State of psychiatry in Hungary

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Abstract

Hungary has a tradition both in biological psychiatry and psychotherapy, and for decades developed together with neurology. From the mid 1980s the speed of development of psychiatry started lagging behind expected standards. Psychiatric care, research and teaching were hit hard in 2007 by unprecedented closures of facilities and budget reductions. Although suicide rates have decreased since the mid 1980s, the country has still the second highest rate in the European Union. The high prevalence of alcohol use and the rapidly increasing prevalence of illicit drug use contribute to comorbidity and related behavioural issues, including the increased frequency of severe violent events committed by people with psychiatric disorders, which have not been properly addressed. The country expects the first major restructuring of its healthcare starting in 2012 since the major political changes of 1989/1990. The profession, patients and their caregivers should use this opportunity to modernize psychiatry in Hungary.

Short historical overview

Hungary had strong schools of both biological psychiatry and psychotherapy in the first decades of the 20th century.

The father of the Budapest School of psychoanalysis, Sándor Ferenczy, and the school’s members, such as Michael and Alice Balint, Imre Herman, Melanie Klein, Sándor Rado, Geza Roheim to name just a few, had major impact on the development of psychotherapy and psychiatry worldwide. The sad developments after World War I (WW I) in Hungary and Germany forced psychoanalysts to flee first Hungary, then Germany (Meszaros, 2009). The few who remained in the country and survived until after WW II were silenced by the communist regime after a very short freedom of teaching. To our knowledge the first official representation of psychoanalysis in the former communist ‘Eastern bloc’ was created within the Hungarian Psychiatric Association (HPA) in 1980 in a wave of reform of psychiatry in this country. The reform contributed to the election of the president of HPA, Pal Juhasz to vice-president of the World Psychiatric Association (WPA) during the World Congress of Psychiatry in Vienna in 1983 (Van Voren, 2010). The reform of psychiatry had elements of grassroots movements, and Juhasz accepted the position of vice-president of the WPA against the warnings of the government. These factors led to governmental restrictions in psychiatry including a tighter control of the international professional relationships at a time when the country became more open and approached the historic years of 1989/1990, when the barbed wires were cut at the borders and the Berlin wall fell.

Hungarian academic psychiatry developed in close collaboration with neurology. Karl Schaffer’s school focusing on neuroanatomy and neuropathology was a leading academic group internationally in the 1920s and 1930s of the last century in the field of what today we call clinical neurosciences (Baran et al., 2008), and the school has strongly influenced the development of both neurology and psychiatry in this country up to today. One of the pupils of Schaffer, Laszlo Meduna (also known as Ladislav von Meduna) developed and introduced shock treatment in the treatment repertoire of psychiatry in 1934 in Budapest (Gazdag et al., 2009; Shorter, 1997). The marriage between psychiatry and neurology was dominated by neurology but resulted in a divorce – the two disciplines were separated both in the medical schools and in the hospitals in the mid 1970s. Hungarian neurology responded to the changes of the last 30 to 35 years with a modernization of research and treatment, which has been only partially followed by psychiatry.
Summarizing the development of the healthcare sector in the last two decades in Hungary one can say that it has witnessed budget cuts with no significant structural changes (exception: general practices were privatized in the early 1990s).

A community social system was developed for psychiatric patients in the first decade of the 21st century. This system has little or no legal or functional relationship with the healthcare system, which deprives many patients from accessing this support. As part of a service delivery development project we tested the efficacy of employing a coordinator for connecting hospitalized patients with both outpatient healthcare services and service providers of the community social system. The project was well received by patients and their families and it was successful in preventing frequent rehospitalizations. The conclusion of the project has been that there is much more capacity in the country to provide social support and demedicalize social problems than is acknowledged by practising psychiatrists and patients. However, for a better care and service the functional connections between the social and healthcare sectors have to be improved. With a few local exceptions we cannot speak about the development of community psychiatry as such in Hungary.

An already weakened psychiatric system, lagging much behind the internationally developed standards for psychiatric research and treatment, faced a disaster in 2007 as a consequence of the so-called ‘Hospital Law’ of 2006 (Kurimay, 2010).

