law, the management of the Health Insurance Fund, record-keeping, financial accounting and reporting.

NEAK manages, operates and develops the IT systems necessary for the performance of health insurance tasks, and ensures the collection and transmission of statistical data. While the sick fund collects and publishes regional and national statistical data on both outpatient and inpatient care and on the use of medicines (mainly turnover/sales data) on a monthly basis:

- structured data collection and evaluation are not carried out either for psychiatric care in general or for the treatment of depression,
- capacity and utilisation data for specialised psychiatric care at regional and national level are not known by treatment centres,
- available patient care and epidemiological data are not used by the health administration, or are used in an ad hoc manner only, to improve psychiatric care and to inform national strategies,
- access to deeper, therapy-specific data can only be provided to institutions through a long and bureaucratic data request process,
- drug therapy-specific data are available publicly only following the publication of clinical trials where Hungarian health care institutions were involved, or through real world evidence studies initiated by pharmaceutical companies.

It is of particular importance that the data currently available are collected and evaluated in a structured way, and that the content of the data is made available to both the treatment centres and decision-makers at regional and national level. Primary or secondary prevention programmes, targeted development projects should be based on real national patient turnover and epidemiological data and on data from the National eHealth Infrastructure (EESZT, i.e., national eHealth data space).

Decision-makers need thorough, detailed analyses on the indirect and direct burden of the disease.

In Hungary, disease burden studies on diseases of major importance are rarely published to support policy and funding decisions by health policy makers. These studies could help to shape sectoral strategies and public health programmes through a deeper understanding of the individual and societal burden of disease, taking into account the magnitude of the direct and indirect economic burden of disease.

Understanding the indirect burden is of particular importance: depression accounts for the largest share of mental health-related burden in the WHO European Region, for 26% of all mental health-related harm in the European Union, and mental health conditions now account for 21.1% of work capacity losses, with depression being the second most important, after stress.[13,14] According to a study by the Hungarian Psychiatric Association, patients with major depression miss approximately 41 days of work due to their illness.[2,28]

In 2021, the Hungarian Psychiatric Association published a report titled *"Individual and socio-economic burden caused by major depressive disorder (MDD)".* Based on this analysis, proposals for solutions have been formulated which could reduce not only the burden of disease of people with major depression, but also the burden on society.[2] The positive reception of the analysis has led to a clear need for professional and health economic support for health decision-makers in setting health promotion priorities, both in general and in the field of psychiatry.

Patient registers are used in isolated cases only in Hungary

Integrated health data management and a system of disease registries supporting decision making with high-quality evidence are of key importance for health policy.

Data from patient registries play an important role in the development of health strategy, the planning of preventive action, the development of the care system, the improvement of patient care and in the conduct of clinical trials. Today, there are nearly 20 patient registries in Hungary (e.g. the National Cancer Registry, the National Stroke Registry, the National Heart Attack Registry or the National Affective Disorders Registry currently required in the field of psychiatry). [29]

At both policy and institutional and patient care levels, it would be a significant step forward to have a detailed understanding of quality and patient flow data on psychiatric diseases, to use the data in a targeted way in health care development, and to develop databases focusing on high-risk groups (e.g., post-suicide survivors and their families).

A suicide register could help to identify intervention needs more precisely – by area – to design targeted suicide prevention programmes, and to monitor more closely the results of these programmes.

Case study[2]

"Individual and socio-economic burden caused by major depressive disorder (MDD)" study

In 2021, a public policy study was published to present the individual and socio-economic burden of major depression. The study, led by the Hungarian Psychiatric Association, also explored the magnitude of the direct and indirect economic burden of depression.

The study shows that the economic burden of major depression is of a similar magnitude to other widespread chronic diseases. Indirect costs significantly exceed the burden of direct costs (92% vs. 8%): the indirect burden on society is approximately equivalent to the total annual pharmaceutical retail budget. According to the analysis, an estimated annual indirect health expenditure of HUF 334 billion and an annual direct health expenditure of nearly HUF 26 billion can be identified as the annual burden/cost of the disease.

The greatest indirect burden of major depression is the loss of working days and loss of productivity.

