JA ImpleMENTAL

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Country Profile Hungary

Community-based Mental Healthcare Networks: Key Facts and National Priorities

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Introduction

The EU-Co-funded "Joint Action on Implementation of Best Practices in the area of Mental Health", short **JA ImpleMENTAL** has a duration of 3 years, lasting from October 2021 to September 2024. Detailed information can be found at the project's website JA ImpleMENTAL (ja-implemental.eu). It aims to promote and improve mental health structures, services, capacity and outcomes in participating countries in 2 specific areas:

- mental health reform (promoting community health services) and
- suicide prevention.

Two national best practices - mental health reform in Belgium and the Austrian suicide prevention programme SUPRA - serve as best practice examples. Selected components of these should be prioritised and implemented over the course of the JA in 14 i.e. 17 participating EU-countries. JA ImpleMENTAL comprises six Work Packages (WPs), four horizontal WPS and one for each best practice. WP5 on community-based mental healthcare aims to implement elements from Belgian Mental Health Reform, which is based on the principle of deinstitutionalization, i.e., the transition from care primarily provided in institutions to community-based care in order to improve mental health outcomes and quality of life and avoid unnecessary hospitalizations. In addition, the reform is based on the principles of rehabilitation and inclusion, decategorization, i.e., multisectoral cooperation, strengthening care in hospitals to make stays shorter, but with more intensive treatment, and the principle of consolidation, providing funds for pilot projects.

The present country profile is one of the major deliverables of the JA, presenting key facts of the national and local mental health system. It summarizes results of the recent situation analysis and needs assessment (SANA), lists lessons learned, recommendations, challenges and opportunities as well as outlining next steps necessary to scale-up, promote national/regional community-based mental health care services. The country profile forms a basis for strategy formulation, decision-making and commitment.

This country profile is based on a situation analysis conducted in two parts and subsequent needs assessment. For the situation analysis, two questionnaires have been developed by WP5, one for the analysis of the situation regarding the overall health system and community-based mental health care at national level, and another one for the analysis at implementational level. Following the data collection, a SWOT analysis was conducted by the countries to assess the needs in terms of community-based mental health care.

1 Situation Analysis (SA)

1.1 Country, Health and Social System at national level

Hungary is a parliamentary republic divided into 19 counties. The capital and largest city is Budapest, and there are 23 larger cities with county-level authority (1). The total population of the country is 9 689 010 (2). Landlocked in Central Europe with a temperate climate, Hungary shares a border to the north with Slovakia, to the northeast with Ukraine, to the east with Romania, to the south with Serbia and Croatia, to the southwest with Slovenia, and to the west with Austria. The country's terrain is mostly flat to rolling plains; hills and low mountains can be found on the Slovakian border (3).

Table 1: Population structure: 2021, expressed as number of persons, by age and sex (4)

	Sex		
Age group	Male	Female	**Total**
<18	876 510	830 175	1 706 685
18 - 64	3 030 362	3 017 059	6 047 421
65+	756 922	1 219 744	1 976 666
Total	**4 633 794**	**5 066 978**	**9 730 772**

In 2021 life expectancy at birth for men was 70.7 years, while for women it was significantly higher (77.8 years), healthy life expectancy at birth is 70, and 12 at age 65 (5-6). A total of 19.4% of the population is at risk of poverty and social exclusion (7). Income inequality, expressed as the Gini coefficient, is 28 (8), and total healthcare expenditure relative to GDP is 6.35% (9).

The Hungarian **health care system** has a single health insurance fund and is highly centralised. It provides health care coverage for nearly all residents. The fund is administered by the National Institute of Health Insurance Fund Management (NEAK). The Ministry responsible for healthcare has exclusive power for setting strategic direction, controlling financing, determining the benefits package and issuing and enforcing regulations. The National Directorate General for Hospitals is responsible for monitoring the public health care system, implementing strategic government decisions, monitoring hospital operations and contributing to the development of a new national health management system. Local county hospitals are responsible for planning and managing inpatient care at the county level, under the aforementioned Directorate-General.