‘In 2007 ... without any appropriate professional preparation, a government ruling resulted in 25% reduction of acute psychiatric beds in the country and in the closure of the Hungarian National Institute of Psychiatry and Neurology … which at that time was the country’s largest psychiatric treatment, teaching and research institute’ (Stubnya et al., 2010 p. 406). The main objective was to reduce the number of hospitals and hospital beds. The law, and its implementation, were heavily criticized both by professional bodies and the political opposition (now the governing parties). The Constitutional Court annulled significant parts of the law, but it was too late to rescue the lost treatment and research capacities. In the same year also other psychiatric capacities including outpatient services were reduced. The National Institute opened its gates for patients in Leopoldfeld as the National Buda Asylum in 1868 (which is now in the western part of Budapest).

The leadership of the National Institute and representatives of the psychiatric profession prepared alternative plans for the development of psychiatry in the country. Deinstitutionalization was properly addressed in those plans, however those plans were not even considered. The Government prepared for a quick privatization of healthcare, but this attempt failed and left crippled services behind. The consequences of this kind of rapid, unprofessional and in many ways inhuman closure of the National Institute can be briefly described based on a summary by Stubnya et al. (2009) as follows:

- the closure of numerous departments and the relocation of others to other institutions resulted in a decrease in the level of psychiatric services
- efficiently operating professional teams with significant achievements have been dissolved
- a significant number of much needed professionals retired early, left psychiatric services or accepted a contract for working in another country
- well-established care pathways have been disrupted leaving many patients temporarily or on a long-term basis without or with reduced psychiatric care (including addiction psychiatry, psychotherapy, psychiatric rehabilitation and child and adolescent psychiatric services)

The current situation

We focus here on the situation between April 2007 (closure of the National Institute of Psychiatry and Neurology) and April 2012.

Mental health indicators

The general indicators suggest that the life expectancy of the Hungarian population is 74 years, which is 5 years below the average life expectancy in the OECD countries (OECD, 2011). The rate of completed suicide is high, the second in the European Union, 24.6/100,000 in 2009, which is a huge reduction from the 1980s when Hungary was number one on this sad world list with a rate of around 45/100,000 (WHO, 2011).

Psychoactive substance use

Addictions continue to be among the most burdensome disorders in Hungary. Increasing illegal drug use has led to growing health risks and placed increasing healthcare burdens in some specific areas according to the health behaviour research of school-age children between 2006 and 2010 (Németh et al., 2011):

- alcohol: about half of the children were drunk at least once by the age of 13
- cannabis use among 15 years old school boys increased 1.7 fold; among 15 years old school girls 1.75 fold, and among 17 years old school girls 1.3 fold
- the use of amphetamines among 15 years old school boys increased 2.4 fold, among 17 years old boys, 1.5-fold
Overall, the prevalence of cannabis use in secondary school students was remarkably higher in 2010 than in 2006 (Németh et al., 2011). The national report to the European Drug Monitoring Agency (Reitox, 2011, p.19) revealed that one and a half times more secondary school pupils in grades 9–11 were using drugs as compared to 2006. Among the different drugs the increase in the lifetime prevalence of cannabis use stands out and the rate of first-time users of amphetamines increased by more than one and a half times. The biggest change was the rapid spread of methedrone use in 2010. Among the causes of the increasing use of methedrone are primarily its low price and easy accessibility as well as its novelty and the presumed low risk. In 2010 methedrone was not yet a scheduled substance. Methedrone has become generally used as a secondary drug: independently from the primary drug, it has appeared beside cannabis, amphetamines or opiate use.

Service providers reported the appearance of synthetic cannabinoids and other designer drugs following methedrone including mainly methylene-dioxypyrovalerone (MDPV). An increasing use of methedrone by injecting was also reported by needle exchange providers (Csák et al., 2010). The widespread misuse of this drug did not result in criminal proceedings, but it was a significant step to the listing of methedrone as an illicit drug in 2011.

Among those who received medical treatment, the data on the distribution of drug use suggest that within the general student population (as opposed to the vulnerable groups), in addition to cannabis, the use of amphetamine and methedrone has increased significantly. Among those clients who entered into the treatment without official co-operation (diversion), the primary substance was cannabis, 42.4% (followed by opiates 21.3%, stimulants 15.6%, hypnotics, sedatives 9.7%, other drugs 6.1%, inhalants 2.3%, cocaine 2%, hallucinogens 0.6%). In the group of those clients who were entering into the treatment programmes with diversion the cannabis use was even higher (81.8%). The majority (42.4% and 81.8%) of these patients used cannabis (Reitox, 2011, pp. 37–38). (In Hungary cannabis use is prohibited by law.)

