

# THE HEALTH POLICY IN CHILD AND ADOLESCENT PSYCHIATRY IN HUNGARY – A REVIEW OF RECENT DEVELOPMENTS

Gábor Kapócs<sup>1,2</sup>, \*Péter Balázs<sup>3</sup>

<sup>1</sup>Department of Psychiatry and Psychiatric Rehabilitation, St. John's Hospital, Budapest, Hungary  
Head of Department: Professor Tamás Kurimay, MD, PhD

<sup>2</sup>Institute of Behavioral Sciences, Semmelweis University, Budapest, Hungary  
Head of Department: Prof. József Kovács, MD, PhD

<sup>3</sup>Institute of Public Health, Semmelweis University, Budapest, Hungary  
Head of Department: Prof. Károly Cseh, MD, PhD

## Summary

Mental health problems affect 10–20% of the pediatric population worldwide, with the same prevalence in both the high-income countries (HICs) and low-and-middle-income countries (LMICs). Hungary has a relatively high prevalence of psychiatric disorders in children aged 4–17 (15.8%). Psychiatric problems in children are an important public health issue in all countries, as the early diagnosis is important not only for the current well-being of the child, but also for their social and economic development throughout their entire lifetime. This paper reviews the relevant health policy acts of the Hungarian government that have been released during the previous 15 years. All governmental programs followed the current WHO (World Health Organization) and European Union guidelines, indicating the growing influence of the international organizations on the domestic health policy. What is interesting, earlier programs concentrated on local governments and actions, and more recent documents underline the responsibility and role of the state and central government. When analyzing the health policy documents concerning child and adolescent mental health services, a gap between the growing scientific knowledge and its implementation can be seen. The situation of the Hungarian psychiatry has been worsening from 2006 in terms of the capacity of both the in- and outpatient care. Hungary has yet to fulfill the aims of already existing programs in the day-to-day clinical practice.

Keywords: child and adolescent psychiatry, health policy, health care, Hungary

## INTRODUCTION

For the last ten years, multiple policy documents have been issued in Hungary and High Income Countries (HICs), which indicated the rising awareness of the public, international organizations, governments, professional environments and civil organization on the subject of mental health and psychiatric care of children and adolescents.

The proportion of children (0–14 years) in world's general population has been decreasing from 1966 (38%) and reached 26.11% in 2015 (1, 2). In Hungary, children represented 25% of the population in 1960 and 15% in 2015 (1, 2). Nearly one third (2.2 billion) of the global population are children and adolescents, but 90% of them live in the low- and middle-income countries (LMICs) (3).

Mental health problems affect 10–20% of children and adolescents in the world. A systematic review of studies conducted in LMICs confirmed that the prevalence of mental health disorders in LMICs is equal to the prevalence in HICs (4). Reliability of the epidemiological data is of primary importance, as on their basis, policies and de-

isions concerning allocating resources are made. However, there is concern that mental disorders might be over-diagnosed in developed countries, resulting in misleading epidemiological data (5). Estimating the real prevalence of mental disorders in pediatric population is particularly challenging because of the different data sources and surveillance methods of pediatric mental disorders. Additionally, cultural differences could have broad implications on the estimates (6). Neuropsychiatric disorders are the leading cause of health-related disability during the first three decades of life, accounting for 15–30% of the loss of disability-adjusted life-years (DALYs) (7). Recent data suggest that currently used approaches underestimate the burden of mental illness by more than a third. Thus, mental illness could be responsible for 32.4% of years lived with disability (YLDs) and 13.0% of disability-adjusted life-years (DALYs) globally (8). According to the Global Burden of Disease Study 2010, mental disorders and substance abuse disorders are among the leading causes of morbidity, being responsible for 7.4% of DALYs and 22.9% of YLDs worldwide, making them the fifth leading cause of DALYs and the leading cause of YLDs (9).

The Atlas Project of the World Health Organization (WHO) on child and adolescent mental health revealed the real global burden of this medical problem. Around 20% of children and adolescents suffer from mental illnesses that end up in disability. Additionally, 50% of all adult mental disorders may be traced back to the adolescence. There were several shortages identified in services concerning pediatric mental health, especially in LMICs, including lacking human resources, services, training, as well as inadequate health economy and policy (10).

