Monitoring of the Hungarian Psychiatric Outpatient Units and Community Services of Psychiatry

An Analysis

2009–2011

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Follow-up study made by

Visits-monitorings (on the basis of monitoring sheets)

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The most recent piece of the usual analyses of Mental Health Interest Forum deals with the problem-complex of the operation of Hungarian psychiatric outpatient clinics and community providers.

This was a two-years' study made between 2009 and 2011.

The sample is representative.

I. THE STATE OF PSYCHIATRY INCLUDING OUTPATIENT CLINICS

Inpatient care is still overrepresented, the system of transitory and rehabilitation institutions is underdeveloped, actually non-existent. As a matter of fact, however, inpatient care is both the least cost-efficient and the most expensive for society. Inmates of inpatient clinics are efficiently treated only in the short run and in acute episodes; following this period outpatient clinics serve as the means of continuous control and daily connection. Although the number of outpatient clinics is insufficient their for the time being their territorial division and the number of their patients do not threaten the efficiency of the structure. The situation, however, became critical by the end of 2009 when the closing down of the outpatient network turned up as a serious alternative. Apart from the fact of the appalling consequences this would have meant for the whole system of health care this decision would have also eliminated a characteristically Hungarian form of care. Furthermore there was no agreement concerning funding for even its most recent variety had been based on a 9 years' old and completely outdated system. Due to an almost unprecedented cooperation involving both the psychiatric profession and its clients a protest movement succeded in preventing institutional closures although some disadvantegous „fusions" did already take place. The „survival" of the outpatient system was due to the fact that patients' and professional interest groups (PÉF-MHIF and Regional Association of Hungarian Mental Health Outpatient Clinics (MPGRE) joined forces to prevent the strivings of the health care administration. Positive results followed in 2010 when a series of talks and defining a model-study cycle managed to assure the existence of the network of outpatient clinics and their funding also changed for the better. Although these changes cannot be regarded as ideal the situation of these clinics still improved somewhat.

The number of outpatient clinics surpassed 100 but it has never reached 150 in the last decade. Being territorially easily accessible they could offer a relatively efficient care and afford a continuous connection between providers and provided. The extremely strained situation of Hungarian mental health care affects outpatient clinics as well; the clinics are crowded, and the consultations are shorter than would be necessary. In spite of all these and other deficiencies outpatient clinics providing both professional medical help and long time care still constitute an indispensable element of of the mental health system and their right to existence should not be doubted; the task is now to make their operation more cost-effective and humane. Financially their efficiency is beyond doubt: it has been sufficiently demonstrated that this form of provision was much cheaper than hospitalization.

Let us now indulge a bit in the history of psychiatry based on data published in the book of Tamás Irinyi *Professional Care in Psychiatry* (Medicina, Budapest, 2002)!

Non-violent nursing that freed patients from the means of coercion was introduced by the Italian Chiarugi in 1788. In 1798 the French Philippe Pinel (1745–1826) introduced changes that had a real symbolic significance: 49 insanes could get rid of the chains fixing them to the walls of the „hospital". Pinel developed the method of studying psychiatry bringing thereby a new discipline into being in the framework of the medical sciences. From now on mental disturbances were already regarded as diseases. The transition from medieval-like nursing to more humane forms was a slow but continuous process. Mental patients could get rid of chains by 1880 in France and by 1890 in Rome, Italy. In the island of Haiti psychotics were guarded by armed personnel until 1936. The larger society has been infected by prejudices, fears, ignorance; nursing staff consisted almost exclusively of primitive, harsh and violent persons and patients were completely exposed to them.

In the second half of the 19. century sedating of patients became a principal objective. The following means were used:

- opiates and their derivatives
- bromid and its derivatives
- cages
- several hours' tubbing under supervision
- from 1877 on chloralhydrate.

With the introduction of active treatments a decisive change occured by the beginning of the 20. century:

- fever-treatment (patients were infected with malaria)
- enduring narcotism (lasting for days)
- artifial catalepsy (tetrachor, ES)
- leucotomy (cutting through the frontal lobe of the brain in order to eliminate some association nervous tracks)
- insulinization (large amounts of crystalline insulin was administered in order to bring about an artificial hypoglycemic coma).

Following the institutionalization of psychiatry research work also developed especially in the field of the pathology of the brain (Griesinger, 1845). One of the largest inpatient psychiatric wards of all times was established by the turn of the century in Munich; its head was Emil Kraepelin the founder of traditional *Nervenkunde* (science of the nerves). His collegues were among others Alzheimer, Brodmann and Nissl. By the turn of the century the theory of the psychogenic functional diseases also took shape (Dubois, Freud etc.). Psychoanalysis was developed by Sigmund Freud (1856–1939) on the basis of the observation of clinical phenomena and the theories and hypotheses concerning their founding psychic mechanisms. Partly as a follow-up of psychoanalysis psychotherapy was also born; suggestive therapies, hypnosis became more frequent. Different forms of psychotherapy have been spreading in recent decades: behavior therapy based on the theory of conditional reflexes and explorative rationalizing therapies. Apart from individual psychotherapies different kinds of group therapies have also developed; their cutting edge form is the so-called therapic community.

At the end of the 19. century it was generally held that mental health disturbances could not be healed; in this period the theory of hereditary degeneration was the ruling hypothesis. A politically motivated distorsion of this conception occured during Nazism. In the framework of Operation T-4 nearly 80 000 mentally disturbed persons were killed during the second world war. The sinister experiences of the world war made „socialization of psychiatry" necessary: mental health institutions have become progressively open door establishments, extremural therapy was born together with a network of outpatient care forms and different transitory institutions like day clinics, club-therapy, work-therapy, protected workplaces, phonecall-services etc. The psychiatric profession has recognized that in the present form of organization it was unable to satisfy an urgent social need – the psychiatrization of society: the treatments of the professional psychiatrist need a social background. According to a most recent tendency the patients have to be treated in the same environment that gave rise to their disease: in their homes or workplaces. Inpatient treatment is only temporarily – for a short period, some days – necessary depending on symptoms. By these means patients are capable of preserving their social connections and these can assist them in the recovery.

The triumph of psychopharmacology began in the '50ties with the appearance of the first anti-psychotic drugs and antidepressants. The first antipsychotic drug, chlorprozamine was synthetized by Charpentier in 1950, and applied in clinical practice by Delay and Deniker in 1952. Antidepressants emerged between 1952 and 1957 and were closely followed by litium-treatment in the prevention.

Although the social perception of mental health patients has improved a lot in recent decades much has still to be done to assure that psychiatric disturbances should be treated by the public like somatic diseases. Both the fast development of psychiatric treatments and the increasing preference for human rights have promoted the dissemination of this positive approach. New specific drugs and psycho- and social therapies together have made available a better quality of life for the overwhelming majority of patients and helped them to better assume their workplace-, family and other roles. The enforcement of human and patients' rights will dissipate the fear of patients that they will be delivered to the arbitrary staff in psychiatric wards.

A BRIEF HISTORY OF HUNGARIAN PSYCHIATRY

There was no psychiatry in Hungary before the 19. century. According to a decree of 1783 mentally disturbed patients were admitted in poorhouses but could also be imprisoned. The first mental health asylum in Hungary was founded in 1852 by Ferenc Schwartzer who also published the first Hungarian language psychiatric textbook in 1858. Another hospital was established 1857 in Kolozsvár and was followed in 1868 by the so-called Lipótmező in Buda; later it was renamed the National Psychiatric and Neurological Institute. The institute was

closed down in 2007. The first psychiatric department in Budapest was established in 1882; the name of its first professor was Károly Laufenauer. The founder of Hungarian experimental psychology, Pál Ranschburg and the world-famous neuropathologist, Károly Schaffer both belonged to his disciples. The second university department for psychiatry was established in 1889 in Kolozsvár (Károly Lechner). In 1867 400 mental health patients were held in different hospitals in Hungary, their number was increased to 7454 by 1899. In the National Lunatic Asylum of Buda 7 doctors, 5 administrative employees and 42 male-nurses cared for 500 patients. The working hours of the staff amounted to 12, even 16 daily, the nurse on duty had to be present in her workplace for 36 hours.

The situation began to improve after 1950: nursing and cleaning duties were progressively differentiated, the first steps in the the training of specialized mental health nurses were made. The job of mental health nurses was transforming as well: from simple controlling towards professional and highly appreciated activity within a healing team. Perhaps psychiatrists recognized first that healing of patients was impossible without the active participation of the staff.