The rate of **health expenditure** growth in Hungary is increasing, but remains below the EU average. In recent years, Hungary has seen an increase in the rate of health expenditure growth. Between 2013 and 2019, the average annual growth rate in health spending per capita was 2.9% compared to negative growth of -0.5% between 2008 and 2013. Despite this recent growth, health expenditure per capita is less than half the EU average after adjusting for differences in purchasing power. Health spending as a proportion of GDP is also relatively low compared to the EU as a whole. This result may, however, be explained in part by Hungary's relatively high rate of GDP growth in recent years (10).

1.2 Mental Health System at national level

Hospital beds include all beds that are regularly maintained and publicly financed, this includes beds reserved for patients with mental health issues, therefore the system cannot be separately described from the whole system and means that mental health illnesses are covered by the national health insurance. In Hungary 24/7 ambulatory and emergency services are available within the healthcare system. Mental health care, psychiatric care and rehabilitation as a standard procedure is available within the health care system. The government's total expenditure on mental health is 3.2% of the total expenditure on health (11).

Mental health patients in Hungary are present in both the **health care and the social care systems**. Social institutions cooperate with health care service providers – in particular, with the patient's physician and house practitioner – when they care for mental patients. This intersectoral cooperation seems to face considerable barriers. Basic social services include village caregiving services, home assistance, meal provision, family support, alarm-system-based home assistance, community services, support services, street social work, and day care for various groups in need. Day care, building on self-

reliance and self-support, includes services for mental patients who do not require inpatient hospital care or placement in a residential social institution. They can also be used by people in crisis, as a preventive measure. Specialized services, within the framework of residential care, include the so-called institutions for nursing and care, temporary homes, institutions for rehabilitation, and residential homes, supported housing also belongs to the circle of specialized care, although it is not considered institutional care.

Part of the primary care system, **general practitioners** have the role and task of recognizing the risk of suicide and if necessary, direct the patient to psychiatric care. After the risk of suicide has passed, the GP is responsible to care for the patient under the supervision of a psychiatrist. In the event of detection of a suicidal patient in a state of imminent danger, the organization of immediate admission to a psychiatric ward is also the responsibility of the primary care physician. Acute care is provided in the psychiatric wards in general hospitals.

There is a nationwide availability of in-person psychosocial and psychiatric crisis services accessible through **ambulatory and emergency services** integrated in the healthcare system. The ambulatory and secondary care is organized on a territorial basis, each emergency care unit and hospital has a designated area of service. Patients living in these areas can come in a 0-24h manner.

The data about the proportion of **involuntary admissions** to the number of total admissions are not specifically collected in Hungary. The follow-up of people with mental health conditions discharged from hospitals within one month is between 51%-75%.

There is a stand-alone policy for mental health, as part of the **"Healthy Hungary 2021-2027" strategy**. The National Programme for Mental Health has been approved by the government as part of the top five key health priorities, but no resources have been allocated for the implementation as a whole. The overall goal of the policy is to develop a health program for mental disorders to contribute to the mental health of Hungary in order for the public health indicators to improve. Development areas of the program are mental health development, with a family-centered approach; development of the psychiatric care system, including community, inpatient and outpatient supply; development of addictology; development of child and youth psychiatry; and the development of psychotherapy and ensuring its better availability. There is no specific policy or procedure for transition age. The protection of the human rights of mental patients is based on the Healthcare Act No. 154. 1997 and conforms with European norms.

There are patient groups for those suffering from mental illnesses, chronic debilitating diseases and patient surviving trauma. The share of people reporting unmet mental health care needs due to financial reasons are 2.6% (12).

