

To ensure the detection of early or mild disorders, training of medical students should include work at primary care clinics. In the forthcoming new editions of ICD and DSM, the criteria for diagnoses must include mild disorders. Early diagnosis and a comprehensive management plan will improve the quality of life of elderly people with mental illness.

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COUNTRY PROFILE

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Mental healthcare in Hungary: contradictions and possibilities

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The Republic of Hungary is a landlocked country of 93 000 km² in central Europe; it is bordered by Austria, Slovakia, Ukraine, Romania, Serbia, Croatia and Slovenia. Its official language is Hungarian. Hungary joined the European Union (EU) in 2004. About 90% of the population of c. 10 million is ethnically Hungarian, with Roma comprising the largest minority population (6–8%). Currently classified as a middle-income country with a gross domestic product (GDP) of \$191.7 billion (2007 figure), Hungary's total health spending accounted for 7.4% of GDP in 2007, less than the average of 8.9% among member states of the Organisation for Economic Co-operation and Development (OECD, 2009). The proportion of the total health budget for mental health is 5.1%, which is low when compared with, for instance, the UK (England and Wales 13.8%, Scotland 9.5%) (World Health Organization, 2008, p. 118, Fig. 8.1).

Hungary has long been a major contributor to the development of psychiatry, psychology and psychotherapy, through the works of Sándor Ferenczi, Géza Róheim, Melanie Klein, Michael Bálint, Lipót Szondi, Ferenc Mérei, Iván Böszörményi-Nagy, Kálmán Pándy, László von Meduna, Pál Juhász, Mihály Arató and the recently deceased István Degrell (Bánki, 1991; Rihmer & Füredi, 1993).

Status of general and mental health in Hungary

The average life expectancy for a Hungarian citizen at birth is only 73.3 years, more than 5 years below the OECD average of 79 years. The mortality rate presently exceeds the birth rate, which means the population is declining. More than half the mortality is due to cardiovascular disease (coronary heart disease is the leading cause of death). As elsewhere, drinking, smoking, obesity, unhealthy eating habits and lack of physical activity undermine the health of the population (Skrabski *et al*, 2005; Tringer, 2005).

The prevalence of both mental disorders and substance use disorders is on the rise. About 300 000–400 000 people (around 4% of the population) experience depression, but only 40 000 of them have a medical diagnosis (European Commission, 2008). A study applying DSM–IV criteria found the current rate for depression to be 18.5% among people attending primary care, while the rate for major depressive episode was 7.3% (Torzsa *et al*, 2008).

The suicide rate in Hungary remains the highest (after Lithuania) in the EU despite the fact that between 2000 and 2005 the decrease in Hungary's suicide rate was the second

largest after Denmark's, not only in Europe but in the world (Rihmer & Akiskal, 2006).

Hungary has among the highest rates in the world of alcohol-related mortality and morbidity (chronic liver disease, cirrhosis and alcoholism). After Moldavia, Hungary has the second highest mortality rate of liver disease and cirrhosis. This rose from 5.0 per 100 000 in 1950 to a peak of 83.9 in 1994, although it has fallen since, to 54.8 per 100 000.

Between 2003 and 2008, the numbers of patients entering treatment for addiction varied from 13 500 to 15 500, with between 4000 and 6300 new patients per year. The most common illicit drug was cannabis, followed by opiates, amphetamines and fewer cases of cocaine usage (OSAP, 2008).

Healthcare system and mental health resources

Hungary's healthcare system is primarily financed through the Health Insurance Fund. The current system of insurance-based funding has contributed to the ongoing funding problems of most mental health programmes and has impaired the ability of psychiatry departments and universities across Hungary to function.

There is no specific law regulating mental health services in Hungary but, on the whole, legislation regarding mental health issues, including protection of the human rights of mental patients, conforms to EU requirements (Tringer, 2005).

In terms of government policy, whereas both the National Programme for the Prevention and Treatment of Cardiovascular System Diseases and the National Cancer Programme have been recently revised, the National Programme for Mental Health was accepted in 2009 but has yet to be financed. In addition, with the Hospital Law of 2006, the government further reduced the number of psychiatry beds (from the previous 4.8 to 3.1 active/acute psychiatry beds per 10 000 population) and the same law also closed the National Psychiatry and Neurology Institute, which was the country's largest in-patient mental hospital, as well as an essential research, information-gathering and training centre.

Attempts to strengthen the mental health of children and adolescents have been made, under the National Infant and Children Health Programme (2007–2013). In addition, a Substance Misuse Policy was formulated in 2000 that ran until the end of 2009. The National Psychiatry Centre was established in 2009 to collect accurate, scientific data about the mental health of the population. Since 2008 the Ministry of Health has made greater efforts to participate in EU partnership programmes, including the European Pact of Mental Health (2008); it also hosted the EU Prevention of Depression and Suicide Thematic Conference in December 2009. The Hungarian College of Psychiatry and the Hungarian Psychiatric Association have been working in collaboration with the EU Directorate General for 'Health and Consumers' and the WHO Europe Regional Office to get through the National Programme of Mental Health (NPMH).

