JA ImpleMENTAL

Co-funded by the European Union

Country Profile "**Hungary**"

Suicide and Suicide Prevention: Key Facts and National Priorities

Author(s):	Lead author: *Gábor Bányai-Márton* Co-authors: *Judit Zsuga, Bernadett Bulyovszky, Dóra Gelencsér, Róbert Wernigg*
Version:	1.0
Date:	19. 05. 2023

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This report arises from the Joint Action on Implementation of Best Practices in the area of Mental Health, which has received funding from the European Union through the European Health and Digital Executive Agency (HaDEA) of the European Commission, in the framework of the Health Programme 2014-2020, GRANT NUMBER 101035969 — JA-02-2020. The content of this report represents the views of the author only and is his/her sole responsibility; it cannot be considered to reflect the views of the European Commission and/or the HaDEA or any other body of the European Union. The European Commission and the Agency do not accept any responsibility for use that may be made of the information it contains.

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 6 Work Packages (WPs), 4 horizontal WPS and one for each best practice. **WP6 on suicide prevention** aims to support improvement in knowledge and quality of suicide prevention services. Defined elements of SUPRA should be transferred and pilot implemented at national/regional level, suicide prevention strategies in participating countries developed i.e. revised.

The present country profile is one of the major deliverables of the JA, presenting national priorities for suicide prevention embedded in contextually relevant facts. It summarizes results of the national Situation- and Needs Assessment (SANA), lists lessons learned, recommendations and prioritized measures for suicide prevention. It includes challenges and opportunities as well as outlining next steps necessary to scale-up i.e. promote national/regional suicide prevention activities. The country profile is a basis for strategy formulation, for decision-making and a declaration of commitment to suicide prevention.

1 Context

1.1 Country, Health and Social System

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	**4 663 794**	**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

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, therefore the total government expenditure on mental health care is also unknown. 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.

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, as also data on the follow-up care of people discharged. The Hungarian Medical Chamber urges the development of a suicide data registry. (11)

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 are patient groups for those suffering from mental illnesses, chronic debiliating diseases and patient surviving trauma. Numerous support groups are available for the relatives of suicide victims.

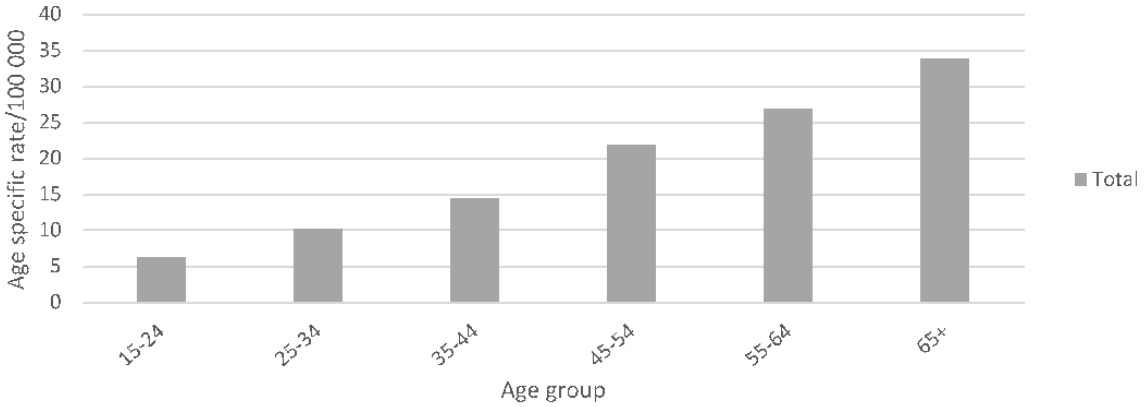
Table 2: Facilities, number of beds and hospital admissions related to mental health, 2021 (12)

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 in general hospitals	Wards/units	187	
	Beds	2 582	29.2
	Admissions	35 911	957.69
Mental health inpatient facilities specifically for children and adolescents	Facilities	16	
	Beds	154	8.17
	Admissions	3 442	206.82