The failure to address mental health problems of children and adolescents in most of the countries is an important public health issue. As a substantial part of adults' mental health conditions has its onset in the early years of life (11), and the early diagnosis is important not only for the current well-being of the child, but also for their social and economic development throughout their entire lifetime (12). Risk factors for mental conditions can present as early as in the preconceptional period, and they include family history, unplanned pregnancy, maternal prenatal and perinatal physical and mental distress, and adolescent parenting (4). Risk factors that appear in the pre-school and school age include: health and nutrition problems, suboptimal psychosocial and educational environment, being orphaned and/or raised in child protection facilities, bullying, perceived obesity, school difficulties, use of tobacco, alcohol, and drugs (4). Risk factors specific for the adult age include career difficulties, unemployment, and other socioeconomic factors (4). Systematic reviews have shown that the prevalence of mental health problems of children in LMICs resembles the prevalence in HICs (4).

Mental health problems are less visible in the society than physical illnesses due to their nature. Their prevalence, as well as their importance, is often overlooked. However, the influence of poor mental health on physical health causes significant costs to the health care. For this reason, health care providers should raise awareness on mental health issues by integrating them into social policies and health programs (13). Primary care physicians play an important role in diagnosing and initiating the treatment of mental health problems in children and adolescents, especially in rural and under-staffed areas, in which the access to psychiatrists is limited. There is need for more systemized and transparent referral process to other specialists, such as pediatricians, psychologists, and social workers (14). Moreover, all the professionals of the mental health care should also cooperate with employees of other social systems (educational, social care, and juridical systems), which should also have a role in promoting mental health (15).

To establish new programs and develop already existing child and adolescent mental health services, it is essential to understand the decision-making procedures

of central governments and the intersectoral competition for financial resources (16). Therefore, there is need to formulate adequate economic arguments to draw the attention of policy makers that can influence resource allocation (16). Studies in HICs have clearly indicated the wide range of long-term consequences of childhood mental health problems, not only concerning the education process (17), but also adult health and labor market conditions (18). Strong economic arguments support the early investment in the mental health of disadvantaged children, for early prevention is often more cost-effective than later remediation (19). Early investments have higher return than those made at a later age (20).

At the beginning of the 2000s, the Atlas of Child and Adolescent Mental Health Resources suggested that governmental child and adolescent mental health policies are rather rare worldwide (21). The United Nations (UN) resolution on a World Fit for Children states that "every child has the right to develop his or her potential to the maximum extent possible to become physically healthy, mentally alert, socially competent, emotionally sound and ready to learn" (1). Unfortunately, this declaration was not followed by the development of specific policies or programs to support the development of pediatric mental health services (22).

The World Report on Violence and Health of the WHO (23) indicated that abuse and negligence in the early life lead to later mental health problems. Following this report, the UN adopted the Convention on the Rights of Persons with Disability in 2007 (24). The Convention included provisions for persons affected with mental illnesses and intended to influence the country-level advocacy for the development of mental health services for children, as well as for the humane treatment of those with mental health problems – including children and adolescents (24).

Although political will is indispensable for the establishment of child and adolescent mental health policies, the education of the public about the need of such services is also vital (25). Reputable international and professional organizations (The World Psychiatric Association Presidential Program on Child Mental Health – a collaboration between the World Psychiatric Association, WHO, and the International Association for Child and Adolescent Psychiatry and Allied Professions) developed an instrument to support the promotion of child and adolescent mental health to develop advocacy programs which could influence the special policies (26).

In spite of growing evidence of the importance of mental health, major international nongovernmental organizations (NGOs) and agencies (except the WHO) seem to pay little attention to the child and adolescent mental health care. The lack of specific interventions may result in long-term negative effects on educational attainment, chronic disability and lost productivity. The

policy development depends not only on the mobilization of financial resources, but also on the mobilization of potential stakeholders (27).

In the USA, the child and adolescent mental health services have been significantly developing in the last decades, but in spite of this, only 20% of children and adolescents in need of psychiatric treatment received help, leaving 80% of children and adolescents with psychiatric illnesses untreated (28). It has been pointed out that in the future, more emphasis in the child and adolescent psychiatry should be put on providing services for a larger amount of patients for less money. As the authors of the study formulate it, "patients should flow seamlessly from the community into child and adolescent psychiatric services and back, and from one program to another, with evidence of constant care coordination and an emphasis on quality. Available resources should follow patient demand so that we can be responsive to populations and to immediate clinical need" (28).

Clinical Centers of Excellence support evidence-based care at the national level. They promote mental health and help establish national health policies to raise public awareness and foster public advocacy related to the mental health of children, adolescents and their families (29).