Engaging and empowering people with depression

Only few patient organization provides dedicated support to people with depression in Hungary

The continued and sustainable functioning of patient organisations, NGOs and mental health first aid lines for depression is essential for the effective management of depression at the societal level. There are several such organisations in Hungary, including Magyar Lelki Első segély Telefonszolgálatok Szövetsége (*Association of the Hungarian Phone Emergency Services*), Búra (*Dome*), Lélekben Otthon (*Home for the Soul Foundation*), Betegszervezetek Magyarországi Szövetsége (*Hungarian Alliance of Patient Organizations*), Ébredések Alapítvány (*Awakenings Foundation*) and the Pszichiátriai Érdekvédelmi Fórum (*Mental Health Interest Forum*).

Patient organisations can help increase the social acceptance of depression, help patients cope with their illness by creating a supportive atmosphere, and play a significant role in reducing the number of both completed suicides and suicide attempts. Social outreach to patient organisations and NGOs is also extremely important. An outstanding, positive example of this is the Deep-Breath Project, which seeks to provide information on mood disorders in an easy-to-understand way in social media.

Both public prevention programmes and national NGOs, patient organisations and patient education programmes have a significant role to play in suicide prevention. Unfortunately, a negative phenomenon in our country over the last 20 years has been the decrease in the number of patient organisations and foundations dealing with depression and suicide. Whereas in the early 2000s there were many patient organisations, today there are only a few.

Involving patients and patient organisations in decision making processes is not common in Hungary

In Hungary, patients and patients' organisations are not, or only rarely, given the opportunity to participate in the preparation of health policy, development, public health or care financing decisions, despite the fact that the articulation and representation of life experiences, social and ethical values experienced with illness can be crucial in decision-making.

This is also true for health technology assessment (HTA, i.e., the evaluation and review of new procedures, interventions, drug therapies). Several technology assessment bodies (NICE, SMC, CADTH) around the world now seek the views of patient organisations, either orally or in writing, to better understand the therapeutic area and to better assess patient needs. Although the latest national health economic guideline mentions patient organisations as potential partners in the validation of the Hungarian standard of care/routine practice of therapies and procedures, patients and patient organisations do not currently play a real decision-preparatory or supporting role in health technology assessment.

The stigma surrounding mental illness in Hungary has a tangible and direct impact on patient care

A high level of social stigma is associated with mental illness in general, and for depression in particular: patients do not have supportive atmosphere they need at work, in their social life, and often not even from their relatives. The lay public often thinks that depression is a 'simple' bad mood that the patient just needs to get over.

Due to social stigma, a significant proportion of patients do not consult physicians at all, fearing negative social consequences.

Many international and national projects have been developed over the last decade to reduce the stigma of the disease, such as depression awareness projects and community health promotion activities[2]. In general, any example of involving psychiatry in the work of any other co-discipline can be considered good practice. Examples include psychiatrists and clinical psychologists in general practice, who assist the general practitioner, raise awareness of the importance of mental illness and diagnose mental illnesses that are not detected by the general practitioner, thereby building trust in psychiatric practices, psychiatrists. This reduces social stigma and significantly improves the effectiveness of communication between psychiatric care and primary care.

Hungary does not currently have a national antistigma programme reflecting a coherent approach, so far mainly local antistigma programmes embedded in the rehabilitation process have been developed, while the transfer of relevant knowledge about mental disorders and the systemic sensitisation of the "general population" has been lagging behind. However, the establishment of the *Hungarian Antistigma Working Group* in 2020 is a positive example; their aim and task are to ensure that in the long run no one living with schizophrenia, bipolar disorder or depression should have to feel ashamed or stigmatised.

Case study
Deep-Breath Project

The operation of patient organizations and non-governmental organizations dealing with depressed patients is essential for the effective treatment of depression at the social level. Patient organizations can help increase the social acceptance of depression by helping patients manage/process their illness by creating a supportive atmosphere. An outstanding and positive example of this is the Deep-Breath Project, which seeks to provide information about mood disorders in an easy-to-understand way through social media.

The Deep-Breath Project has been sharing patient education content on social media since 2020, focusing not only on raising awareness and promoting mental health, but also tackling the stigma surrounding people with mental illness. The success of their social media pages and the demand from people living with mental illness for meaningful patient education is demonstrated by their 100 000 + followers.