Activities in priority areas

Two successful current programmes should be noted: the Suicide Prevention Programme in Regions with a Very High

Suicide Rate, which aims to determine the effectiveness of an educational programme on the management of depression for general practitioners (Szántó *et al*, 2007); and a programme in Szolnok, which is part of the European Alliance Against Depression collaborative project (Hegerl *et al*, 2008).

Civil organisations have begun to play a more significant role in both health services and social care. The Hungarian Alzheimer Society, representing the interests of relatives of persons with Alzheimer's disease and other forms of dementia, is an example of an effective organisation supporting mental health in Hungary.

Research

Hungary has no central body coordinating mental health research. Major research centres include: Semmelweis University Budapest's Psychiatric and Psychotherapeutic Clinic (Simon *et al*, 2009); the Mental Hygienic Department, Institute of Behavioral Medicine; the Institute of Psychology of the Hungarian Academy of Science; Eötvös Lóránt University; Budapest University of Technology and Economics Research Centre for Cognitive Science; the University of Szeged; the Albert Szent-Györgyi Medical and Pharmaceutical Centre's Department of Psychiatry; the University of Pécs; the University of Debrecen; the University of Gáspár Károli; and Péter Pázmány Catholic University.

One of the major national sources of finance for scientific research is the National Scientific Research Fund (OTKA). In 2004, Hungary was second in terms of indexed impact factor for scientific publications on neuropsychiatry and psychology (Scheffler & Potucek, 2008, p. 236).

The Hungarian Psychiatric Association organises a congress every year, and over 2000 professionals from the mental health field participate. Its member societies (e.g. the Psychoanalytical Society, the Psychopharmacological Society and the Hungarian Family Therapy Association) also have annual meetings.

Training

Medical undergraduate training

There are four medical universities in Hungary, located in Budapest, Debrecen, Szeged and Pécs. Although undergraduate training in psychiatry is based on a national curriculum, the medical universities develop their own programmes. The 6-year medical training includes medical psychology, behavioural medicine and elective courses in psychotherapy.

Postgraduate training in psychiatry

Hungary is an active member of the European Union of Medical Specialists.

Postgraduate training in psychiatry is a 5-year programme with obligatory theoretical courses. Because of new EU regulations, child and adolescent psychiatry training has been a basic 5-year course in Hungary since 2005.

A secondary specialisation in psychotherapy is available only for medical doctors and psychologists. Psychotherapeutic training is efficiently organised in Hungary, and since 1990 a non-governmental organisation, the Hungarian Psychotherapeutic Council, has been coordinating the standards of

training and practice. The Council is an accredited member of the European Association of Psychotherapy.

Allied professions

Basic training for nurses (BSc) consists of 4600 hours in 3 years and for masters training in a specialty (MSc) another 3 years of training. Postgraduate psychology training for clinical psychology requires 4 years of training and clinical practice. There are accredited postgraduate courses for psychiatric social work.

Human rights issues

In terms of patient rights, Hungary follows international norms and the EU directives. There are few violations and those that do arise are, in general, a consequence of inadequate infrastructure, or more especially the low numbers of nurses and therapists.

Issues surrounding the treatment of high-risk and violent patients, their legal regulation and forensic management remain unresolved. Hungary has no high-security wards or units, nor does it have a forensic psychiatry institute. The profession has prepared concrete plans for the introduction of both, but these have yet to be officially endorsed.

Current obstacles, future challenges

Key areas for mental health policy and services are:

- integration with primary care
- the skills mix of the workforce
- the implementation of community services
- the collection of adequate information.

Although the National Programme for Mental Health addresses all of these challenges, there are still systemic problems to solve. For instance, community mental health services (community psychiatry, mobile teams, in-home treatment) – an essential part of the Programme, with an emphasis on civil and user-led services – have been introduced in only a few areas.

The overall number of mental health professionals is low and they are unevenly distributed across the country. Many psychiatrists and psychiatric nurses are leaving for jobs in the UK, Sweden and Denmark. As a consequence, there are places in Hungary where basic mental health services are in jeopardy.

Conclusions

Mental health must overcome party politics and become a government priority in Hungary. This is crucial in light of Hungary's comparatively poor mental health indexes. The programmes need adequate funding for training and research, otherwise the mental well-being of the population will deteriorate further. In addition, there needs to be a willingness to find new and creative ways to strengthen prevention and make treatment more effective.

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International electives in psychiatry for UK medical students

As part of the College's strategy for recruitment into psychiatry, we would like to enhance opportunities for UK medical students to undertake psychiatry electives overseas. This will entail developing a database of international members of the College willing to provide an elective in psychiatry. A notice with information on the initiative and how to get involved will be available in the next issue.

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