## MATERIAL AND METHODS

In order to compare the health policy acts of the Hungarian government with the worldwide trends in child and adolescent psychiatry, we analyzed the governments' programs. We analyzed four basic programs of successive Hungarian governments:

1. National Program of the Decade of Health (30),
2. Our Children Our Treasures – National Infant and Child Health Program (31),
3. Semmelweis' Plan for Saving the Health System – Revitalization and Treatment (32),
4. Healthy Hungary 2014-2020 (33).

## RESULTS

### National Program of the Decade of Health (30)

The program was adopted in 2003 by the new Parliament after the general elections in 2002. It was an improved and updated version of the former Public Health Program of the previous government. The new program emphasized the very poor health status of the Hungarian population, reflected by morbidity and mortality statistics. The description of the program focused on historic facts of the two decades after the fall of the Communism (1989-1990), describing the widening economic gulf of social classes and the wave of unemployment, with male citizens particularly affected. In order to solve these social problems, the government decided to start a general socio-economic program

that was supported by all the non-governmental organizations of the Hungarian society. The program also targeted the mental and physical health of children and adolescents, emphasizing the role of the prevention of avoidable mortality and morbidity. Pre-school and elementary school children were concerned a primary target group of health education and promotion programs.

The prevention of mental health diseases was discussed in a separate chapter. It was aimed to improve the mental health status of the general population by improving the quality of life and health awareness. Limited clinical data available indicated the gravity of the situation. Suicidality was the main concern, as with the suicide rate of 45.9/100,000 before 1994, Hungary had the highest suicide rate in the world. Although the rate has been decreased by one third by 2002, the program also indicated that the consumption of alcohol and illegal drugs is causing suicides to be the main cause of death in the 16-24 year-olds.

Based on these facts, seven key objectives were set for the following 10 years: 1) the reduction of general prejudices and misconceptions related to mental illnesses and mental health disorders; 2) primary prevention of mental disorders by health education and promotion; 3) early detection and treatment of psychiatric disorders by sensitizing primary health care providers; 4) development of mental health programs and improving structures and functions of the psychiatric inpatient care; 5) reduction of the suicide rate of children and adolescents by at least 20%; 6) reduction of the general suicide rate to the 20/100,00; 7) increasing the number of registered depression patients by at least 30%.

In order to achieve these goals, the following actions were suggested: 1) primary prevention programs targeting mainly family and school environment; 2) review of structure and function of mental health facilities; 3) the introduction of the recommendations of the community psychiatry model to the inpatient facilities; 4) decentralization of outpatient psychiatric care with the help of financial incentives for local governments and facilities; 5) increasing the number of health professionals by the training of community psychiatric nurses, social workers and rehabilitation experts; 6) supporting local governments participating in pilot projects; 7) developing new outpatient psychiatric units; 8) increasing the number of children and adolescent outpatient care units in close collaboration with children's right societies.

Another chapter was devoted to the prevention of alcohol and drug abuse. The chapter described the current situation. Great emphasis was put on the high alcohol consumption in adolescents, as well as its early initiation and an increase in illegal drug use among minors. The prevention of early initiation of alcohol consumption and illegal drug use was indicated as one of the most important objectives of the program.

### **Our Children Our Treasures – National Infant and Child Health Program (31)**

The program was created in 2005 by the government in close collaboration with national health institutes, universities, and non-governmental organizations. The WHO slogan “children are our investment in tomorrow’s society” was quoted in the preamble as the motto of the program. In the United Nations’ Convention on the Rights of the Child, children were defined as persons under 18 years of age, including infants and adolescents (1).

In 2003, child and adolescent health and health promotion was given the highest priority on the 53th session of the WHO Regional Committee for Europe, and in September 2005, the WHO European strategy for child and adolescent health and development was created (34). The Hungarian program was based mainly on these recommendations. The basis of the long-term program was the belief that the first 18 years of life determined later physical and mental capacities, as well as morbidity. Maternal and child health care service was given particular importance in the Hungarian system, employing specialized, licensed nurses.

The program was supported with detailed statistical analysis, it must be however underlined that the reliability of the data provided by the National Statistical Data Collection Program was questionable.