One of the merits of the Deep-Breath Project is that it destigmatises psychiatric illness and encourages people to dare to ask for support and to seek professional help.

Harnessing technology to improve access to care

Restrictions caused by the coronavirus epidemic have advanced the widespread use of telemedicine services

In connection with the COVID-19 epidemic, the health government recognised that in many cases institutional care might be associated with infection risks, thus the use of telemedicine services has come in focus in Hungary. According to a government decree issued in April 2020 *(Gov. Decree 157/2020 (29 April 2020)* on certain health measures ordered during an emergency), the use of telemedicine platforms has become available and reimbursed for several medical specialities.

The regulation allowed specialists to diagnose, prescribe, advise, consult, refer or prescribe medicines online.

The use of telemedicine during the epidemic has supported patient care, physicians were able to reach patients who would otherwise not have seen a physician in person due to restrictions or fear of the epidemic.

It is worth noting that the reimbursement of publicly funded mental health telemedicine services is currently inadequate. According to the relevant regulation, only two procedures for the provision of psychiatry care can be charged to social security budget:

- check-ups, consultations outside of the doctor's office or within the frame of telemedicine services
- documented psychiatric counselling by telephone.

The two procedures cannot be recorded and reported together in one session, and the funding value of both procedures is currently very low, with HUF 1,121 and HUF 224 respectively.[30], i.e. telemedicine psychiatry care is not financially sustainable for the publicly funded treatment centres.

e-Prescription is available and frequently used in Hungary

Hungary's e-health system is the National eHealth Infrastructure (EESZT), which was introduced on 1 November 2017 for GP services, outpatient and inpatient care institutions and for all Hungarian pharmacies. The e-Prescription module offers centralised services that support all functions of prescribing and dispensing. The treating physician and pharmacist can access the data recorded in the system, in line with data privacy regulations and the system provides the treating physician with options as one-off prescriptions, recurring prescriptions, revoked prescriptions and the possibility to query based on social security number. The treating physician can check and monitor whether the prescription has been dispensed, i.e., whether the patient has started or is continuing therapy.

The EESZT System is a major step towards high quality patient care and also towards strengthening the follow up on treatments; further system developments will also improve the quality of care for patients with depression.

Alongside the rise of telemedicine services, Phone Emergency Services indirectly support the acute psychiatry care

The free S.O.S. Helpline is a substantial element of psychiatry system providing real support for patients with depression. The Association of the Hungarian Phone Emergency Services (LESZ) was established in 1991 and it has been uniting the emergency telephone services operating across the country since 1970.[31]

The Association has 22 members in 2022, with around 500 operators on call 24 hours a day. In the LESZ, patients are assisted mainly by psychiatrists, psychologists, social workers, educators, mental health professionals and chaplains. The operators on duty are specially trained specialists who undergo several months of theoretical and practical training to acquire the knowledge that is essential for the helpline services.

The helpline service plays an important role in helping people in mental health crisis or suicidal crisis, referring them to the right health care professional or institutions. The number of calls per year is between 100,000 and 120,000 and is increasing; 8-10% of them are due to plan for committing suicide or other serious crisis.[2]

The most important challenge to solve for the Phone Emergency Service is to gain adequate funding, as the current resources are covering the maintenance of services only, but are not sufficient for continued development of the services.

The guidelines for helpline services are more than 6 years old. While the principles and procedures laid down in these have not changed in recent years, a formal update is required.

Conclusion and recommendations

Based on statistics, major depression affects 7% of the adult population in Hungary every year.[1] Despite the high number of patients, the depression patient care in Hungary does not receive adequate attention in health policy: limited attention is paid to this mental disorder outside of the scientific literature, having significant economic and societal consequences.