As mentioned earlier the second system of of mental health provision is made of the network of mental health outpatient clinics. The common characteristics of their patients is that they are all ambulant persons; in case of a prior agreement or when having complaints they are capable of coming to consult competent mental health professionals. Mental health outpatient clinics keep on revealing psychiatric problems in their respective districts, looking for and treat those in need, follow-up and supervise them and provide welfare services to the persons they care for and also offer many-sided help to their rehabilitation.

COMMUNITY PSYCHIATRY

Community psychiatry is a part of integrated psychiatric care (IPE) (Optimal Treatment Project, OTP). An institutional revolution has started in psychiatric care in the second half of the 20. century. Ther following factors served as its background: the political movements of the ’60ties in Western Europe; the structural change in inpatient treatment; the number of hospital beds was decreasing; the prices of the medical industry have dramatically increased; new methods of therapy have appeared (new types of psychopharmacons). All these required new types of psychiatric service as well.

Their common characteristic feature is that provision becomes light[*] institutions- instead of hospital-centered. The new types of institutions are structurally less rigid, more elastic, manifolded and are adapted to local (community) needs. Services are adapted to the local surroundings, as if trying to preempt mental disturbances and offering help on the spot (family, workplace, school etc.) whenever it’s possible. The services have become progressively de-medicalized. The role of the psychiatrist is by no means exclusive. Different types of helping professions come into being inducing a significant transformation of the role of the psychiatrist (consultant, educator, supervisor).

The new types of services make use of the experiences of the earlier local community oriented psychiatric provision as well. Concerning these services the term „community psychiatry” is generally used by the recent literature. For a Hungarian form or application of this philosophy see the „Nap street” model that was developed on the basis of the university clinic in the beginning of the ’90ties.

Well trained nurses play an important role in the traditional psychiatric medical team operating within institutional frames. Their tasks can be achieved in an even more autonomous and non-directive way in community psychiatry. But this requires a change of outlook not only from the nurses but also from the medical and welfare professionals who all belong to the system of provision. (Vitalitas-Joginfo). When we talk about community psychiatry special mention is due to the outstanding activity of Judit Harangozó M.D., assistant professor, psychiatrist, psychotherapist, neurologist and rehabilitation professional. Dr. Harangozó is an unavoidable „bulwark” of community psychiatry; she also had a pioneering role in its popularization. Her primary mentor was the late Professor Ian R. H. Falloon whose above mentioned IPE/OTP program was introduced in Hungary by Dr. Harangozó. It may sound strange today that there were times when it was almost risky to talk about community methods applied the day clinic of the Psychiatric and Neurological Clinic led by

[*] It is debatable how light these are (RI)

Professor Tringer. Professor Tringer called that day clinic (that is still existing but is now operated by Awakenings Foundation the head of which is Harangozó) a kind of movie theater. For like in a cinema life-saver instruments, e.g. respirators were missing in the day clinic. In a television program Professor Tringer even declared his preference for cages in the treatment although this coercive instrument was already nowhere regarded as comme il faut and was soon to be banned. From all this the reader will see the difficulties awaiting anybody who was courageus enough to make ideas about community psychiatry around 1995. With the passing of time this kind of provision – which is among its other advantages is also cost-efficient – was of course gaining ground. A miriad of its opponents became suddenly enthusiastic supporters, there were several protagonists who began to regard themselves as pioneers of this form instead of its opponents. As a matter of fact this method is already extensively applied, although its state funding is still very modest and this will exclude a considerable number of potential clients from this cutting edge provision. In a modern system of provision addicts are also part of community provision. The core of the matter was first summarized by Dr. Harangozó: see Judit Harangozó et al. (2001): Paradigmaváltás a pszichiátriában (Paradigm change in Psychiatry). *Lege artis medicinae:* Orvostudományi továbbképző folyóirat 2001, 11. évf. 8/9. sz.

The subject of our research is the everyday practice of provision with all its difficulties and from the perspective of the patients.

Unfortunately some providers have denied taking part in monitoring. Dr. Róbert Kárpáti is a real „medical oligarch of Székesfehérvár"; in spite of previous talks with competent managers of the Hungarian Psychiatric Association and ignoring the support of the National Psychiatric Centre (not to speak of other national and international agents) he has consistently undervalued the importance of monitoring and has simply prohibited that our collegues should enter into his institution.. It was not only this monitoring case that made his role so negative: owing to other aspects of his activity we even had to apply to the European Union for help. Police and ombudsman investigations, patients' complaints also point to the fact that this is not an institution Hungarian psychiatry could be proud of.

Monitoring was also rejected by Szigony-Útitárs for Complex Psycho-Social Rehabilitation Nonprofit Ltd, formerly called Szigony (Harpoon) Foundation for Community Psychiatry. Serious complaints were made against the foundation and its head; one of them even had to be forwarded to the police. We investigated the institutional environment on the spot and found that serious patients were not at all enthusiastic about the activities of the establishment.

The Integrated Day Care Social Home of the city of Pécs was also a community provider that dealt with our effort in a stuck-up manner. Its manager declared that it was up to himself to decide whether monitoring suited him. And he did actually decide…Nevertheless state funding was offered them but this will perhaps change next year…The services of this provider extend to the following townships: Abaliget, Egerág, Cserkút, Bosta, Bogád, Birján, Baksa, Bakonya, Téseny, Tengeri, Szőkéd, Szőke, Szilvás, Szemely, Szalánta, Romonya, Regenye, Áta, Pogány, Pellérd, Pécsudvard, Pécs, Orfű, Ócsárd, Nagykozár, Magyarsarlós, Lothárd, Kozármislény, Aranyosgadány, Kővágótöttös, Kővágószőlős, Kovácsszénája, Kökény, Kisherend, Keszű, Husztót, Gyód, Görcsöny, Ellend. According to the manager of the sevice neither the territorial extension, nor the number of patients would require that he should be included in a national monitoring survey. Why not?

Splitting between welfare and medical provision although its non-viability has been demonstrated many times still remains a significant problem. Neither legal, nor advocacy and professional-financial aspects can justify this division. Moreover representatives of the welfare profession believe in a significant proportion that problems of mentally disturbed patients can be solved merely by resorting to professional welfare expertise - which is an obvious nonsense.

The well-functioning welfare provider in Szeged had to be closed down owing to financial reasons. This is an unprecedented case that should be corrected as soon as possible all the more so because the competence of the former manager of the institution has been demonstrated beyond doubt.

To the positive cases we must include the activities of senior medical officers Lajos Balczár (who is also the manager of the community provider in the city of Veszprém) and Magdolna Nyisztor of Dunakeszi who also holds both positions. Even though the overwhelming majority of our partners proved to be highly cooperative special mention should be made of both these collegues who are practizing their profession with the

utmost devotion. Dr. Kelemen in the city of Hatvan also tried to do his best although the local manager of the service judged the importance of monitoring somewhat differently.

By now it became obvious that outpatient psychiatric clinics and community providers have both their raison d'être. Both are ineluctable pillars of the efficient (also cost-efficient) treatment. Problems are to be found elsewhere: the lack of competent staff, aging professionals who are still capable of „driving a flea against cross-wind to Saint Petersburg". The newcomers who are replacing great witnesses of great times are tempting the impossible under not too easy circumstances. Both the „exclusively medical or exclusively welfare" perspective and the striving to make community provision the entail of otherwise enthusiastic but not omnipotent professionals need to be corrected. The enormous advantages and professional knowledge of specialist psychiatric multidisciplinary teams have to be fully exploited.

II. THE MONITORING OF PSYCHIATRIC OUTPATIENT CLINICS

The facilities of the outpatient clinic: Considerable differences are revealed in the facility level of the outpatient clinics (waiting and consulting rooms, technical conditions). Generally speaking minimal standards are everywhere met. Outstanding conditions were found in two cases: *„Waiting rooms were not crowded. A television set stood at the patients' disposal. Waiting room was decorated with many flowers",* and: *„The waiting room, the consulting room and technical conditions were unambiguously good."* Unfortunately the overall picture is not as good as this, some buildings need to be repaired (water- and heating system, canalization, insulation, complete accessibility). There are frequently common waiting rooms with other outpatient clinics and these are therefore crowded. The computers in many clinics are outdated and their number isn's sufficient either: *„owing to new rules concerning prescriptions specialist doctors ought to have their own computers."* Appropriate facilities for visiting patients in their homes (e.g. means of transportation) are frequently missing.
It was our general experience that almost all the clinics had the opportunity to improve their facilities recently. Sponsoring (also foundations) have been the main source of funding in many places. (In the city of Békéscsaba I made photos in the waiting room where patients could watch the television while waiting.)