Epidemiological studies conducted at that time underlined that 2 out of 10 children suffered from emotional or behavioral problems (31). Moreover, psychosomatic signs (most frequently headaches and abdominal pain) and signs of tiredness and anxiety were frequently observed. 18-28% of children were diagnosed with aggressive behavior, and 16% - with deviant behavioral disorders (23). Concern was expressed about the increasing use of personal electronic devices, such as mobile phones, as they decreased physical activity and induced mental and psychosomatic changes (31).

In the chapter devoted to lifestyle risk factors in adolescents, data concerning smoking, alcohol consumption, drug abuse and early sexual initiation were presented. The most striking data concerned early initiation of smoking (< 10 years of age). The life prevalence of illegal drug use had doubled during the second half of the 1990s. What is more, drug-addicted patients that were less than 16 years of age were not provided with adequate care due to the low number of specialized pediatric mental health care facilities.

The authors of the program stated that the available network of mental health facilities and educational facilities was unable to manage the most severe cases of mental health problems. It also confused the competencies of educational counseling services and of crime prevention organizations. 15.8% (n = 347,000) of children and adolescents required psychiatric care in Hungary, but only 10% of them received psychiatric help. More-

over, help in the regional centers was provided mainly to the 16-18-year-olds, and there was little services available for illegal drug users under 16 years of age.

The seventh chapter of the document concerned the main objectives for child and adolescent psychiatry: 1) first, pediatric psychiatry wards and outpatient care units were to be established in Hungary’s four biggest cities; 2) subsequently, the minimal ratio of 6 beds / 100,000 inhabitants had to be achieved and guidelines for psychiatric emergency care should be developed by health specialist of different groups; 3) rehabilitation services should be available for patients with behavioral disorders; 4) professional supervision in each of the Hungary’s seven regions was required; 5) special trainings for general practitioners and other professionals working with minors concerning the early identification of drug abuse should be available.

### **Semmelweis’ Plan for Saving the Health System – Revitalization and Treatment (32)**

This strategic document was issued by the health secretary of the Ministry of the National Resources in 2011 after consultations with 114 national institutions, as well as professional and social organizations (32). Moreover, the chapter on public health had also been consulted with WHO experts. The pediatric health care was described as a complex subsystem of health care that should concur with educational, athletic, and social programs.

Earlier in the history, Hungary met the highest international standards in psychiatry (32), but in the modern times, it is faced with the world’s highest incidence of mental illnesses and alcoholism. Due to financial cuts in the 2000s, psychiatric inpatient capacities decreased by 24%, becoming the smallest in the European Union (EU). The Semmelweis Plan put a lot of emphasis on the child and adolescent psychiatry, as it had been demonstrated that 15.8% of Hungarian children aged 4-17 years old had been suffering from a mental condition (32). There were few mental health care professionals and little institutional infrastructure, which resulted in the vast majority of patients being underserved in terms of diagnosis and therapy alike.

Goals for child and adolescent psychiatry were set: 1) increasing the number of psychiatry specialists, clinical psychologists, specialized licensed nurses, educational advisors, and behavioral experts; 2) establishing a national network of school psychologists; 3) increasing the capacity of inpatient psychiatric facilities with high security wards; 4) establishing pediatric mental health centers in the seven regions of the country with specialized, multi-disciplinary teams (child psychiatrists, psychologists, special educational advisors, speech therapists, social workers, children’s rights employees, family therapists, and psychotherapists; 5) establishing emergency units for patients after suicide



attempts and in crisis situations; 6) increasing the number of rehabilitation beds for patients suffering from schizophrenia, autism, eating disorders, etc.; 7) developing outpatient care and rehabilitation network, that would also take care of pediatric drug abuse patients staying in the facilities of the National Children and Adolescents Protection Agency.

### Healthy Hungary 2014-2020 (33)

The newest act was issued in 2014, resulting from the cooperation of the Government and the Ministry of Human Resources (responsible for the health services). The strategy was based on the Semmelweis' plan 2011, updating its priorities and objectives.

The following goals were listed for the years 2014-2020: 1) improvement by at least 10% of the general mental health of the population; 2) reduction of the general suicide rate by at least 10%; 3) reduction of in-school and domestic violence; 4) improvement in the preconceptional care available and increase in the number of planned pregnancies; 5) development of the rehabilitation services available for pediatric psychiatric patients.

To achieve the goals, the following health policy priorities have been established: 1) widely available preventive psychological care and psychotherapy; 2) improvement of the community psychiatry for patients with depression and anxiety disorders; 3) development of the outpatient psychiatric care with the cooperation with social care facilities; 4) development of a network of mental health coordinators responsible for children and adolescents discharges from psychiatric wards.