Certain dysfunctions can be detected within the healthcare system related to drug abuse. The number of seriously ill drug users is relatively small, they are much more likely to be seen at needle exchange programmes. The needle exchange programmes see injecting drug users in serious conditions who rarely enter the healthcare system; very few of them receive treatment. It is estimated that they represent about 25% of all injecting drug users, which is estimated to be between 2,200 to 4,700 in the country (Reitox, 2011, pp. 37–38). Recent decrease in the funding of the needle exchange programmes (such as harm reduction and low-threshold services) comes with the risk that we will completely lose sight of this severely ill population suffering from comorbid conditions including infectious diseases (e.g. HIV and hepatitis C) and this could lead to uncontrolled spread of infections and even to an increase in injecting drug use.

Alcohol consumption (11.8 L of alcohol per adult in 2008) and mortality associated with alcoholism (Bodonyi-Kovács et al., 2011) is still above the EU average in Hungary (OECD, 2011). The consumption of alcohol within the Hungarian population started to decline in the late 1980s, people consumed 2 L less beer in 2006 than in 1990, consumption of hard liquor also decreased by 4 L in the same period. The trend in wine consumption was different: since its low point in 1988, there has been a continuous increase in consumption; in 2005 it exceeded the 1976 rate of 4.89 L per capita by 0.05 L (Bodonyi-Kovács et al., 2011).

An epidemiological analysis addressed temporal changes and spatial inequalities of premature mortality related to alcohol consumption between 1979 and 2009 in Hungary. Furthermore, frequencies of ‘alcohol-related crime’ (where the offender had taken alcohol at the time of the incident) were examined between 2003 and 2010 at regional level. The premature mortality due to alcoholic liver diseases and cirrhosis in the south-western part of Hungary (areas within the counties of Zala, Somogy and Baranya), and at the northern border Hungary (Borsod-Abauj-Zemplén, Nógrád, Komárom-Esztergom County) were higher than the national average between 2003 and 2007. In these areas the highest rate of alcohol-related crime (the three highest rates within incidents: vandalism, drink driving and aggravated assault) was reported among age groups of 15–59 years (Bodonyi-Kovács et al., 2011). These data also demonstrate that aside from the high incidence of alcoholism in Hungary, there are also large differences between areas within the country in terms of alcohol-related death, as well as in terms of the number of crimes committed under the influence of alcohol. It would be necessary to have specifically designed prevention programmes and also ensure the provision of care where it is most needed.

**Mental health policy, mental health care system and delivery**

No mental health law, officially approved mental health policy or programme exists in the country. However, mental health is specifically mentioned in the general health policy (Semmelweis Plan, 2011).
Since 2008 the Hungarian College of Psychiatry (an advisory board to the minister in charge of health care) and the Hungarian Psychiatric Association have been working in collaboration with the Directorate General for Health and Consumer Protection of the European Commission (EC) and the Regional Office for Europe of the World Health Organization (WHO) to create the National Programme of Mental Health (2008) (WHO, 2008) (NPMH). As part of a Biennial Collaborative Agreement (BCA) 2006–2007 with WHO Europe, NPMH was ratified in 2009 as a Ministry of Health programme, but it has not become an official government programme yet, and has never received any financial support. The programme aims, among others, are for a shift of mental health services and resources from hospitals to community mental health facilities services, and the integration of mental health services into primary care. In two consecutive BCA programmes a coordination model was successfully tested, which helped patients in finding most needed health and social care and support in the incomplete and fragmented landscape of services.

With the introduction of public health taxes in 2012 the government aimed both to reduce the lack of resources in the healthcare system and also improve health indicators. In addition to reducing the government deficit the Hungarian parliament intended to promote healthy lifestyles and to make those people with unhealthy drink and food consumption contribute to healthcare expenditure. The new special tax makes products such as soft drinks (that have at least 8 g per 100 mL of added sugar), energy drinks (with minimum of 10 mg caffeine per 100 mL), pre-packaged sweet products (25 g or more of added sugar per 100 grams), salty snacks (1 g or more of salt per 100 g), condiments (5 g or more of salt per 100 g) more taxable. Intriguingly however, the scope of this tax does not extend to tobacco and alcohol products (2011 CIII Act, 2011). In fact, according to the 2003 CXXVII Law, private distillation of alcohol (spirits) is permitted and tax-exempt in Hungary up to 50 L per year, provided that it is for the household and for personal consumption.