Table 2: Facilities, number of beds and hospital admissions related to mental health, 2021 (13)

Indicator at national level		Number	Rate per 100.000 adult/minor population
Mental health hospitals	Facilities	1	
	Beds	311	3.21
	Admissions	628	8.11
Psychiatric wards/units of general hospitals	Wards/units	187	
	Beds	2 582	29.2
	Admissions	35 911	957.69
Mental health community residential facilities	Facilities	907	9.37
Mental health inpatient facilities specifically for children and adolescents	Facilities	16	
	Beds	154	8.17
	Admissions	3 442	206.82

Table 3: Mental health workforce (14)

	In MH service (all)		In child & adolescent MH services (totals of government and non government services)	
	Total number	Rate per 100 000 of adult population	Total number	Rate per 100 000 of adult population
Psychiatrists	1 170	12.08	---	---
Child psychiatrists	---	---	182	9.66
Mental health nurses	1 052	10.86	---	---
Psychologists	1 535	15.85	---	---
Others*	266	2.75	---	---
Total	**4 023**	**41.54**	**1 963**	**104-15**

* Others include e.g. Social workers, Speech therapists, Occupational therapists

1.3 Population profile in pilot area

Hajdú-Bihar county is located in eastern Hungary, bordered by Romania to the east. Debrecen is the county seat and largest city in the county. The county occupies a large part of the Great Hungarian Plain east of the Tisza River. Although Hajdú-Bihar is one of the less-industrialized areas of the country, the manufacture of chemicals and pharmaceuticals, the machine industry, and food processing contribute to the local economy (15).

Table 4: Population structure in 2022 of Hajdú-Bihar county expressed as number of persons, by age and sex (16)

	Sex		
Age group	Male	Female	**Total**
<15			79 399
15 - 64			343 588
65+			101 285
Total	**253 217**	**271 055**	**524 272**

The unemployment rate of pilot area is at 5% (17). The life expectancy is 70.44 years on average for women and 77.73 years for men (18). Mental health is a significant concern in Hajdú-Bihar County, with a high prevalence of mental health problems such as depression, anxiety, and substance abuse. The prevalence of depression and anxiety in the county is higher than the national average. Access to mental health services is limited, particularly in rural areas, and there are only a few psychiatric facilities in the county. The population of the pilot area faces socio-economic challenges, including higher unemployment rates and lower average wages. There is a network of long-term community mental healthcare outpatient services, aligned with a specialized network of social services for community patients with the abovementioned limitations. Patients also receive long-term, personalized, continuous health care at the place of residence from the general practitioner of the district, based on his or her choice, regardless of gender, age, and the type of illness (this includes family pediatric care, dental care, services of the childcare officer, on-duty care related to primary care, school health care, occupational health care, home care linked to primary care and home hospice care). The pilot area is only special in the sense that it has a clinical center located in the capital of the municipality that provides the highest level of care for mental health patients, which is not standard for every municipality.

There are no specific mental health hospitals in the pilot area, the county has an integrated healthcare institution that provides mental health services for the population in question, but that is not categorized as an independent mental hospital. Also institutions for the nursing and care of mental patients, residential, rehabilitation institutions can be found in the pilot area. There are two hospital-based facilities in the pilot area, one in Berettyóújfalu and one in Debrecen, but based on two separate campuses. An integrated social service system is available, that can be categorized as a community-based facility. Day care services are provided in Debrecen also as part of the social service system, which also serves as an outpatient clinic for the pilot area.

1.4 Community-based mental health care at pilot level

Recent programs focusing on mental health reform did not include investments into community-based services, but mostly on the reorganization of selected institutions, more akin to a large-scale infrastructural investment, which included the pilot area. The abovementioned strategy is the only focusing on mental health, no other specific policies or plans are focusing on the issue, none specific to Hajdú-Bihar.

The relevant legislation is also national level, which consists of the Healthcare Act (No. 154. 1997) with specific paragraphs for mental healthcare patients, the Disability Act with specific parts for the mentally ill, and various decrees on person-centered social care, including community social services for mental health patients. The principles guiding community-based mental health care are fostering self-sufficiency by deinstitutionalization, services targeting recovery, destigmatization by individual placement and support (IPS). Forms of community-based mental health services include small group homes that maintain elements of both institutional culture and community-based services (19).

Only isolated development of social and other community services has taken place. There has been no national and comprehensive process to provide services to those who have been deinstitutionalized. Community caregivers typically attempt to rely on community resources as much as possible, especially the participation of relatives, and other “natural helpers” (20).