It is clear that, in addition to suicidal behaviour, episodes of major depression have a significant impact on the quality of life of patients, their work, their family role and the lives of their relatives and social networks. Common consequences of untreated depression are long-term disability, secondary alcohol/drug abuse and dependence, increased somatic (cardiovascular and cerebrovascular) morbidity and mortality, and a markedly increased risk of suicide.[2]

Considering the high number of patients impacted, the disease burden and the systemic problems of psychiatry patient care in Hungary, a comprehensive approach to the care of patients with major depressive disorder should be prioritised. In addition to the traditional non-pharmacological and pharmacological therapies, a systemic approach to care will focus on disease awareness, prevention and education, reducing stigma, and further developing both primary and specialist care, increasing capacity, ensuring adequate funding, and promoting interprofessional communication and patient follow-up.

Despite many positive interventions in the field of mental health, there has been no systemic change in the last decade:

- In 2019, the government approved five National Health Programmes for 2019-2030, which aim to comprehensively reform the health system to reduce the greatest health losses, maintaining mental health as a priority (Mental Health Programme[32]), but the programme has not been implemented and dedicated resources for mental health area has not been allocated yet.
- The new Healthcare Legal Status act came into force, and while the capacity and structural issues of patient care did not improve, the salaries of psychiatrists and hospital psychologists were increased. All of this indirectly contributes to maintaining the quality of care and to improving the financial remuneration of specialists and psychologists providing care.
- A new version of the *Medical Guideline on the Diagnosis and Treatment of Unipolar Depression* is available from spring 2021, and the *Health Professional Guideline - Guideline on the Diagnosis and Treatment of Mood Disorders in Children* was also updated in 2020. The guidelines have also been sent to relevant patient organisations for assessment.
- At the primary care level, GP communities have been established, allowing primary care physicians to develop closer forms of cooperation and to ensure the involvement of psychologists in mental health care in some districts.

In summary: While the long waited systemic changes have not been implemented yet, the structure of speciality care is basically appropriate. Numerous reimbursed services and medications are available in the country, several specialised care facilities have been developed over the last decade, a new primary care structure has been developed and the salaries of psychiatrists and psychologists in state-funded institutions have started to be adjusted (however, there is a shortage of professionals in adult, child and adolescent psychiatry), but the necessary

systemic change has not yet taken place.

The increasing prevalence and burden of mental illness requires a modern prevention and care system in Hungary. There is a need for partnership between all actors who can contribute to the prevention and treatment of mental disorders, to improve the health and quality of life of people living with mental illness, and to reduce the burden of mental disease.

A comprehensive national programme to support psychiatric care, including depression care, should, in addition to developing institutional capacity and improving care financing, place particular emphasis on close cooperation with health, social and educational institutions, care providers and local government bodies, as well as NGOs. The focus of system development should be on strengthening primary care, community care and outpatient care, while maintaining inpatient care capacity. Online forums, digital applications and the media should play an increasingly prominent role in disseminating knowledge and best practice about depression and dispelling misconceptions about the illness, in addition to professional communication in primary and specialist care.

In the development of care, focused attention must also be paid to the information of patients and their carers: it is important that they have access to real-time information on the details of access to care (availability of professionals and institutions, range of professional services, patient pathways), regional services, prevention and awareness-raising programmes, and an accurate status of the civil and public/governmental organisations representing their interests, the range of support services and financial resources available, and the possibilities of applying for them.

It is also important that data already available regarding depression should be collected and evaluated in a structured way, and made accessible to treatment centres and decision-makers at regional and national level, so that in the future patient care can be developed in a targeted way, in line with the needs of regional and/or high-risk groups.

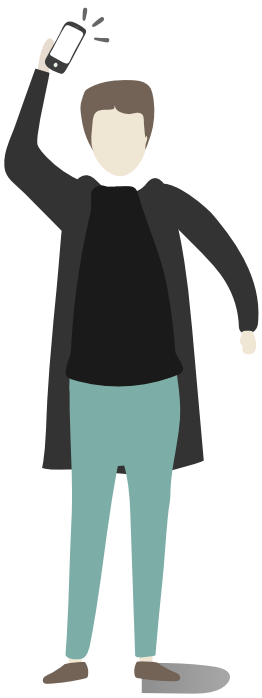
Priority recommendations

Joined-up and comprehensive depression services:

- There is a need to build awareness and sensitise primary care physicians to mental disorders and thus encourage more effective involvement of primary care in psychiatric care. More effective involvement of primary care would allow patients with mild symptoms in the early stages of depressive disorder to be treated successfully at the lowest level of the care system, allowing more time for moderate and severe patients in specialist care, where capacity is limited. Based on international practice and a national proposal published in 2016, it may be worth introducing rapid screening tests of 5-10 questions to screen for the most severe mental disorders in general practice.[26,33]
- The higher involvement of primary care can be promoted and encouraged in several ways: either by changing the power of GPs to issue a prescription (linked to a specialist examination/licence exam) or by the provision of reimbursed psychiatric consultations and by making them more widespread. This would require the definition of a new diagnostic and therapeutic ICPM *(International Classification of Procedures in Medicine)* code. The strengthening of general practitioners' services/practices with a clinical psychologist is also justified to meet the increased demand of patients.
- The underfunding of psychiatric care (e.g., psychotherapy sessions) greatly reduces access to adequate and modern care for patients in need, and contributes to the migration of physicians working in the public health care system to the private sector. There is a need to maintain/significantly increase funding values (in outpatient care).
- In Hungary, patient pathway management for major depression care is sub-optimal and communication between levels of care and between allied professions needs to be improved.
- Available pharmacotherapy alternatives need to be expanded, and new, innovative medicines must be made available to Hungarian patients.
- Among the non-pharmacological alternatives, the access to treatments (partial sleep deprivation, light therapy) that have been shown to be effective in certain forms of major depression and the provision of funding for the latter are also recommended.

Data to drive improvements in depression care:

- There is a strong need for a centrally compiled depression patient registry. The process has already started, the registry could provide detailed information about depression patient care and quality of care thus accelerate informed planning. Continuous monitoring and control of regional (psychiatric) capacities and knowledge of turnover and outcome data on the treatment of patients with depression will help both the health government and regional and national treatment centres.
- Primary or secondary prevention programmes, targeted development projects should be based on real national turnover and epidemiological data. Although data are collected systematically in Hungary, the available patient and care system statistics are not yet used for decision making.
- When updating and developing reimbursement protocols, policy programmes and strategies, it is necessary to use the available public turnover and epidemiological data (payer and institution databases) in a targeted manner in the future to better explore and understand the area.
- The establishment of a national suicide registry is justified alongside the development of suicide prevention programmes.
- The significant disparities in capacity and regional care obligations of psychiatric outpatient care must be reduced, however this requires the targeted assessment of the available capacities and patient care data. Proposals for capacity allocation must be developed based on the assessment.



Engaging and empowering people with depression:

- The social stigma surrounding mental disorders, including major depression, needs to be reduced in order to provide more effective care. Using best practices of psychiatry to develop national public health programmes and comprehensive awareness campaigns could enhance the social acceptance of depression and other mental disorders.
- National suicide prevention programmes should be launched. Both state prevention programmes and national NGOs and patient organisations have a significant role to play in suicide prevention and their involvement should be strengthened.
- The role of patient organisations in the preparation of health policy and financing proposals should be strengthened, and the current low level of representation should be increased.
- In addition to improving the care of patients by specialists, there is also a need for increased support for patients' carers. Although no financial resources are available at system level to support carers, patients and carers are not always aware of other support options (e.g., housing assistance, emergency financial aid from municipal or public funds, home assistance, tax relief). People in need should receive information, educational materials on the range of supports available and also on how to apply for them.

Harnessing technology to improve access to care:

- The infrastructural conditions for telemedicine must be provided in all regions of the country and at all levels of progressivity (i.e., already at the level of outpatient care) and of adequate quality.
- Various forms of telemedicine are being used increasingly by many specialities. Based on the feedback from specialists, there is a need to define telemedicine codes that can be recorded/financed in the psychiatric profession, not only in emergency but also in general practice, in order to improve both adult and paediatric care; this requires the integration of new ICPM codes into the Outpatient Handbook. It is also appropriate to revise the financing of the current telemedicine codes that can be used in psychiatric care and to increase the financing point values.
- There is a need to create digital platforms that are easily accessible to patients, both to reduce stigma and to advance the rate of properly diagnosed patients.
- Patients must made aware of mental health helpline services and these services, as a preclinical level, should be integrated into the therapeutic system.

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