Staff: One specialist for 30-40 000 clients: this is the average. There are clinical districts where 1,5 specialists serve 100 000 clients. Let us mention an extreme case which is, however, not unique: *„The district consists of 32 settlements, the number of inhabitants is around 50 000. A 73 years' old specialist works in the consulting room."* Apart from full time specialists there were also part time specialists as well but there there was a permanant lack of specialist staff in many districts. Doctors were assisted by psychologists, professional nurses, social workers, assistants. Their number varied by clinics and districts: psychologists, social workers, professional nurses were missing in many places, and the number of jobs wasn't sufficient either: *„we would need psychologists' and nurses' jobs."* Owing to missing funds only few new collegues could be employed, cutbacks were permanent. The lack of professional nurses was mainly due to deficiencies in training. Working teams are generally stable: *„We try to organize provision in such a way that patients should be affected by the lack of professional staff as little as possible."*
Specialists were ageing; it was a permanent problem to replace retired specialists. In the city of Tatabánya there were no candidates for a specialis's job in the outpatient clinic; temporary replacement was needed and the replacement doctor could not get acquainted with the living conditions of patients.

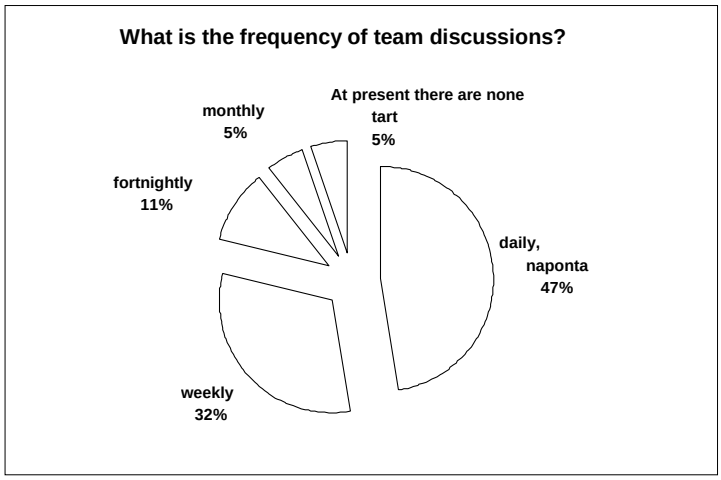
Specialists were generally assisted by trained assistants, professional nurses, social workers and in some places part time psychologists. The massive provision of patients relied on their elasticity. In some places the established practice was the following: if the professional nurses did not judge it necessary, or in lack of an explicit demand of the patient the specialist wasn' expected to see the patient at each supervision.

Complete satisfaction was almost nowhere present among the clinics that were monitorized; staff and/or financial problems have to be dealt with in many places.

Computers wereslow and overloaded in many places; clinics were overcrowded. Fluctuations were not common in this field. In one clinic no team discussions were held; this was the same institution that had been employing a replacement specialist for more than two years.

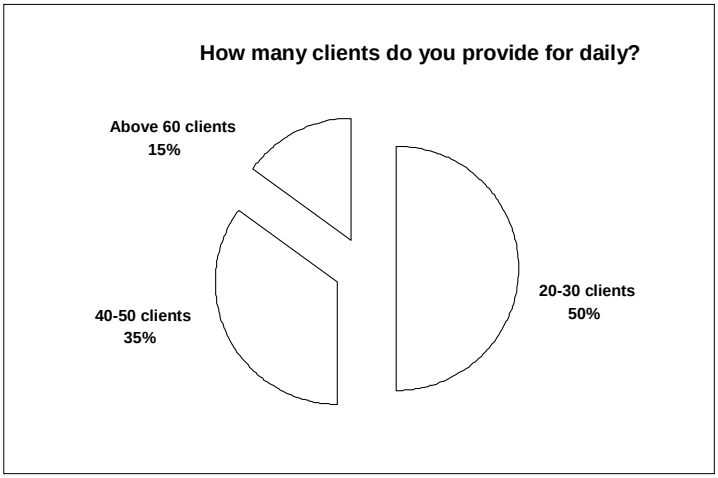
Retraining of the staff was generally assured; different forms of preventing the burn out syndrome were available.

What is the most urgent problem that hinders your work? The answers to this question were presented individually for they very clearly illustrated the most urgent problems and their varieties: *„Computarization of prescriptions is no help, work was done faster by handwriting." „The present staff is sufficient for our work." „Staff is small, patients are many." „We would need at least one more specialist. Staff is small, patients are many." „Slowness of computers, deficiencies of the program." „We have less financed hours (with Social Security) than would be needed by the number of patients and our turnover. The number of doctors is sufficient but the number of consultation hours is less than would be needed in this district. According to a social security survey our turnover exceeds by two-three times the national average – the regional medical service proposes an extension of working hours but the national social security cannot take in the claim." „We would need modern computers, printers and copy-machines." „The state of the building." „Lack of specialist doctors." „We can solve our problems." „There are no special obstacles." „No problems." „Consultations are too short." „We have permanent, chronical problems. The head of the clinic was the sole person to provide medical service for years. Overstress and responsibility are enormous. Time is never enough. Patients are frustrated by sometimes having to wait for long hours. There is no fluctuation." „There is no child psychiatry. Children have to be sent to the nearby town which is a problem for parents and children alike. No social worker's position. The capacity for psychotherapy is insufficient. The problem is now solved by declaring Friday as psychotherapy day." Permanent difficulties and uncertainties, lack of time and money in medical care." „We would urgently need doctors. Administrative work has also to be changed, it takes an awful lot of time." „Separate consulting room." „The most urgent need is the lack of a permanent specialist doctor; this is why patients cannot visit the same specialist all the time. The professional staff is too small, there are no means of transportation to visit patients in their homes. We have not visited patients for a long time. Technical deficieincies make the work of our professional staff extremely difficult." „Modernization of information system, psychiatric retraining of nurses."*

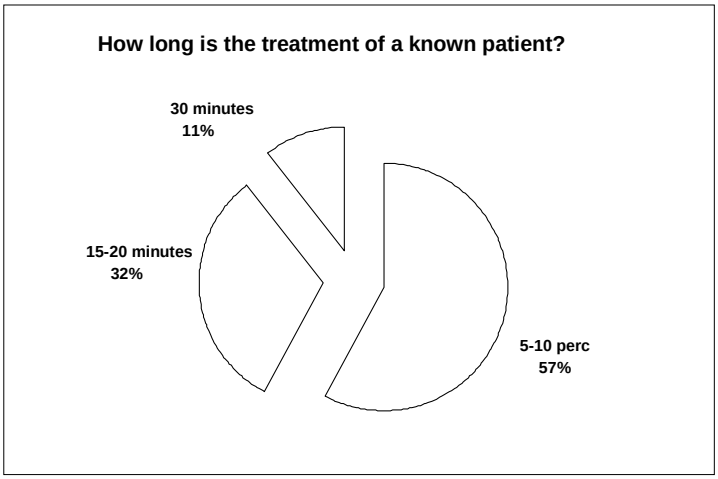


The diagram shows the frequency of „team discussions". The possibilities of staff retraining were available in all but one clinic (in the last mentioned case it had financial obstacles). Retrainings took place within the institution and taking into external sponsors in several cases.

What could be done for preventing burn out? The methods available were varied. Let us see the different possibilities: *„Due to tendering there are training groups to deal with stress in our hospital." „We discuss this and support each other. We can rely on the help of a psychologist in the district clinic." „We embrace all possible forms of cooperation to diminish psychic burdens and to delegate tasks (community provision for mentally ill patients, day care, part time staff positions)." „Good workplace atmosphere, members of the staff are helping each other. Work is manysided, challenges are numerous, the sense of achievement are present. There is a possibility of supervision." „Common programs, retraining, case-discussions, group discussions for the staff." „Good staff enhancing each other during intervals." „We support each other in the so-called smoking intervals, no organized discussions." „Participating in trainings." „Team work, supervision, individual fill-ups." „Retrainings and familial support help in preventing burn out. Members of staff make out of work programs together." „We try to prevent it by pleasant retrainings."*



Medical care: Generally speaking outpatient clinics were overstressed: the number of patients exceeded the ideal by 40-50%. *„We care for 60-70 patients daily. Several patients visit us for depot injections or prescriptions, sometimes they don't even see the doctor. (e.g. injections are given fortnightly but the specialist sees him only once a month if his or her state doesn't require more frequent supervision; or the patient comes for new prescriptions each month while medical supervision takes place threemonthly.) The specialist sees 30-40 pateints daily. Booking in advance is needed."* As a consequence of overstress consultations generally did not last long: in case of a known patient the time span was 5-10 minutes in almost 60% of doctor-patient encounters. According to our survey the time spent for one patient was at least 30 minutes in only 11% of all encounters (by one patient in ten).