2 Suicide and Suicide Prevention

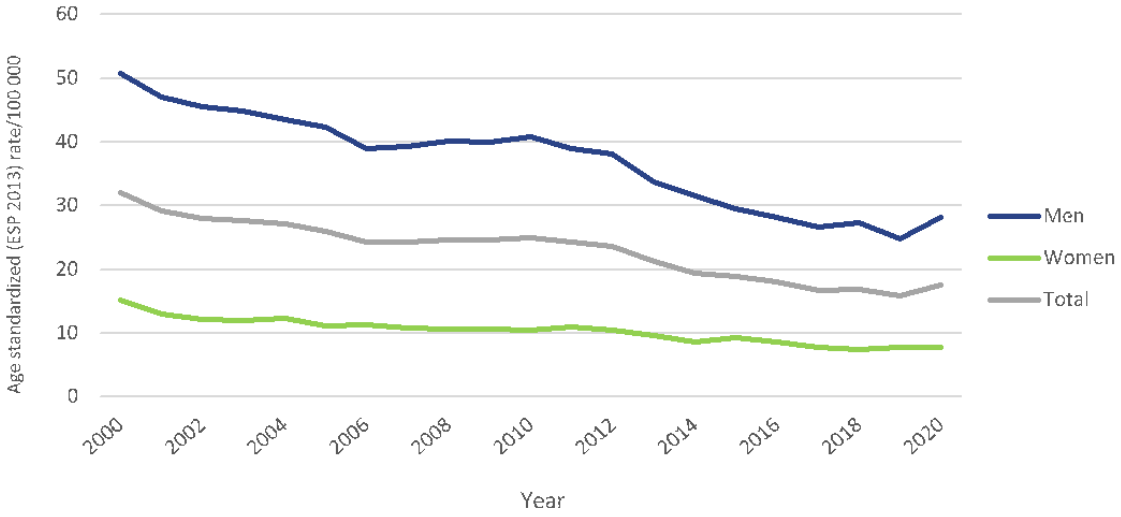
2.1 Situation Analysis (SA)

Figure 1: Suicide rate, 2020, by age groups (13)



Between 2000 and 2019, there was a 51.4% reduction in the **suicide mortality**. The greatest decline occurred among middle-aged males. At the same time, the rate of young single females declined only slightly. During the 20-year-long period investigated, there was a temporary halt between 2006 and 2010 in the otherwise steadily declining trend. One of the major underlying causes of this plateau is presumed to be the healthcare reform commenced in 2007 with negative impacts on psychiatric services. This plateau was observable in almost all subpopulations irrespective of their age, marital status and the suicide method they used. The decline of the rate restarted only after 2010. In the last 10 years, suicide mortality has decreased by 36.3% in Hungary, which is a very good result in a European comparison. (14)

Figure 2. Suicide deaths trend, 2000-2022, by sex (15)



The number of suicides rose significantly in some subgroups of the Hungarian population during the COVID months of 2020. (16) The Annual Yearbook of the Hungarian Central Statistical Office reports each year on suicide. This is available in terms of males and females and age groups of 5-10 years. The most common methods of suicide was hanging in 2020 (59%), followed by poisoning and jumping from heights. At the same time, the differences between men and women are significant, 64% of men chose hanging, compared to 43% of women, while poisoning is higher for women (30%) than men. (17)

Box 1. Groups most vulnerable to suicide

- Prior suicide attempt by patient or close family member
- Psychiatric disorder in case history and/or prior suicide attempt
- Early traumatic life events
- Chronic debiliating diseases
- Old age

The most common disorders in the case history of the patient are unipolar major depression, bipolar depression, alcoholism, other addictions, anxiety, schizophrenia and eating disorders. (18)

Box 2. Most common barriers people face when seeking psychosocial help

- Lack of information regarding who to contact
- Being ashamed
- Current mental health state (anger, hoplessness)
- The psychosocial status that triggers the crisis
- Self-reproach

The list of most common barriers people face when seeking pschospcial help was created by a focus group of experienced psychiatrists, mental health specialists, psychotherapist, lawyers and teachers.

A **standardised follow-up care** is outlined in the guideline of the the College of Psychiatrists titled Medical guideline regarding the early detection of suicid intetntion, prevention of suicide, long term therapy and treatment plan).

There is a nation-wide 24/7 **hotline for crisis intervention and/or suicide prevention** available, the phone number are available at: https://sos116-123.hu/

Apart from the crisis hotline services, **media reports** on suicide are followed by information on how to reach out in case someone feels the need, including crisis hotline numbers. There is an ethical guideline for media on how to report on suicide created by a non-governmental agency. Any projects on suicide prevention are not monitored regularly on regional or national level, there is no inventory of these projects by government agencies or non-governmental organizations.

2.2 Needs Assessment (NA)

The Needs Assessment was based on relevant literature review, including research articles, reports, and policy documents supplemented by targeted discussions with mental health care professional, managers, other experts in the field and policy makers. The results were summed up in Table 6.