In Hungary there is national-level obligation for every school to employ a school psychologist and a system established of so-called health visitors to be actively looking out for the mental health of school children. At primary care level the duty is to recognize mental health conditions, and if necessary, direct patient to a specialist.

The training of mental health professionals at primary care level does not differ in the pilot area from the national level. The curriculum of BSc training for healthcare workers includes pre-service management of mental health (21). The curriculum of compulsory continuing education for health workers includes one or more courses focusing or touching upon mental health conditions of patients (22). There is a close collaboration between primary care and specialised care level as it is part of the same system, with direct connection between the primary care provider to the higher, specialised care system. The Mental Health Information System collects data uniformly on a state level. The National Health Insurance Fund of Hungary defines this set of data.

There is an existing addiction and substance abuse prevention collaborative programme between local government and NGOs. Existing crisis helplines are the national-level services.

Figure 1: Inpatient admission and outpatient visit rate per 100 000 in Hungary (23)

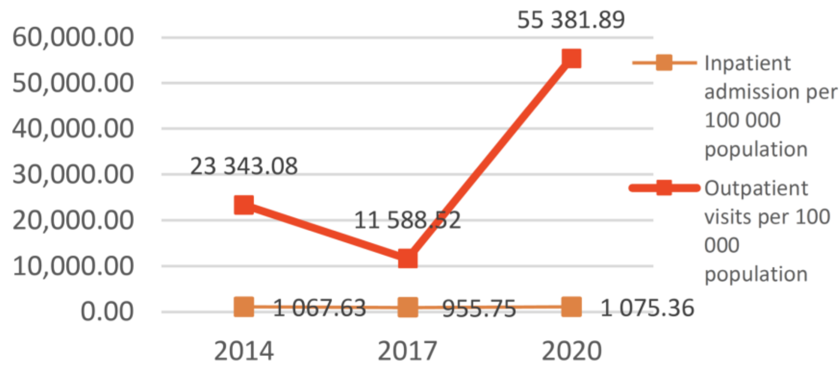
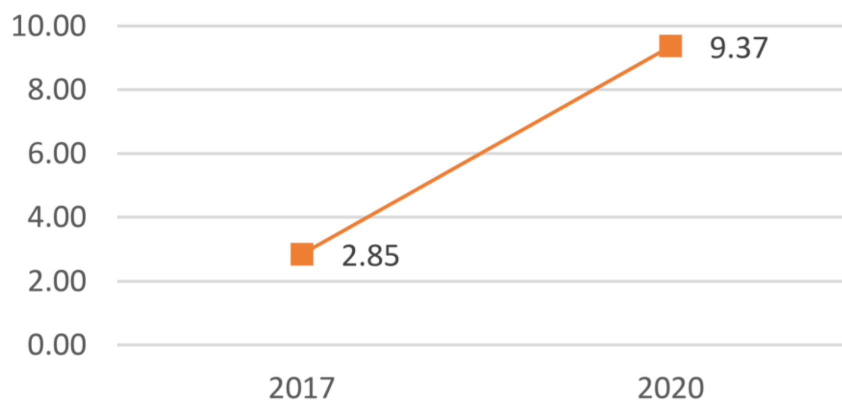


Figure 2: Community-based mental health service rate per 100 000 in Hungary (24)



2 Needs Assessment (NA)

The Needs Assessment was based on the review of relevant literature, such as research articles, reports, and policy documents supplemented by targeted discussions with mental health care professional, managers, other experts in the field and policy makers about the circumstances surrounding employment and workplace integration of mental health patients, the results of which were summarized in Table 5.