The picture was somewhat modified by the fact that in case of new patients and depending on the psychic state of the patient.first consultations could extend up to 2 hours One example: *„The time spent for one patient varies. It can extend from 5-10 minutes up to 2 hours. In case of new patients or those who haven't been seen for years exploration will be made by the psychologist if he/she is on duty. Informative discussions, social amnestic explorations will be made by assistants who also make the patients' records. This is followed by the medical examination. Reviewing and recording former medical evidences also takes a longer time. Making a heteroamnesis can also become necessary by some patients, etc. Psychodiagnostic investigations are made by the psychologist at the request of the doctor; for these investigations that also require a longer time the patient will be recalled to a later appointment."* Apart from exceptional cases the outpatient clinics did not serve children and adolescents (under 18 years). They were cared for in special child psychiatric clinics if such wereavaillable; otherwise their provision was quite problematic in the majority of cases. No previous papers from the family doctor were needed for consultations in any of the clinics we have monitored. As a general rule consulting occured after advance booking, then in the order of appearance, in case of emergency (acute states, patients coming in emergency cars) also out of turn.

One specialist saw 30-35 patients daily which of course seriously affected the quality of provision and made consulting a conveyor-belt like activity. The ideal number of patients would be 20 persons per day. According to the specialists we talked to the time spent for each patient varied a lot. For new patients at least 30 minutes were needed, consulting recurrent patients was also dependent on their actual state. There were some who had to satisfy with no more than 5-10 minutes.
An extreme case from Békéscsaba: the doctos had just returned from his one week's leave and had to see not less than 74 patients in his first consulting day. There was no prebooking system; everybody was consulted who happened to turn up in the clinic. In spite of a prebooking system there were considerable delays in some clinics. Owing to the enormous turnover of patients there was a tendency to diminish the number of patients by giving them fixed appointments for supervision.

In accordance with legal rules provision could (also) occur without previous notification.

„Government decree 217/1997 (XII. 1.), § (1) The insured person – with the exception of cases defined by Ebtv. 20 § (4) – is authorized without doctor's pre-notification to have resort to

👉 a) specialist's clinic
👉 ad) psychiatric and addictology clinic"

Also in accordance with the rules every patient will be informed about his/her new medications, and/or in case of a change in medication about eventual side-effects and expected results.
„Health Care Law (CLIV/1997)
135 § (1) The informing of the patient will be made by his/her doctor carefully, gradually if needed, taking the state and circumstances of the patient into consideration.
(2) In informing the patient special attention should be attended to generally known, significant side-effects of the treatment, eventual neopathies, the possible consequencies of medical interventions and their frequencies. The doctor should be convinced that the patient understood the information, further on the informed person should be psychologically looked after if necessary."

Provision of adolescents was much more problematic. Their special treatment was available only in some settlements.

Our experiences concerning the follow-up of patients leaving hospital were rather varied. In some cases supervisions were regularly made after hospital treatment owing to a good cooperation with community

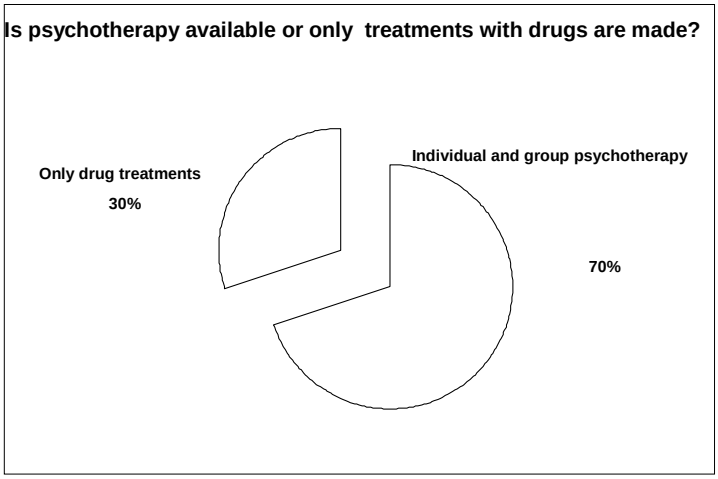
providers but in others no such cooperation existed. This kind of cooperation, however, would have been indispensable since both organizations were publicly funded. This inadequate practice could be abolished by legal regulation. Individual cases of call-up or contacting family members or the family doctor also occured.

The frequency of visiting pateints in their own care homes or domiciles was varied although it could be achieved through the cooperation of the outpatient clinic and the community provider (if any).

In cases of a good cooperation the rehabilitation of patients has also better chances. E.g in Keszthely the community coordinator helped in making prescriptions and the taking out of medicaments; similar results of a good cooperation could be experienced in other cases as well. A growing number of jobs for rehabilitated patients would very much further the process of rehabilitation.

Some outpatient clinics had the ambition to maintain good connections with psychiatric wards, the staff of family doctors' services, other outpatient clinics, family therapists, children welfare services, social care homes and other social providers, major's offices, different authorities and NGO-s in order to achieve better results.

In case of serious and menacing disturbances initiating hospital treatment was the regular practice by outpatient clinics; initiating guardianship procedures was also frequent. In many cases occured in a scandalous manner with complete disregard of the involved person and/or his/her family members who weren't even informed about the process either.



Outpatient clinics always stressed that patients should be informed about their new medication, and its possible side-effects. *„This is very important, should be done, this is our task."* According to the law patients' information is compulsory. In some clinics even leaflets received from the pharma-industry were distributed. Follow-up of patients leaving hospitals was varied: in some districts there was a close cooperation between outpatient clinic and hospital; in others regular cooperation was missing.

Can you follow-up the state of patients after hospitalization? Do they come for regular supervisions and prescription of drugs? *„Yes, hospitals always send their final report." „Upon leaving the patient has been given the prescription of the medicaments he got in the ward and he/she should come and see the outpatient clinic within soma days." „Yes, we have no problems with follow-up." „There is a good cooperation between outpatient clinic and hospital." „The hospital hasn't informed us about the patient who has been released." „There is a close cooperation between the hospital and the outpatient clinic. A professional member of the staff visits the hospital weekly, all the inmates are seen, final reports taken, he/she act as an intermediary. Giving information about the activities of the outpatient clinic." „It depends. We don't know those in the ward. I used to get one copy of the final reports and patients were warned that they should go and see the outpatient clinic. Such informations are missing nowadays." „The psychiatric ward usually sends a copy of the final report and sends the patient to the clinic." „Yes, although patients are frequently leave the ward without final report. We tried to discuss this many times but without success. From the point of view of funding the outpatient clinic belongs to the hospital. This used to mean a surplus of 10 millions for the hospital but this has changed: now it takes away 10 million." „Follow-up occurs according to forms of disturbances: contacting the family doctor or the nurse visits them in their homes." „If the patient has not been sent to hospital by the outpatient clinic we can lose sight of him/her if he/she doesn't come and see us." „Patients leaving the hospital generally come to supervision. Wit those who don't regularly attend the clinic the community provider will be contacted if possible." „For the time being the follow-up of patients is only possible when he/she comes to see us by his/her own. Patients as a rule come for supervision and for their prescriptions."*

What is the proportion of the patients who come for supervision and what do you do in such cases? The answers implied that the overwhelming proportion of patients came regularly for supervision. In one outpatient clinic we got the following answer: *„Around 30-40% of the patients do not turn up, they don't know what*

to do; patients with panic disturbances usually return within some months." 30-40% seemed to be the worst proportion, 2-10% seemed to be the average; one district reported a proportion of 25% who failed to turn up for supervision. In this case the clinic made phone calls or sent out a polite invitation by post eventually the family doctor was be informed. *„The overwhelming majority of patients comes regularly. If not we send an invitation or contact a family member or the family doctor." „Only a few patients don't come; in these cases phone calls are made, letters will be sent out or the family doctor will be contacted. The clinic has good contacts with the family doctors anyway." „In case of definite forms of disturbances we send out a letter of invitation." „We don't have any informations whatsoever, no follow-ups of supervised patients."*

45% of all outpatient clinics had no programs whatsoever to visit patinnts in their homes. 55% did have such a program, although its intensity and the frequency of visits varied from district to district. *„Members of the staff only sporadically visit patients in their homes, staff of the Family Service, however, have daily contacts and the flow of information between both services goes on a regular base." „Nurses' visits occur every three month or more frequently if needed. Specialis's visits occur twice a year." „Only if visits becoma necessary, e.g. owing to unexpected events, or when the patient fails to turn up etc. It is our aim to extend informations on the patients' state. Therapic reasons can also have a role: family therapy interventions, consultations, milieu-interventions etc." „The territorial nurse makes regular visits."*

We were pleased to experience that 84% of the outpatient clinics under monitoring were cooperating with a community provider in their vicinity (town, district): *„We have very good connections, they are very competent." „We have a cooperation agreement with the Family Centre." „There is a community provider in our district and we have a good cooperation with them." „Yes, provision is excellent."*

Rehabilitation of patients was supported by verbal counselling (life-style advices), medical aid involving also social workers or psychologists if needed. It was a recurrant problem that information had little value if there were no rehabilitation jobs. In some cases it was rather community psychiatry than the outpatient clinic that supported rehabilitation.