The high prevalence of alcohol consumption and drug use has several important implications for psychiatric care. They are comorbid with many psychiatric diseases and are associated with significant increase in violence. Although there was no systematic data collection in this regard, compared to the pre-2007 period the number of serious violent offenses committed by psychiatric patients has increased. It is not surprising considering the deteriorating level of psychiatric services in the country combined with the high level of alcohol use and with the increasing level of illegal drug use: ‘Alcohol or other drug abuse problems combined with poor adherence to medication may signal a higher risk of violent behaviour among persons with severe mental illness’ (Swartz et al., 1998, p. 226). These problems have not been properly addressed in this country.

In this context, the Ombudsman (Parliamentary Commissioner’s Office, 2012) has recently conducted a survey and made recommendations to the government about the establishment of a so-called civil high security unit. Many issues were addressed and scrutinized in the documents of the Ombudsman, including the following.

- the rights of patients
- the legal status of violent patients who are treated in general psychiatric units
- how to deal with acutely threatening conditions in a general psychiatric unit without having any secure facility and proper number and training of the staff
- the dilemmas of performing psychiatric observations ordered by the courts in general psychiatric units serving large catchment areas financed by state insurance
- the rights of aggressive patients within long-term residential institutions and the safety of their inmates

In Hungary there is no high (medium or low) security psychiatric unit or even an ‘intensive’ unit or subunit of a psychiatric department with the exception of a prison unit for those individuals with psychiatric disorders who committed a criminal act and were sentenced to forced psychiatric treatment by a court. This unit is under the supervision of the Hungarian Prison Service of the Ministry of Interior (Hungarian Prison Service, 2011) rather than the health department.

The creation of a ‘civil’ psychiatric department with high, medium and low security units (3 × 15 beds) has been proposed by professional bodies to the Ministry of National Resources, which is in charge of healthcare in Hungary. This department would provide services (mainly diagnosis and treatment, and referral to further healthcare and social services) for highly violent psychiatric patients who have not committed a crime. The proposal was developed with the support of the Section of Forensic Psychiatry of the European Psychiatric Association.

The medical treatment of acute and sub-acute alcohol-related disorders and psychiatric disorders comorbid with drug abuse is taking place in departments of psychiatry of general hospitals and university clinics and state financed outpatient facilities. The community social care of psychiatric and addicted patients is part of the social welfare system, with independent financing. This parallel organization of health and social care systems unfortunately left a gap in the complex care of these patients and has made access to those services difficult.
After the Hospital Law in 2006 the level of psychiatric care is lower and more uneven than before and there is a lack of coordinated action of different service providers and other stakeholders. The coordination between psychiatric caretakers, hospital psychiatric departments and social sectors including community care providers is incomplete, the legal and financial basis for such cooperation is only partially developed, and the incentives and quality criteria are either missing or weakly developed in the healthcare system. For this reason some psychiatric patients do not have access to the available services, and the hospitalization rates remain high, and are even increasing, leading to ‘revolving door’ psychiatry for many patients with severe mental illness. In certain areas access to care is lower than the average, e.g. child and adolescent addiction, mother–child units, forensic psychiatric units, early treatment programmes, where almost the entire care spectrum is missing.

Prevention programmes and initiatives that promote, enhance, and sustain mental health are still sporadically, and often fail to reach the targeted populations due to lack of adequate professional (including methodological) support, their effects are not visible. In the most important areas of everyday activities there is still a lack of mental health supporting activities.

**Lack of human resources and brain drain**

In the last six years, one of the biggest obstacles for proper delivery and development of psychiatric services is the declining number of staff in the mental health workforce.

Although Hungary’s four medical faculties provide high quality graduate and postgraduate education, the number of residents who choose psychiatry has recently decreased. There are a number of reasons, including the overall loss in prestige of the medical establishment, unsatisfactory working conditions and low financial compensation. An aggressive recruitment of psychiatrists – and recently psychiatric residents as well – from other EU countries created further issues. The number of child and adolescent psychiatrists, psychologists and those focusing on addiction are alarmingly low. This trend also holds true for nurses, social workers and consultants.

