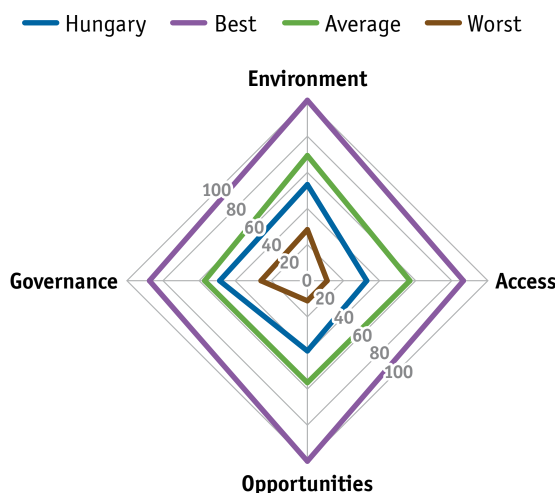
Hungary Country Report
The consequences of a policy void

Mental Health Integration Index: Results for Hungary



Mental Health Integration Index Results

Overall:	43.9/100 (25th of 30 countries)
Environment :	53.3/100 (23rd)
Opportunities:	38.9/100 (21st)
Access:	32.9/100 (26th)
Governance:	48.6/100 (19th)

Other Key Data

- Spending: Mental health budget as a proportion of government health budget (2009): 5.1%.
- Burden: Disability-adjusted life years (DALYs) resulting from mental and behavioural disorders as a proportion of all DALYs (World Health Organisation—WHO—estimate for 2012): 11%.
- Stigma: Proportion of people who would find it difficult to talk to somebody with a serious mental health problem (Eurobarometer 2010): 25% .

Highlights

Hungary does poorly across the board in The Economist Intelligence Unit's Mental Health Integration Index, coming 25th overall.

The country lacks any formal mental health policy, which reflects a long-term lack of interest in the issue at the political level.

The country has low, and declining, levels of mental health professionals and few care facilities between hospitalisation and local clinics.

Human rights protections for those living with mental illness are weaker in Hungary than in many other European countries.

On the other hand, existing social care provision by local governments and a network of local mental health clinics provide sometimes excellent services and could be the building blocks of more integrated care.

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Hungary's constitution guarantees its citizens "the right to the highest possible level of … mental health", yet the country has one of the lowest rankings in the Mental Health Integration Index, coming in 25th position overall. Among the individual categories, it finishes above 20th place only once, in "Governance" which covers a range of issues. Even there, however, it ranks just 19th and has a score of less than 50 out of 100 (48.6). The Index findings are consistent with other worrying data, including high alcohol consumption, a growing problem with illegal drug use, and one of Europe's highest suicide rates.[1]

The main reason for this is clear: the lack of any kind of mental health law. Indeed, the country does not even have a formal, approved, mental health policy or programme. Policies in other areas help fill in the gap to some extent: the National Children's Health Policy makes improved mental health for children and students a high priority. For the most part, however, an absence of any kind of specific policy means that mental health is parcelled together with general healthcare provision. Although such an arrangement could, in certain circumstances, enhance the integration of people living with mental illness, in Hungary it has too often left mental health provision at the mercy of economic retrenchment and political disagreements.

Apathy and political bad luck

Hungary has not had a functioning mental health policy for some decades. Worse still, occasional efforts to create one show how low a political profile the matter has, with progress dependent not so much on the party in power as on the attitude of individuals in the Ministry of Health.

In 2005 Hungary was one of just three European countries not to send a minister or deputy minister to sign the WHO's European Mental Health Declaration and Action Plan. One Hungarian psychiatrist present recalled that mental health "was so … marginalised by the Ministry that [it failed] to recognise the importance of the meeting"[2]. Nevertheless, soon after the declaration, the health ministry began to work with the Hungarian Psychiatric Association (HPA) on a new policy, but after a cabinet reshuffle following an election the ministry lost interest while the HPA continued alone. When, in 2007, the government needed a mental health plan to meet international commitments it had made, it unenthusiastically began to consider the HPA plan, but its overall attitude towards stakeholders involved in mental health nationally and internationally was hostile. A further cabinet reshuffle in 2008 led to a more positive attitude within the ministry and, after over a year of consultation, the government issued the country's first draft National Mental Health Plan in 2009.

The result was underwhelming, however. As Istvan Bitter—professor at the Department of Psychiatry and Psychotherapy at Semmelweis University—explains, "just to [seem to] do something, the Ministry of Health decided to accept the programme. It was purely a declaration, with no budget. Nothing happened. It is a document that had no effect." Instead, the government failed both to complete and fund the draft programme, before losing the 2010 general election. The incoming government did not pursue the programme.