For the sake of increasing their efficiency outpatient clinics had many-sided cooperations with other institutions on a regular base. E.g. *„Psychiatric ward, family doctor, other outpatient clinics, family provider, child welfare service, social care homes and other social providers, major offices, different authoroties, NGO-s. All these can help us and the other way round: they ask for information."*

In case of emergency states immediate hospitalization occured as a rule: *„In case of emergency or damaging states the patient will be urgently sent to hospital. This can also be done by the family doctor or by the emergency medical service. It can occur that the patient will be sent to the outpatient clinic and we send him/her forward to the psychiatric ward. In cases when the patient potentially endangers his/her surroundings and doesn't comply with treatment we initiate compulsory hospitalization by court decision. In recent times this has been a rare event in our district and the court by ordering the treatment has found all these cases justified. We can also initiate both partial and plenary guardianships if needed. This, however, almost never occurs simultaneously with hospitalization." „This depends on the state of the patient. Immediate hospitalization is also possible. If the emergency occurs at home there is no time to visit the patient on the spot, it is the family doctor's duty to see to hospitalization." „It's a lucky circumstance that the outpatient clinic is in the same building as the psychiatric ward; this is way hospitalization can occur immediately. In urgent cases we immediately send a fax to the town court." „Initiating compulsory treatment, or partial or plenary guardianship, immediate hospitalization. In case of endangering states we ask for help of the family doctor."*

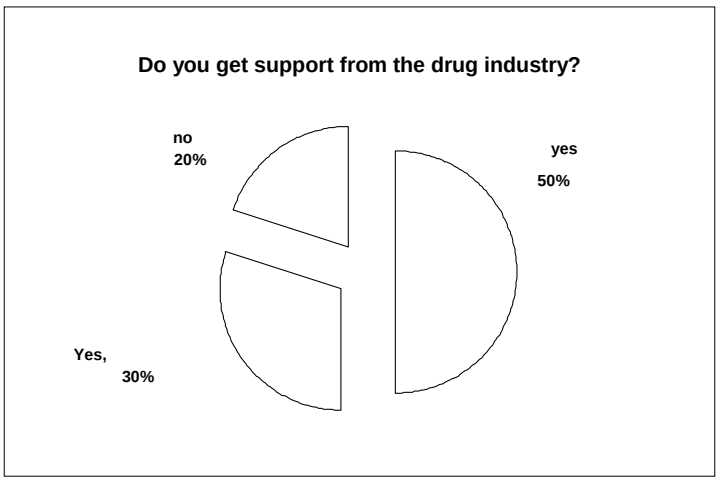
Patients' rights and advocacy aspects. Patients' opinions and complaints could be forwarded to the representative of patients' rights whose availability was shown in each of the outpatient clinics. Civil control was non-existent in all but three districts; in one district civil control was exercised by a member of PÉF. 55% of all clinics had contacts with self-help groups (e.g. AA movement, club of mental patients) or they supported the creation of such organizations: *„Our clinic has connections with members of borth Voice of the Soul Association (a self-help group) and PÉF who also attend our sociotherapy programs. We also have a self-help group supported by them: the Empathy Club." „Yes, we do have connections with a self-help group. We do our best to support it (activity room etc.)."*
We found that although patients as a rule were adequately informed in the clinics about the available ways of sounding complaints in many cases they did not dare to enforce their rights. The majority of NGO-s were still inadequately equipped to achieve their aims. Advocacy was rather a question of help but help was only reluctantly given if the problem involved anomalies in health care. Having resort to a psychiatric clinic was in itself a stigmatizing factor that was a major concern of patients in the first period of their treatment although this feeling became less vigorous later. This is why they generally kept attending the outpatient clinic.

Doctors frequently maintained good connections with the drug industry that tried to draw their attention to certain products of theirs by small presents and by covering their costs in professional conferences.

How do patients get to outpatient clinics? Is sending patients to the outpatient clinic after hospitalization an automatic process? *„It depends on the character of the disease. Not every patient is sent automatically to the outpatient clinic after leaving hospital." „The type of disease is the decisive factor. Only certain types of patients are sent to the clinic." „No, it is not an automatic process. The decisive factor is how severe the disturbance is and what is the number of fallbacks." „After multiple supervisions all patients are sent to the outpatient clinic after leaving hospital." „All patients are sent to the outpatient clinic by the psychiatric ward. It is, however, our responsibility to decide whether he/she needs to be permanently supervised or will be consulted in the outpatient clinic. Only patients with chronic disturbances who need a long term treatment will be permanently supervised." „It depends on their diagnosis and states. Permanent suprvision is no automatic process." „Yes. All patients leaving hospital will be sent to permanent supervision, eventually to regular treatment. Permanent supervision can occur by the family doctor's suggestion, moreover at times without any previous history when the patient's state is judged severe enough upon the first consultation." „Permanent supervision occurs according to the official protocol. It depends on the diagnosis. A patient leaving hospital will always be supervised by the outpatient clinic."* What happens if the patient doesn't want to draw on the service any more (voluntary vs. non-voluntary patient)? „If he/she doesn't want to draw on the service any more and his/her disease doesn't incapacitate him/her we suggest the patient and/or family member to consider the continuation of supervision." „We go to see the patient but coercion is out of question."

In outpatient care every patient can be considered as voluntary. *„We try to persuade them about the desirability of supervision by motivational interviews, techniques of improving compliance." „We try to reveal the reasons and motivations of fall-offs." „We try to discuss why do we regard this as necessary, and ask the patient to bring the person who cares for her. We also offer alternatives. If medication doesn's seem necessary we accept the patient's decision but i f the patient's state makes medication important we try to persuade him/her, discuss it with family members, consult the family doctor etc." „The psychiatric ward sends all patients to the outpatient clinic. Then we decide whether the patient should be under permanent contol or only temporarily provided for in the clinic. Permanent control is only suggested to patients with chronic disturbances who need a long term treatment." „We are trying to keep contact patients, however, come to see us on a voluntary base; in some cases the patient is not willing to take medicins but regularly comes to supervisions. Cooperation with family members can also help." „First we send out a letter, further steps depend on the state of the patient. By patients under guardianship the guardian will also be contacted."*

The visit to the outpatient clinic can have a stigmatizing effect in the beginning; in spite of this, however, patients with the exception of some did not fall out, or did not worry about this problem. *„Unfortunately they still feel this, although the outpatient clinic offers a pleasant surroundings with music in the waiting room; patients have first reservations but later on the feeling of being stigmatized decreases and they become more positive." „We often meet patients who consider any form of psychiatric treatment (ward, outpatient clinic) as stigmatizing. It is alreqady a positive sign if they explicitly state this for this is a precondition of the possibility of a dialogue on this subject."*



50% of all outpatient clinics got some kind of sponsoring from the drug industry (participation in congresses, purchase of computers, free medicaments). Sponsoring was quite modest and temporary in 30% of all cases: promotion presents, stilos, calendars, information leaflets. *„Yes, we get material sponsoring although it would be better if we were able to get what we need without having to resort to sponsoring." „No. They would give us free samples but I don't accept it."*

III. MONITORING OF COMMUNITY PROVISIONS

Organizational problems

What is the aim of community provision? *„The aim of community mental health provision is to promote reintegration into the environment on the individual level and to prevent the patient's isolation."*

What does a community provider do? *„This service offers a long term care that is adequate to the individual needs and relieson both the active and responsible participation of all involved and the natural resources of the community."*

What is the mission of community provision? *„Our mission is… to support the way of life of local patients with chronic psychiatric disturbances, assure their psycho-social rehabilitation, improve their life-quality by applying professional methods and offering adequate conditions."*