This is not just a Hungarian problem, but could be a general challenge to our profession (Katschnig, 2010). Since 2004, when Hungary joined the EU, migration of medical professionals from the country became easier. This is a hot topic in Europe, and also worldwide. According to the EC, by 2020 there will be a shortage of approximately one million health force workers in Europe (Commission of the European Communities, 2008; WHO, 2010; Wismar et al., 2011). The career choice and the migration of medical professionals are hot topics for Hungarian health managers and decision-makers, although they do not specifically look at issues that are key to the future of psychiatry, but more broadly at overall medical services in Hungary. The statistics on these issues are that there are about 36,000 active medical doctors, the shortfall of medical doctors in the system is about 1,500. They stopped practising, or changed full time work for ‘locum’ part-time jobs, in both Hungary and abroad. In recent years 800–900 medical doctors graduate annually, and 700–800 (1,111 in 2010) medical doctors apply annually for the certification which is needed to work abroad (OHAAP, 2012). The growing number of applications indicates the growing interest in migration by medical doctors, including psychiatrists. The age distribution of medical doctors working in clinical settings in Hungary shows a great shift, as 52% of them are 50 years old or older. Similar patterns are true for psychiatrists. More young, than older doctors leave Hungary. Young doctors are aware of the high market value of a medical diploma, and consider migration as one main factor in their motivation when choosing a medical profession; there is similar pattern among nurses (Girasek et al., 2011).

Psychiatrists are part of the group of medical professionals who have the highest migration potential. In one survey, the main reasons they expressed to leave were (in descending order) low salary, quality of life, working environment, future prospects of Hungarian healthcare, social prestige, professional opportunities and learning a foreign language, whereas their motivations to stay in the country were closeness of friends and family, other aspects of family life, would like to live in Hungary, cannot imagine his/her life in another country, responsibility for the healthcare or Hungarian patients, and difficulty of assimilation in a foreign society (Girasek et al., 2011).

Distribution of mental problems and illnesses and distribution of services need to be matched. But dysfunctional distribution of human resources influence and even help services deteriorate. This is the case in Hungary, especially after the Hospital Law in 2006. Lacking or insufficient psychiatric and addiction services countrywide (including acute and chronic care and rehabilitation services for all ages) may lead to further deterioration of these services especially in the poor, most neglected areas of the country.

Since 2007, the professional leaders of psychiatry, including the Hungarian Psychiatric Association, had difficulty finding a proper method to measure the number of psychiatrists working in the country. The country report of the WHO (2008) indicated twice as many psychiatrists working in Hungary in clinical practice (n = 1,370) than the number estimated by professional bodies (n = 680). For the estimation of the ‘real’ number professional bodies
used the information available from the Office of Health Authorisation and Administrative Procedures, from the Hungarian Psychiatric Association, and from the National Institute for Quality and Organizational Development in Healthcare and Medicine.

We believe that more is needed than issuing a green paper (Commission of the European Communities, 2008) on this alarming issue, which is a threat to healthcare for millions of European citizens.

Mental health research in Hungary

As briefly described in this paper, major recent issues have hampered mental health research, such as the closure of important research sites and laboratories (imaging including 3T fMRI, psychiatric genetics, electrophysiology, neuropathology, clinical therapeutic blood level monitoring, etcetera) at the National Institute of Psychiatry and Neurology and the weakening of the four university psychiatric departments (much larger catchment areas – up to 300% – with lower or the same number of employees after the Hospital Law of 2006, and decreasing finances for care, research and education). Due to the objectives and the space limitations of this paper we did not aim to provide the readers with a review of mental health research in Hungary. However we would like to highlight some traditional and new areas of research with a short list of research areas:

- depression and suicide (e.g. Balazs et al., 2006; Fekete et al., 2002; Gonda et al., 2011; Rihmer, 2009)
- epidemiology (e.g. Kopp et al., 2011)
- cognitive sciences (e.g. Kiss et al., 2010; Racsmany et al., 2008; Topal et al., 2009)
- dementia (e.g. Feher et al., 2009)
- adult ADHD (e.g. Bitter et al., 2010)
- psychiatric genetics (e.g. Horvath et al., 2011, Réthelyi et al., 2010).

Future

In 2012, Hungary is starting major restructuring of its healthcare system. Based on promises made by decision-makers, psychiatrists and psychiatric patients expect the establishment of a new, 21st century national institute of mental health and funding to restart research and technology transfer discontinued by the closure of the historical National Institute of Psychiatry and Neurology. The major challenges include budget issues which are heavily reflected in the planning. A plan of increasing the number of beds or creating a new institution with a hospital focus without investing in community services, research and technology transfer created tensions which have yet to be resolved at the time of the submission of this manuscript.

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