Although the same party remained in power after the 2014 election, the government seems yet again to have changed tack on mental health issues. Tamas Kurimay, former president of the Hungarian Psychiatric Association and chair of the National Advisory Council for Psychiatry, sees a great deal of

[1] Istvan Bitter and Tamas Kurimay, "The State of Psychiatry in Hungary", *International Review of Psychiatry*, 2012.

[2] Bori Fernezelyi and Gábor Eröss, "Lost in Translation: From WHO Mental Health Policy to a non-Reform of Psychiatric Institutions" Know & Pol Working Paper 12, 2009.

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openness from the current government to the idea of giving mental health a much higher priority. He notes that the current prime minister has asked the WHO to review Hungary's mental health system – a particularly important development as the person leading healthcare in the country has, since 2010, been a Minister of State in the larger Ministry of Human Capacities rather than a member of cabinet. Nevertheless, Mr Kurimay adds, no changes in policy or practice have yet occurred and mental health will need to compete with other priorities, whatever happens. Similarly, the WHO reports that it understands a national mental health plan is being prepared, but the government has not made any details available to it.[3]

This long-term failure to focus on the issue of mental health has allowed the field to suffer whenever the cost of healthcare has been a political issue. One of the most dramatic examples of this has been the decline in the number of psychiatric beds. Hungary has more people living with mental illness in the community than in long-stay hospital accommodation, and accordingly does relatively well in the Index's "Deinstitutionalisation" indicator, ranking 13th out of 30. This situation was not, however, reached through considered psychiatric reform. In the 1990s and early years of the last decade, the total number of psychiatric beds in all hospitals declined by around 2% per year. However, the decline in the number of beds both in psychiatric institutions and in general hospitals, reflects cost-cutting rather than a deliberate move to community care.[4]

In 2007 the government started looking at further reducing the number of hospital beds as part of a wider, controversial plan to prepare for substantial privatisation within the health service. During this process, the government suddenly and unexpectedly announced that it would be closing the Hungarian National Institute of Psychiatry and Neurology (OPNI), which, in addition to being the country's biggest psychiatric hospital, had for over a century been Hungary's leading psychiatric research institute. This decision was justified entirely in financial terms rather than as a step towards improving care standards. Worse still, as Mr Bitter explains, although large psychiatric facilities should not indefinitely remain part of mainstream care provision, in this case "patients were just put on the streets. An 800-bed hospital was shut down in the space of a few months, without due consideration for those who were supposed to be treated, and capacity was not, or was only in part, replaced". Despite this closure and a number of bed reductions in other facilities across Hungary, although total psychiatric hospital beds dropped by 12%, the number of chronic—as opposed to acute—beds actually increased, indicating that this was a step back for deinstitutionalisation.[5]

Problems of access to care and services

Looking at the present situation, Hungary's low score in the Index's "Access" category reflects a number of ongoing problems. One is that primary-care physicians often lack the skills to diagnose and treat mental illness, but referral rates to secondary care are low by international standards. Another is a funding system which, in effect, encourages repeated short stays in hospital at roughly two-month intervals, even for more stable cases, rather than community treatment.[6]

"The biggest obstacle" to better provision for those with mental illness, Mr Kurimay believes, is a lack of human resources. The Index numbers illustrate this clearly. Hungary comes 26th out of 30 for the size of its mental health workforce. It has a particularly low number of specialist

[3] WHO "An Assessment of the Hungarian [sic] Mental Healthcare", March 2014.

[4] Long-term figures for psychiatric hospital beds are difficult to use because of a break in how they were calculated in 2001 (see Eurostat healthcare database); Martin Knapp et al, "Economics, mental health and policy: An overview", MHEEN Policy Briefing, 2008.

[5] Gusztáv Stubnya et al, "Deinstitutionalization in Europe: Two Recent Examples From Germany and Hungary", Psychiatria Danubina, 2010.

[6] WHO "An Assessment of the Hungarian [sic] Mental Healthcare," March 2014.

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nurses, where it finishes 28th (7 per 100,000 people) and of psychiatrists where it ranks 21st (11 per 100,000 people). Although the country places better in the number of psychologists (15th), this reflects the relative lack of members of this profession in much of Europe, rather than national strength: Hungary has fewer psychologists than psychiatrists (8 per 100,000).

Worse still, these data, based on WHO figures that in turn are derived from information provided by that organisation's member states, are likely to be substantial overestimates. Professional bodies, using the Hungarian Psychiatric Association's own data and publically available government information, estimate that the actual number of practising psychiatrists is about half that of the WHO figure: were this the case, it would move Hungary to around 27th for the number of psychiatrists and 29th for overall mental health workforce in the Index. Similarly, Mr Bitter notes, official figures for numbers of psychologists include all those licensed or qualified in Hungary. Some of these individuals, however, will have emigrated, and others will no longer be practicing anywhere. The number actually providing care in Hungary, therefore, is likely to be lower than that reported by the government.