Whom with? Do you cooperate with any interest or self-help organizations? If yes, please specify! The following are positive examples: *„Yes; among others: Interest Group of Psychotics in Szabolcs-Szatmár-Bereg County, ÉFOÉSZ, Association for Family Protection, Organization of Deaf People" „Federation of NGO-s, Békéscsaba", „Give Me a Hand Foundation, Békéscsaba", „AA Movement", „Club of People with Tumour Disease".* A rather interesting example: *„Office of Justice".* Another example reveals the difference between self-help and professional organizations; i.e the professional provider was unable to differentiate among self-help and professional organization or was tired while answering; Or: how diffuse is man as a social being! *City Welfare Service of DMJV (home care), Kenézy Hospital-Outpatient Clinic Health Service Ltd Psychiatric Ward for Adults, Kenézy Hospital-Outpatient Clinic Health Service Ltd, Daytime Ward, Debrecen University Medical and Health Care Center Department of Psychiatry, VESZ Psychiatric Outpatient Clinic and Care Home Department for Adults, Welfare Center of the Hungarian Ecumenical Church Debrecen, DMVJ Institute of Child Protection, Family Protection Service and child protection center, ReFoMix Nonprofit Ltd. Center for Welfare and Health Care (homeless provision), 'Mental Strength' Young for Young Association, Debrecen Office and Service Center of the Észak-alföldi Regional Labor Center, SHAKE HANDS Mental Help Phonacall Service, Community of Active Love SOS Service for the Community Provision of Addicts, House of Therapy, XY clinical psychologist, XZ supervisor in family therapy, Dr. ZZ legal counsellor, Dr. KK family doctor, ALETHEIA Welfare Service Center Home Aid,* „What are your fields of cooperation (in concrete terms)?"

The self-image of staff members. What kind of difficulties did they mention? *„Too many office tasks, lack of cooperation in the health care system, the patients are not wholly aware of the new forms of provision, strict monitoring with ever changing criteria, new stages of rehabilitation (day care and job-finding) take a lot of time and money." „Fluctuation in workforce", „there are no rehabilitation and free-market jobs", „cooperation with different fields of health care, changing professional and legal requirements", „lack of trained staff, vocation-minded staff, the geographical distance of the provision center, work is hard, salary is low, fluctuation is big".* Do you expect any changes in the system of provision? *„Tenders are called for funds to finance day care and employment within welfare institutions; a rise in the basic salary of KJT (for not only clients but staff members are also becoming poorer), professional trainings in the vicinity of the workplace, extension of psychiatric knowledge, development of skills of community providers". „Development of the readiness for cooperation within the health care system (first of all legally, with a structural change). Community care should be achieved predominantly within institutional frameworks (day care), there is probably a higher need for day care and employment; very few people are competent in community care; new patients, families can be made „more open and competent" by other forms of provision. Professioonal decisions in community provision should be based on realistic knowledge of patients' needs (rehabilitation, recovery, social development, characteristic features of the welfare system); this has a major role in the process of controlling, target-definition etc."* Professional re-training: **„Is community training sufficient for satisfying qualitative requirements? In this respect s**taff members are divided: 50% said yes, 50% no. „Community training doesn't seem sufficient for satisfying qualitative requirements although previous job experiences (e.g. the respondent used to work in a psychiatric outpatient clinic) can put up for this shortage. Against this background the psychiatric team functioned well." Is re-training assured?" 20% of the respondents answer with „no", 80% of them with „yes". „Would you need retraining?" The answer was unanimously „yes".

How do you judge the efficieiency of your work? Do you fill in client-satisfaction questionnaires? If yes, what are the results? A striking experience: in 3 of 4 institutions there were no client-satisfaction questionnaires – i.e. the efficiency of community provision could not be measured on the clients' level; ne feedback existed. Methodically such a measurement would be possible although it is doubtful whether its functioning can be scientifically verified. Let us see three very instructive examples:

„Assesment have shown that 44 respondents of 50 were provided for, 2 respondents were not provided, 4 respondents were family members. 44% of the respondents were addicts, 56% got community psychiatric provision. The measurement of the satisfaction with our services gave the following results: 58% were completely satisfied, 24% partially satisfied, 16% were moderately satisfied and 2% were not satisfied with our services. 40% were completely satisfied, 28% were partially, 10% moderately and 4% were not satisfied with our different programs. Satisfaction with the staff gave the following results: completely satisfied 72%, partially satisfied 20%, moderately satisfied 8%, not satisfied 0%. According to our clients better internet accessibility, an increased number of programs (presentations, excursions, gym) and more individual care would have been needed. Creation of groups with the members of which have identical or similar problems were also needed. They suggested to make community provision better known and also urged for welfare employments. In summary: respondents were generally satisfied with the activities of the community provider. They regarded the staff as attentive, amiable, helpful and positive minded. They thought our work was important in the field of mental hygiene. ***They also thought that our staff was overburdened by administrative tasks and had less time for actual provision work."*** *(A doctor who didin't take part in this research once said: „Because of the patients we don't have time for working".)*

„We made up a questionnaire in January 2009 to get to know opinions concerning our activities so far and to assess new needs. The questionnaire was short and conscise, to fill it in needed no considerable effort since i t had been meant for mentally disturbed patients. The samle was not representative: out of 52 clients 14 filled in the questaionnaire. Among our services the respondents resorted to supporting conversation most frequently. As second they mentioned welfare administration and life-style counselling. The least popular were crisis management and legal counselling. All the respondents were completely or almost completely satisfied with our services. The degree of satisfaction was highest with supporting conversation. We also wanted to know what kind of new services, forms of counselling were needed but these open questions remained unanswered. As to division by sex, 50% of the respondents were male and 50% female. The average age of the respondents was 27 years. Summarizing the results the assessment of our work was decisively positive; those clients who filled in the questionnaires were to a high degree satisfied."

„…within community provision we succeeded in protecting mental health and its change for the better. The considerable decrease of the length of inpatient treatments implies an improvement in the state of our clients; another outstanding result is that 7% of our clients have not been forced to resort to hospitalization for psychiatric reasons since they are provided for by the outpatient clinic. Sociall support offered by friends, familial or professional provider plays an important role in overcoming the disease in our clients' life. A considerable part of our clients do not live in partnershisp and share their home with the parents; this is also a reason why they feel community psychiatric services indispensable.

Professional strategies in community provision in order of importance: 1. individual welfare work, 2. administrative help, 3. problem-solving training and development of skills, 4. (the order here is not significant) communication training, psychoeducation, involving a family member, team-discussion, 5. case-conference.

The place of community provision of clients with mental disturbances in the national system of psychiatric care. Community providers in the network of institutions have a stable place on the map of psychiatric hospitals and wards, psychiatric outpatient clinics, care homes and notaries. They are both the agents of the legal-administrative establishment and of the medical and welfare systems. In psychiatric hospitals administrative functions are mainly represented by the policeman and the secretary of court, in the system of community providers by the guard of legality: the notary. The function of another guard of legality, the prosecutor does not sufficiently affect the Hungarian system of mental health. This is one of the reasons why the activities of PÉF in this sense are somewhat nearer to the function of the prosecution. Territorially the system of community providers and outpatient psychiatric clinics can be identified by five axes the direction of which is divergent. The Kecskemét-Kiskunhalas axe is directed towards the courts of law – following the accusation by the prosecutor. One axis in Budapest is directed towards denial of monitoring. A third, extremely resolute axis is directed towards clients and patients. In Gödöllő almost community services have been offered by the psychiatric outpatient clinic (perhaps owing to the correct organizational self-interpretation and the presence of excellent personalities); in Debrecen the axis is directed towards a good cooperation among community provision, psychiatric hospital and a dozen of other organizations. We should admit, however, that a certain axis interprets its activity as a sort of mental health pre-home care hereby advocating an incorrect practice that is opposed to the idea: „We are almost the sole agents who are directly related to the client." As it turned out from the answers concerning cooperation the main choices of clients were rehabilitation, accomodation in permanent welfare and care homes, day care and suicide – individual accomodation was painfully missing which is a problem in itself.

How many clients are provided for? One community provider supported 49 persons on the average. This number is curiously similar to the established minimum norm. From 2012 on even those won't get more funding who would wish to provide more clients and would perceive a need for it.