Table 5: SWOT Analysis

Strengths	Weaknesses
Job stability (1 year+) Job security (short term) Untapped human resource	Limited number of job openings locally Lack of awareness regarding appropriate job opportunities Financial disincentives – part of welfare support would be lost Local transportation insufficiency Lack of support from family and friends Bad past on-job experience (isolation, discrimination) Diagnosis stigmatizes (No information on those who are diagnosed but not on any form of disability pension) Those on some sort of disability pension usually have lower educational level Early disability retirement Lack of public awareness of current job prospects for mentally-ill patients
Opportunities	**Threats**
There is a need Well-planned workplace integration program (IPS) could be the potential radical change in the course of their lives, total individual rehabilitation Creating a uniform employment contract template, with mandatory content elements, which could be incorporated even into all potential employer's templates Learning about the employment contract template could be part of the rehabilitation process (seal of approval)	Lack of legal adherence Fixed-term employment Equal or proportionate salary (protected jobs are not calculated with market-based salary) Long term job security Diagnosis threatens carrier prospects Devaluation of their worth on the job market

3 Reflection on SANA results

Box 1. Prioritized measures for pilot implementation

1st selected Strategic Area: Ensure (strong) governance structures/mechanisms
Sub-strategic area: Governance conditions
Expected outcome: Sustainable financing and developed protocols have been granted
Measures:

- Map out policy framework
- Disseminate results to encourage funding
- Reach out to possible funders
- Develop a guideline/pathway for the procedures involving IPS

2nd selected Strategic Area: Development or transformation of MH services and interventions (incl. multidisciplinarity approach)
Sub-strategic area: Developing new (non-existing) OR transforming/adapting existing MH services (reinforcement of multi-disciplinarity and improvement of evidence-base, quality, efficiency continuity of services) in the areas of (five functions of the Belgian BP)
Expected outcome: A model for an IPS-type intermediary organization providing rehabilitation service aiming at reintegration and social inclusion has been developed
Measures:

- Research a model for an IPS-type intermediary organization
- Engage stakeholders
- Source a supporting partner that can help develop the model
- Develop a model for an IPS-type intermediary organization
- Pilot test the model

3rd Strategic Area: Extensive global training programme of stakeholders (in support of the refo & cultural change in service provision)
Expected outcome: There are trained IPS professionals available
Measures:

- Develop a training/certification programme
- Informing and training of healthcare professionals
- Embed the 'pathway' into health care professionals' education

4th Strategic Area: Intensive continuous communication, information and awareness rais among/towards stakeholders and users (in support of the reform and a culture of change)
Expected outcome: Healthcare professionals and social workers have been informed IPS-model and organization
Measures:

- Raising awareness of IPS

5th Strategic Area: Data collection, monitoring & evaluation
Expected outcome: The effects of the intervention have been monitored and evaluated.
Measures:

- Monitoring (and evaluation of) the activity of the IPS organization

The primary focus of the pilot is to create real opportunity for those dealing with mental health issues to seek regular, paid employment, just like everyone else. With this, help those who face challenges feel as a valuable part of the society, without any discrimination, also their environment accepting their hardships without any negative connotations.

It is essential to raise awareness and train health care experts and social workers for IPS, as it is not part of the integrated care and is unknown by the system. Also, financial resources are not readily available to start a pilot program based on IPS.

4 Priorities & Next steps

The difference with the content in Box 1 is that this is about the specific next steps with a defined time frame that will be implemented in the process of adopting the Belgian mental health reform.

1st selected Strategic Area - Sub-strategic area 1.1.:

- Map out policy framework (until August 2023)
- Disseminate results to encourage funding (until October 2023)
- Reach out to possible funders (until December 2023)
- Develop a guideline/pathway for the procedures involving IPS (until December 2023)

2nd selected Strategic Area - Sub-strategic area 2.1.:

- Research a model for an IPS-type intermediary organization (until December 2023)
- Engage stakeholders (until December 2023)
- Source a supporting partner that can help develop the model (until January 2024)
- Develop a model for an IPS-type intermediary organization (until June 2024)
- Pilot test the model (until September 2024)

3rd Strategic Area:

- Develop a training/certification programme (until March 2024)
- Informing and training of healthcare professionals (until September 2024)
- Embed the 'pathway' into health care professionals' education (until October 2024)

4th Strategic Area: Raising awareness of IPS (until September 2024)

5th Strategic Area: Monitoring (and evaluation of) the activity of the IPS organization (until October 2024)

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