Even worse than the small current number of professionals is the continuing decline in their numbers. Mr Bitter estimates that, in the last two decades, the number of psychiatrists has dropped by around 40% and the total number of specialist social workers has also gone down, although it is harder to know the precise figures. In recent years in particular, relatively low wages and poor working conditions, combined with greater emigration possibilities after Hungary joined the EU in 2004, has led young medical graduates and doctors to consider moving to other countries: the WHO estimates that the equivalent of 12% of current psychiatrists have left the country.[7] According to Mr Kurimay, "there is significant migration of all medical staff out of Hungary, but this is especially true for psychiatry and psychology". The closing of the OPNI certainly did not help. Although some research teams found homes in other universities, several were forced to disband and many in psychiatry saw the closure as a symbolic indication of a lack of governmental respect for their profession. This may have accelerated the "brain drain" or discouraged young doctors from choosing a career in mental health. "Unfortunately criticisms of psychiatry, which are based on stigma", adds Mr Kurimay, "are a real problem."

Besides personnel deficiencies, Hungary lacks certain facilities that are common in mental healthcare provision in other parts of Europe. Mr Bitter explains that, although it has several, albeit too few, specialist facilities and a system of community care, "the structures between the outpatient clinic and the hospital are basically missing." As the Index shows, for example, very few assertive outreach teams are present in Hungary. Similarly, there are few support mechanisms for families or carers beyond a general statutory allowance for parents of disabled children. As numerous commentators have noted, the field of community psychiatry in Hungary is largely non-existent.

Similarly, adds Mr Bitter, "I have the strong impression that it is becoming harder for those with a mental illness to get access to jobs and to [social] services from the state". For example, Hungary is one of only six Index countries that do not have any work-placement or training schemes for people living with mental illness. At the same time, notes Mr Bitter, the employment levels of this group have been particularly badly affected during the economic difficulties that have, on

[7] WHO "An Assessment of the Hungarian [sic] Mental Healthcare", March 2014.

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and off, affected the country since 1990, and that resumed with a vengeance during the global financial crisis. Nor is state money made available to provide practical support to workers with mental health issues returning to or staying in work. Instead, taking even part-time work leads to the loss of the very small state disability pension available to those with a mental illness, reducing the incentive to engage in the task of finding employment.

Progress still needed on human rights

In addition to political apathy and poor care and services, people living with mental illness in Hungary face greater than average restrictions on their rights. According to the WHO, one-quarter of mental health patients in Hungarian hospitals are there by court order, a high figure by international standards, which the organisation blames on insufficient regulation of involuntary admissions.[8] Several recent international rulings have undercut Hungarian laws that prevented many of those with a mental illness from voting in local and national elections, but it remains the case that having a mental health condition can be cause for losing of custody of one's children. Another issue where "legal protections need upgrading", says Mr Bitter, is the treatment of potentially violent patients who have not committed any offense. The country has no medium- or high-security facilities beyond a single prison-based unit run by the prison service (rather than the health ministry), leaving "a major problem on the border between civil and forensic treatment," he notes.

A bigger concern is in an area where the country has admittedly made some progress. When it signed the Convention on the Rights of Persons with Disabilities, Hungary committed itself to eliminating guardianship—a legal status in which court-appointed individuals make decisions on behalf of those with mental illness—and replacing it with supported decision making, in which those with diminished capacity are assisted in making their own decisions. Initial efforts to legislate this change were blocked by Hungary's constitutional court. Parliament then passed a second attempt to reform the civil code in this direction, which formally came into effect in 2014. The new law creates a structure for supported decision making. The problem, however, is that rather than replacing guardianship, supported decision making is merely an additional option. Moreover, it appears to be available only to people with milder mental health issues rather than people living with serious mental illnesses.[9]

What increases the significance of this issue in Hungary is the history surrounding non-medical residential facilities in the country. Outside the healthcare system, Hungary has a large number of social-care homes for a variety of specific groups. The majority are for the elderly, but about 7,000 beds are for people with mental illness. These latter homes have long been the target of human rights campaigners and the small activist service-user community in Hungary. Among their many complaints are that these institutions have no rehabilitation facilities and are, in fact, long-term custodial institutions with generally poor conditions. In theory, patients cannot be made to stay in these homes against their will—in the Index, Hungary's laws on involuntary placement score a reasonably high 75 out of 100, with the country tying in 12th place—but this belies the fact that if an appointed guardian asks a home to house an individual, this admission is by definition classified as "voluntary."