Rehabilitation and suicide statistics. On the question: „What is according to you the greatest difficulty in community work?" one of the community providers gave the following interesting – and depressing – answer: *„the incompetence of the health care system (its structure, culture and moral). Insufficient and structurally inadequate funding. Professional „idealism" on the level of decision-making the actual result of which is merely 'reaching out for more and catching less'. Succesful professional dialogue between decision-makers and professionals is missing or inadequate. Families, social resistance, stigma, prejudices.."* Facing this situation the aim of community provision interpreted as a welfare service were rehabilitation and recovery. But this would have required that the social majority should be more cooperative; the fact that this cooperativity was frequently missing has been formulated by the above mentioned provider; to the question: „What kind of change would you propose in the service?" she gives the following answer: *„The improvement of cooperative skills on the part of all protagonists of the health care system (above all on legal level, with structural change). Community provision ought to be achieved in institutional frameworks (day care); day care and jobs are probably more needed: less people are 'open-minded and competent' to community services;* a new kind of service could make new clients and families „competent and open-minded". Professioonal decisions in community provision should be based on realistic knowledge of patients' needs (rehabilitation, recovery, social development, characteristic features of the welfare system); this has a major role in the process of controlling, target-definition etc."
To the question „How many clients left the outpatient clinic in 2009 owing to succesful rehabilition?" positive answers were given by 15 providers; as data have shown an aggregate of 65 clients have left community service owing to succesful rehabilitation. There are no data from 9 settlements (no data, monitoring denied, there is no community provider). The questions „Did suicide cases occur? If yes, how many?" refer to one of the saddest aspects of human life. 13 communities have registered suicide; of the 8 cases one was „succesful". It should be stressed, however, that this was no statistical survey. Monitoring is no personality research, the questions concern primarily the social aspect since the disturbance is psycho-social in nature. Some providers referring to non-existent legal rules failed to give exact information and only the occurance of suicide was admitted. Succesful rehabilitation as a positive aspect in proportion to failure as a negative side offer a favorable overall picture: 65 to 8. Nevertheless it is astounding that concerning recovery statistics the rate of patients or clients who had died amounted to 10% of all cases.. The answers to the questions, „How many clients have moved to day care? Were there clients who had to be sent to welfare homes? (If yes, how many?)" are interesting as well. 18 clients moved to permanent homes, 78 to day care. This latter data is probably not correct for more than 50 persons are given day care by one provider while the maximum number is in the majority of cases 8 clients per provider. In one community 27 persons were offered a welfare employer institute for there was officially no day care.

It seems that community provision alone could not achieve tha task of healing, recovering and employing mental health patients either; the decisive factor are to be found outside the system: mainly in the fields of the constitution, morality, financing and social cooperation. This is one of the reasons why we should extend monitoring to basic and constitutional rights too.

IV.

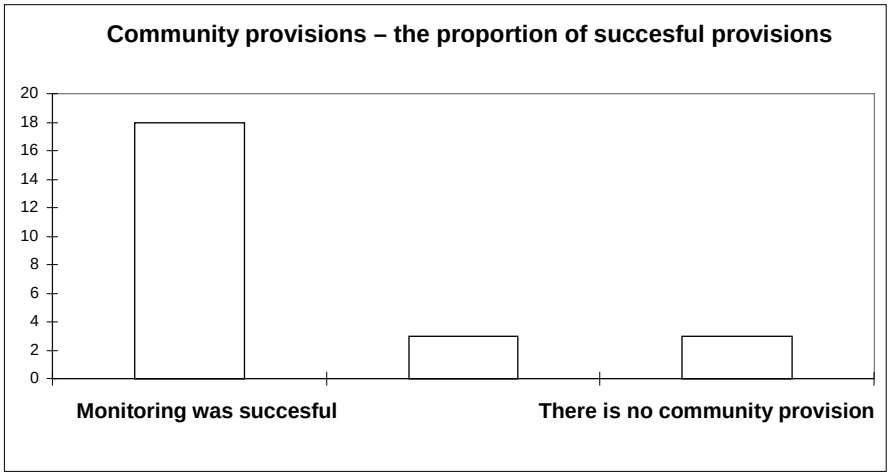
COMMUNITY PROVIDERS - CLIENT-SATISFACTION MONITORING

During regional monitoring particular emphasis has been put on meeting clients and filling in questionnaires concerning their degree of satisfaction. Both health care outpatient clinic and community provider serve the interests of clients; this is why questioning and monitoring them is of utmost importance. This is also connected to our principle: *„Nothing about us without us";* our analysis would be insufficient if the opinions of the users were not involved. 11 questions have been formulated by our research team. The confidential nature of the data have been taken into consideration; the sheets were completed in such a manner as to exclude identification. In case of clients only sex and age have been specified.

How long have you been drawing on community provision?
Have your personal aims been specified? yes no ambiguos no answer
Would you please give an example
Has community provision help you in attaining your aims? yes no ambiguos no answer
Have you learned psychoeducation Problem solving Correct communication
Are you informed about the possibilities of treatment? yes no
How frequently do you meet a doctor or psychologist? weekly monthly
In case of a problem what time is needed until you can see your doctor? immediately within some days within some weeks
Do you regularly ask questions concerning treatment? yes no ambiguos no answer
Has your provider informed you about available self-help or fellow sufferer's groups in your surroundings?
Do you participate in such a group?
Has your provider informed you about interest groups?

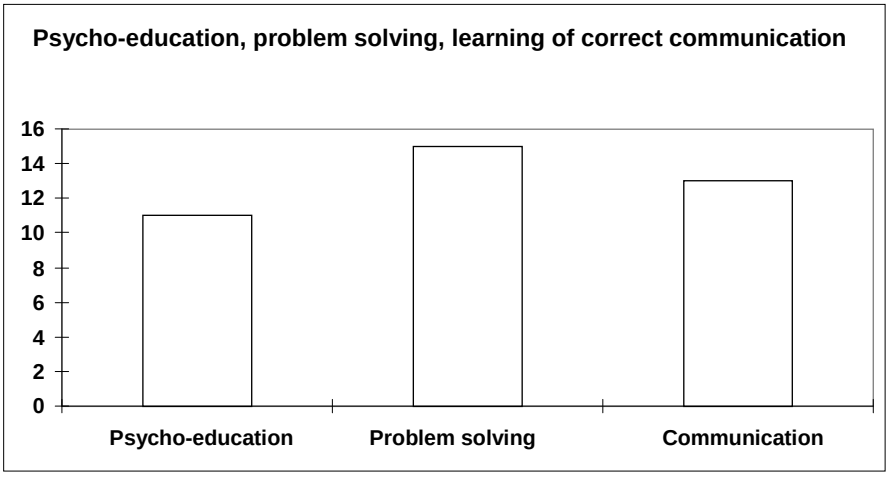
Date: *Name of person filling in the questionaire* *Site of monitoring*

Community providers were called by phone asking for an appointment to make monitoring; we also informed them that we wanted to ask clients for their opinions about community provision.

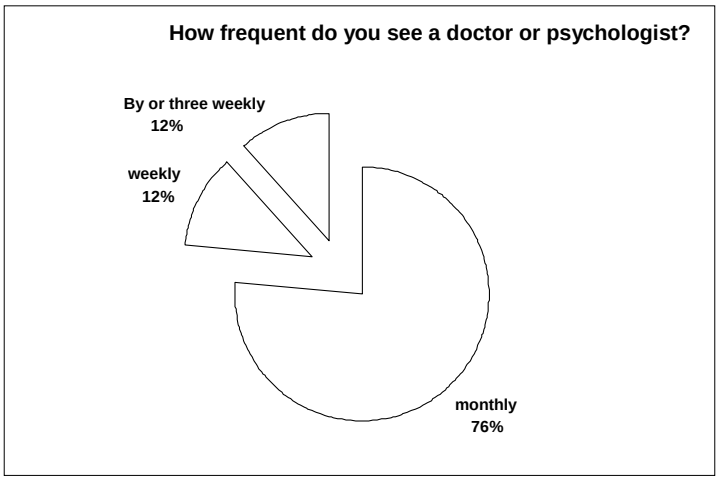


As the diagram shows client-monitoring was succesful in 18 cases; our demand was rejected by three community providers and there was no community provision in three districts. Community provision has been drawn on by the majority of the respondents for 1-2 years, the longest period being 4 years and the shortest 6 months. In one case the client confided us that his pride prevented him accepting provision although his psychiatrist proposed him to grasp this possibility. This fact shows the frequency of insecurity, lack of information among clients: they didn't know community provision and therefore felt repugnance for it. By informing them with the help of NGO-s made the first steps easier and anxieties could also be better overcome. Personal aims were assessed in each case. These included to look for an employment or job in many cases; as significant motivating factors the development of skills, lifestyle development, group activities, treating of partnership problems could also be mentioned. People with mental disturbances are cumulatively handicapped: they are both ill and poor. In community provision they were assisted by professional social workers in handling and budgeting money, dealing with debts, drawing on different kinds of welfare services (e.g. asking for a fair increase of their pension). Leisure programs, activities that are best suited for getting to know other people (city walks, gym, common riddles, handicrafts) were also targeted. A disabled person was assisted in making his apartment cleared. Monitoring has revealed that the community provider succeeded in contributing to achieve these aims by all the clients.