Table 6a: SWOT Analysis (Strengths – Weaknesses)

Strengths	Weaknesses
Knowledge & correlation (medical & scientific)	Suicidal persons are still under detected and undertreated
Medical contact helps recognition and prevention even before the first suicidal act, which is common before suicide (GP or mental health exp.)	Gap between the accumulated theoretical knowledge and available treatment strategies and implementation
Predictability – past suicide attempt is the best single predictor	Rate of available appropriate treatment still low
Mental health helps in recognition	Current best practice on prediction and prevention of suicide is not optimal
Detectability – strong relations to mental disorders	Suicidal behavior is not predictable with 100 % precision
Better care for psychiatric patients markedly decreases suicide rates	Low availability to psychiatric care and psychotherapy apart form developed countries
Available pharmacological treatment: appropriate acute and long-term use of antidepressants, mood stabilizers and atypical antipsychotics	High rate of non-adherence

Electroconvulsive therapy Effective supplementary psycho-social preventive interventions Good availability of medical/psychiatric/social care services in suicide prevention in developed countries Covert strength – suicidality develops in relatively later stage of the illness, increase of antidepressant prescription is one of the most important contributors in the significant decrease of suicide mortality	

Table 6b: SWOT Analysis (Opportunities – Threats)

Opportunities	Threats
Translation of knowledge into everyday clinical practice More widespread distribution of knowledge and better implementation of it in the daily practice among professionals Multi-level suicide prevention programmes - Appropriate detection of depression, etc. - Gatekeeper training - Public education - Appropriate media coverage of suicide Regular psycho-social assessment and interventions markedly decrease the rate of repetition Indirect clinical markers can predict first suicidal act for mood disorder patients Restricting general access to dangerous means are underutilized Regular physical activity and healthy lifestyle are also contributing factors in improving depression and reducing suicide risk Ketamine (NMDA receptor antagonist) for the treatment of resistant, frequently suicidal depression Future research of the role of dietary factors, as well as low lithium and high arsenic in drinking water in suicidal behavior	Suicide related materials on the web Anti-psychiatric and "anti-antidepressant" campaigns in the media and on the internet Misunderstanding and misinterpretation of the complex relationship between antidepressants and suicide by non-professionals Decreased use of antidepressants (partly due to improper warnings) JA ImpleMENTAL (international exchange of knowledge and experineces)

3 Reflection on SANA results

The primary focus should be on activities that **raise awareness, promote help-seeking behavior, and enable timely identification of individuals at risk**.

Develop and implement campaigns and initiatives to raise public awareness about suicide prevention, that may include public service announcements, online information campaigns, and all forms of media outreach.

The goal is to educate the general population about the signs of suicide risk and available support services within the healthcare system and also outside of it. Also, organizing training sessions and workshops to enhance the knowledge and skills of key professionals who frequently come into contact with individuals at risk, that could include teachers and other relevant personnel, so they would be able to identify warning signs. Additionally fostering an environment where open discussions about mental health and suicide are encouraged and stigma is reduced, especially focusing on how the media reports about these incidents.

Box 3. Prioritized measures for implementation according to the SUPRA columns

Strategic area 1 - Column 1: Coordination & organization

- Draft strategy for suicide prevention (aligned to WP5 mental health initiatives)

Strategic area 2 - Column 2: Support and treatment

- 1. Operational goal: Gatekeepers' ability to notice individuals at risk of suicide and direct them to care is increased
  Measures
  - **Quick wins** Develop and deliver educational materials for schools and workplaces
  - Create and disseminate social media content
    - Organize training sessions and workshops to raise awareness and to enhance the knowledge and skills of key professionals who frequently come into contact with individuals at risk

Strategic area 3 - Column 4: Awareness raising and knowledge

- 1. Operational goal: Journalists are better informed on suicide, and this is reflected in more responsible and informative reporting:
  Measures
  - Improve and provide education on suicide for journalists
  - Provide training for first responders on how to report responsibly on suicide to journalists
  - Develop and approve a Code of conduct for responsible reporting
  - **Quick wins** Media award for responsible reporting on suicide
- 2. Operational goal: Reach of anti-stigma information on factors predisposing to a crises is increased
  Measures
  - Organize event where influential people share their stories
  - Develop educational materials for schools and workplaces
  - Create and disseminate social media content

4 Next steps

The difference with the content in Box 3 is that this is about the specific next steps with a defined time frame that will be implemented in suicide prevention.