The need for the development and modernization of pediatric health care facilities, as well as for the creation of new pediatric health care centers with active psychiatric and addiction treatment departments and integrated outpatient units has been underlined, so as to enable early intervention.

### DISCUSSION

Psychiatric care for children and adolescents is the domain of both pediatrics and psychiatry, therefore, all the developments in any of these fields affect it.

When analyzing health policies that had been issued, the excerpts concerning pediatric populations had to be taken into account. The policies should respect the results of the current international and domestic studies and the principles of the evidence-based medicine.

All the programs discussed above followed the WHO and EU policies, indicating the growing impact of international documents on local health policies. Initially, the impact was most prominently visible in the main goals of the program, as in the program "Our Children our Treasures", but in the newest program, "Healthy Hungary 2014-2020", many parts of the WHO policies (34) were simply adjusted to the domestic circumstances.

The continuity between the Hungarian policies remains clear in spite of the changes in governments who varied in ideology, and who sometimes struggled to reject all the health policies created by their predecessors. From the professional point of view, the continuity is of primary importance not only for the pediatric patients and their parents, but also for the health care professionals and entire health care facilities, as radical changes in the system every four years are difficult to implement and they hinder the quality of the services provided. Moreover, a system as big as health system or educational system is slow to change, thus, they may be improved only with consistent, gradual changes.

The issues concerning mental health, especially pediatric mental health, were approached differently in all the documents analyzed. The importance of the prevention in school health services and in the shape of pediatric mental health care network varies between the policies. From the professional perspective, "Our Children Our Treasures" and "National Program of Mental Health 2014-2020" seem to be the most important documents for child and adolescent psychiatry. The medical and social basis of all the policies varies.

In the period that we reviewed (1990-2015), fundamental changes in the Hungarian society have been observed, concerning, among others, unemployment, common values, etc. It is interesting to note that the earlier programs put a greater emphasis on local governments, while the recent policies seem to underline the role of the central government.

The greatest merit of the National Program of Decade of Health was that it was the first program aiming to reduce the prejudice related to psychiatric conditions. It also introduced the primary prevention of mental health disorders with community psychiatry models. Thanks to the program, the 20% reduction of the suicide rate was observed. Traditional psychiatric facilities were transformed into institutions in line with the community psychiatry model. Local governments were supported in their rearrangement of the primary health care and given financial incentives for these actions. The funding of mental health education and prevention was modified. The role of child and adolescent psychiatry was underlined.

"Our Children Our Treasures" program, issued in the 2000s, emphasized the need for creating new beds on pediatric psychiatric wards, extended the competences of the outpatient care units and psychiatric emergency units for underage population and supported school health services.

The Semmelweis' Plan for Saving the Health System underlined the threat of mental health disorders epidemics, indicated by the high prevalence of psychiatric conditions in 4-17-year-olds. At the same time, it was acknowledged that Hungary was lacking human and financial resources to provide adequate mental health

care to all the patients needing it, resulting in an impaired availability and social inequity. The Plan aimed to increase the number of the specialists, enforce the network of school psychologists, increase the number of beds, and extend the competencies of the outpatient care facilities, enabling them to manage minor patients suffering from drug addiction.

The current policy, based on the Healthy Hungary 2014-2020 program, underlines the role of family physicians in the diagnostic process and basic treatment of mental health disorders.

## CONCLUSIONS

When analyzing the health policy documents concerning child and adolescent mental health services, a gap between the growing scientific knowledge and

its implementation can be seen. Hungary's problems, dominated by the shortages in human and financial resources, are the problems of the middle-income countries, as it was clearly stated in the audit report by the State Audit Office of Hungary (35). However, it must be underlined that this report concerned only the use of financial resources, without the analysis of the theoretical or practical aspects of psychiatry. The report stated that the psychiatric health care, including child and adolescent psychiatry, had significantly worsened from 2006, as the capacities in the in- and outpatient care had decreased, in some cases (especially concerning long-term care) putting the services at risk of failing to operate. Hungary still has a lot to do to fulfill the goals of already existing programs in the clinical practice.

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**Conflict of interest**

None

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Correspondence to:

\*Péter Balázs

Institute of Public Health

Semmelweis University

4 Nagyvárad Sq., 1089 Budapest, Hungary

tel. +36-204-511-506

e-mail: [balazs-peter@windowslive.com](mailto:balazs-peter@windowslive.com)