Accordingly, the UN Committee on the Rights of Persons with Disabilities wrote that it was concerned in Hungary "about

[8] WHO "An Assessment of the Hungarian [sic] Mental Healthcare", March 2014.

[9] Barbara Méhes, "Mental Disability Law: The recognition of legal capacity and the replacement of substituted decision making", LL.M degree thesis, Central European University, 2014.

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the situation faced by persons under guardianship, where a decision on institutional care is made by the guardian rather than the person him/herself, and guardians are authorised to give consent to mental healthcare services on behalf of their ward. The Committee further regrets that disability, in some cases, can be the ground for detention."[10] As critics of these institutions point out, a large majority of residents are under guardianship, suggesting the possibility of at least some such coercion, but, as Index data shows, inspection of mental health facilities is irregular.[11]

The building blocks of a better system

Given the difficulties surrounding mental healthcare and service provision, as well as broader social integration, it may be surprising to find that the Hungarian healthcare system has two significant elements that could easily become important parts of an improved, coherent system. First, local governments are required to provide a range of community-based social services for a variety of groups including those with drug addictions and with more general serious mental health issues. The services can include cash payments in order to subsidise specific needs and some direct social support, including help with basic domestic needs and personal administration, as well as family assistance if a mental health crisis takes place.

In practice, these services are a patchwork, with the range of requirements varying with the size of the locality and with some governments not meeting their obligations. Nevertheless, notes Mr Kurimay, these are generally well supported. The difficulty is that they are not integrated at all with the healthcare system. Both Mr Kurimay and Mr Bitter tested the value of employing a co-ordinator for hospitalised patients to help them receive outpatient medical and social services upon discharge. The initiative, on its own, led to reduced levels of rehospitalisation, indicating that existing social services, if properly targeted, could benefit those living with mental illness. The problem is financing. Mr Bitter says that they are hoping for a Norwegian grant that would allow the opening of "40 sites in the country where we would try to bring medical and social services closer together, with the help of specially trained personnel".

The other important asset is a group of community-based psychiatric clinics spread throughout the country that date back to the 1950s. Mr Kurimay explains that these form "a unique network that you would not find elsewhere". They are not community mental health centres such as are available in other European countries, although they can have multiple staff members including psychiatrists, psychologists, and social workers. Instead, Mr Bitter characterises most of them as more like a general practice for psychiatric care, providing outpatient clinic-based and home care as well as prescribing pharmaceuticals and administering long-acting anti-psychotic injections.

In practice, the availability of these clinics varies widely, with only around 120 available for a population of roughly 10m people. Mr Bitter explains that "wide parts of the country are not covered by any community care, but some are covered rather well". Quality varies just as much. At some, according to the WHO, "Their way of working was as comprehensive and inclusive as any mental health team in Europe".[12] At others, the situation is quite different. A recent survey by Hungary's Mental Health Interest Forum, a users' organisation, found that the facilities were frequently short staffed and that 30% offered only drug-based care without any psychotherapy.[13]

[10] Committee on the Rights of Persons with Disabilities, "Concluding observations on the initial periodic report of Hungary, adopted by the Committee at its eighth session", September 2012.

[11] For the activist position, see Hungarian Disability Caucus, "Disability Rights or Disabling Rights? CRPD Alternative Report," 2010.

[12] WHO "An Assessment of the Hungarian [sic] Mental Healthcare," March 2014.

[13] Mental Health Interest Forum, "Monitoring of the Hungarian Psychiatric Outpatient Clinics and the Community Services of Psychiatry, An Analysis 2009-2011", 2012.

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Other clinics, notes Mr Bitter, "provide traditional outpatient services. Some have social workers, psychologists and good connections to social services." Indeed, the survey found that co-operation between clinics and other medical and social service providers was common. Overall, then, says Mr Kurimay, while far from providing a comprehensive solution, these clinics are "a very important resource for a community-based service development".

When the Hungarian healthcare system and its political leadership are ready to focus on the country's burden of mental illness, they will not have to start from scratch. Until they choose to do so, however, people living with these conditions will have to piece together care as best they can.

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About the research

This study, one of a dozen country-specific articles on the degree of integration of those with mental illness into society and mainstream medical care, draws on The Economist Intelligence Unit's Mental Health Integration Index, which compares policies and conditions in 30 European states. Further insights are provided by two interviews—with Istvan Bitter, a professor in the Department of Psychiatry and Psychotherapy at Semmelweis University, and Tamas Kurimay, former president of the Hungarian Psychiatric Association and chair of the National Advisory Council for Psychiatry—along with extensive desk research. The work was sponsored by Janssen. The research and conclusions are entirely the responsibility of The Economist Intelligence Unit.

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