- Column 1: Draft strategy for suicide prevention (aligned to WP5 mental health initiatives) (until April 2024)
- **Quick win 1** (Column 2): Develop and deliver educational materials for schools and workplaces (until June 2024)
- Column 2: Create and disseminate social media content: Organize training sessions and workshops to raise awareness and to enhance the knowledge and skills of key professionals who frequently come into contact with individuals at risk (until May 2024)
- Column 4: Improve and provide education on suicide for journalists (until August 2024)
- Column 4: Provide training for first responders on how to report responsibly on suicide to journalists (until August 2024)
- Column 4: Develop and approve a Code of conduct for responsible reporting (until August 2024)
- **Quick win 2** (Column 4): Quick wins Media award for responsible reporting on suicide (until August 2024)
- Column 4: Organize event where influential people share their stories (until September 2024)
- Column 4: Develop educational materials for schools and workplaces (until September 2024)
- Column 4: Create and disseminate social media content (until September 2024)

5 References

(1) European Union. Principles, countries, history. Hungary. Retrieved April 10, 2023 from https://european-union.europa.eu/principles-countries-history/country-profiles/hungary_en

(2) Eurostat. Population by broad age group, 2021. Retrieved April 10, 2023 from https://ec.europa.eu/eurostat/databrowser/view/CENS_21AG/default/table?lang=en

(3) The World Factbook. Hungary. Retrieved May 10, 2023 from https://www.cia.gov/the-world-factbook/countries/hungary/

(4) Eurostat. Population on 1 January by age and sex, 2021. Retrieved April 10, 2023 from https://ec.europa.eu/eurostat/databrowser/view/DEMO_PJAN__custom_2986693/default/table?lang=en

(5) Eurostat. Interactive Publications. Demography 2023 edition. Retrieved May 18, 2023 from https://ec.europa.eu/eurostat/web/interactive-publications/demography-2023#fragment-15944082-xtpc-inline-nav-8

(6) Eurostat. Healthy life expectancy based on self-perceived health, 2020. Retrieved May 15, 2023 from https://ec.europa.eu/eurostat/databrowser/view/hlth_silc_17/default/table?lang=en

(7) Eurostat. People at risk of poverty or social exclusion, 2021. Retrieved May 15, 2023 from https://ec.europa.eu/eurostat/databrowser/view/sdg_01_10/default/table?lang=en

(8) Eurostat. Gini coefficient of equivalised disposable income - EU-SILC survey, 2021. Retrieved May 15, 2023 from https://ec.europa.eu/eurostat/databrowser/view/ilc_di12/default/table?lang=en

(9) Eurostat. Total health care expenditure, 2020. Retrieved May 15, 2023 from https://ec.europa.eu/eurostat/databrowser/view/tps00207/default/table?lang=en

(10) WHO. European Observatory on Health Systems and Policies. Country Profile – Hungary, 2021.

(11) Medicalonline.hu MOK: szuicid regisztert kellene indítani. Retrieved May 22, 2023 from http://medicalonline.hu/eu_gazdasag/cikk/mok__szuicid_regisztert_kellene_inditani

(12) Kórházi ágyszám- és betegforgalmi kimutatás. NEAK, 2022

(13) Központi Statisztikai Hivatal. A halállal végződött öngyilkosságok százezer lakosra jutó száma, 1. ábra. Retrieved May 19, 2023 from https://www.ksh.hu/ffi/1-16.html

(14) Németh A, Döme P, Drótos G, et al. Statistics on completed suicides committed in Hungary in the period between 2000 and 2019. Orv Hetil. 2021; 162(32): 1283–1296.

(15) Központi Statisztikai Hivatal. A halállal végződőött öngyilkosságok százezer lakosra jutó száma, 2020. 1. ábra. Retrieved May 19, 2023 from https://www.ksh.hu/ffi/1-16.html

(16) Lajos Balint, Peter Osvath, Balazs Kapitany, Zoltan Rihmer, Attila Nemeth, Peter Dome, Suicide in Hungary during the first year of the COVID-19 pandemic: Subgroup investigations, Journal of Affective Disorders, Volume 325, 2023, Pages 453-458.

(17) Központi Statisztikai Hivatal. Öngyilkosság, 2020. Retrieved May 19, 2023 from https://www.ksh.hu/ffi/1-16.html)

(18) Egészségügyi Szakmai Kollégium és Tagozatai Tanácsai. Szakmai irányelvek. Retrieved April 30, 2023 from https://kollegium.aeek.hu/Iranyelvek/Index

6 Corresponding authors

Gábor Bányai-Márton
University of Debrecen
banyai.gabor@econ.unideb.hu

Prof. Judit Zsuga
University of Debrecen
zsuga.judit@med.unideb.hu

www.unideb.hu