We also wanted to know whether **the clients had learned psychoeducation, problem solving or correct communication.**



All but one respondents (who said *„service is available but I feel uneasy there this is why I am not willing to participate")* answered with „yes"; in 8 cases all three methods were mentioned: psychoeducation, problem solving and teaching correct communication. As the diagram shows the primary concern was problem solving (15 cases), followed by communication (13 cases) and psychoeducation (11 cases).
Tha available treatments were also discussed in all cases but one. The frequency of the discussions with the doctor or psychologist is shown in the following digram.



In case of a problem the clients usually could turn to their specialist within some days; in rare cases this happened only in some weeks. Two thirds (67%) of the clients asked questions concerning their treatment, 22% never had any questions and 11% was ambiguous. Two third of the clients also got information about the whereabouts of a nearby self-help or fellow sufferer's group. Seven respondents were members of a self-help group, ten persons did not participate (the reason was often the absence of such a group), one expressed an explicit aversion towards this possibility.
78% of the respondents were informed by the provider about advocacy organizations.

V. WHAT HAS HAPPENED TO OUR COMMUNITIES IN 100 YEARS? - ON THE PROTECTION OF MENTAL HEALTH COMMUNITIES

IV. generation basic human rights *(a suggestion to the ombudsman of basic rights)*

That the societal nature of the human being is a fundamental legal issue from the point of view of the sustainable development of the Earth goes without saying. The catalogue of our basic human rights is also developing; in our post-20. century state we are already speaking of IV. generation human rights. These are the rights of humans as social beings. Personality can be regarded as a creation of eternal Rome but to connect today's legal systems exclusively to Roman law seems to be inadequate in many respects. The principle of strict enforcement seems to be a bit outdated following the second world-war, and especially after 9/11, i.e. during the world-wide struggle against terrorism. Personality is networked into a wider world-web and its reciprocity with other factors of our social environment is an indispensable condition of any taype of personality. Our social being has been torn out of a social network the relevancy of which had not been questioned for many generations. Normality, human values, meanings have become somehow relative, nothing seems to be absolute any more. Psychiatry could just recently get rid of absolutist (earlier administrative and police) determinations. The medical model has already been overcome in mental health and psychiatry. Dictatorial and punishment-based psychiatric institutes housing an enormous number of inmates have had a legitimate place among the great riddles of history following the emergence of metropolitan police from the 17. century on in Europe. Medical researches based on the ideology of social exclusion failed to verify why is it necessary to keep human beings in cages. The dream of peacceful happy times disappeared by the end of the 19. and the beginning of the 20. century; the hidden cruelty of the human race was shown in such an unveiled brutality by agressive autocratic

experiments that this could hardly be mentally elaborated by means of outdated ideas the irrealistic dream-like quality of which was already corroded by the fire of history. The fundaments – at least some necessary requisits of them – of a medical model of psychiatry have disappeared.

Personality and social being. The pyramidal structure of human needs described by Maslow also concerns community – or else legitimate human – needs. Human beings are certainly human by their capacity of thinking but this alone doesn't make them community beings yet. The Copernican world-outlook meant certainly a great scientific paradigm change; humans, however, were not yet involved in it. Mental Health Interest Forum undertook an interesting venture: it began to investigate the institutions providing mental health services in Hungary and monitoring the clients' human rights. These monitorings have never aimed at individuals, i.e. methodologically they differ to a considerable extent from the ancient Roman conception of personality. During monitoring the universal nature of human dignity must of course be stressed; this, however, is not sufficient; the embeddedness into the social environment should be investigated as well. Ours was not a survey of personality and was not a social statistical data-survey either; rather a collection of data on unworthy situations. For it is unworthy in itself that the person gets dehumanized and is unable to express his/her will during psychiatric procedures and will be accorded not even the legal presumption of innocence; by this means this person gets to an extra-familial and extra-constitutional situation, and is bereft of his/her personality.

Three kinds of psychiatric procedures. In the so-called psychiatric field three unwritten basic procedures can be observed. One of them is familial in origin; the other can be characterized as endlessly cooperative; and the third is rather restraining and sometimes it is based on malevolent suspicions. The Constitution that was in force until December 31, 2011 simply sanctified familial psychiatrization, and having failed to create constitutional guarantees it approved the right of families to initiate gurdianship actions at law and to exclude undesirable persons from the family by dispossessing them; no constitutional guarantees were in force againts these procedures. Benevolent procedures are usually referred to by the creators and guardians of the medical model; their main point is the assertion that they were the ones who had taken off chains from the patients. Those chains, if I may add that were put on them by the metropolitan police from the 17. century until the end of euthanasy programs of the 20. century. Maslow, Rogers and their Hungarian companions like Béla Buda and Tamás Vekerdy, the outstanding personalities of humanistic psychiatry were also benevolent people, mixtures of scientific talent and benevolence. Violent procedures and treatments, stigmatizing guardianships and other constraints and interferences that were based many times on evident lies and initiated by a few people, i.e. issues that were formulated in a legal language but were constitutionally or legally nor confirmed have lead to abuses in a significant number of cases. Our knowledge of the interactions between the human soul and the social-community environment is perhaps still inadequate; this is one of the reasons why there are so many underregulated and misunderstood elements in the field of psychiatry. Compared to this human-rights centered psychiatric outlook that suffers from many „child's diseases" criminal law must be regarded as a grand old man.
If a family excluds people who in the traditional manner were regarded as mentally disturbed, well, this would still affect one of the fundamental requisits of our social being as humans. It is impossible to live without a family; everyone of us comes to this world by our parents and we all have some kind of family origin. It is difficult for our common sense to imagine a person without a family. The question of belonging to a community or the exclusion from the community also arises for those who are delegated to medical treatment or mental health wards out of mere good will. Whom the social majority has picked out from their original environment and legitimized the whole process by medical reasons. Constraint by the legal and state establishments also affects our social being. This is a legally justified interference of the social majority into the personality that is otherwise considered as holy and immune.

Healing of our social being. The aim of the above considerations was to articulate the close connection between mental disturbances and building or decline of communities. The great personalities of the cultural tradition of humanity like Buddha, Jesus Christ and others were all community builders and these communities were generally inclusive, open and positive. Buddhist psychology prefers to speak of the mind and questions of the consciousness although it has no concepcion of mental disturbances. The Gospels also witness the rejection of all kinds of stigmatizings; they emphasize that religious community is available for all, that each and every person can be included and no one should be discarded; there are no hopeless cases.

Healing communities, supporting and work circles, free rehabilitation communities, advocacy federations. What happened to the respectable institutions and communities of the past after the world-wars? Towards the end of the 2. worldwar such considerations led e.g. Jan Vanier or Dr. Karl König to establish the community of the Barge and the community of Camphill respectively. These communities soon became professionally based therapy communities and such professionally minded communities have been unfolding ever since. Their source was an intellectual idea and like free acts of the human spirit their pragmatic fruits blossomed in an austere reality of everyday life. Then these marvellous communitarian ideas were transposed

into legal regulation and „Community provisions of patients with psychiatric and/or addictology disturbances" as regulated by legal-administrative laws were born. It must be emphasized that these communities have a legal base although are not subjects of the Roman law. Which is an interesting fact. They represent new developmental perspectives as advocacy communities or free rehabilitation communities founded by disabled people. Human beings are certainly capable of development; recent legal consciousness is different from that of 400 years ago. Social institutions need a solid awareness of personality; the development of the human self, however, destroys coercive institutions no matter whether they are this-wordly or refer to another world. Human thoughts and aims became autonomous; they cannot be predicted even by sociological research; these aims are in harmony with internalized fundamental rights. They show they way out of the vicious circle or liberate people from institutional or financial restraints. Internalized aims are by themselves the principle of freedom. This human freedom can be promoted and driven to develop by positive minded environments and new communities mentioned above. The fundemantal principle of these new communities has not been hidden in administrative instructions; as if in the form of a reversed pyramide the forms of welfare care are created by the clients' purposes. Moreover the legal and administrative mechanisms of the majority society determine the funding the clients' efforts – e.g. community provision of clients – in a legally regulated way.

The network of mental health outpatient clinics as a specially Hungarian way; community provision of mentally disturbed persons as a welfare service regulated by the welfare law. In Hungary both the network of mental health outpatient clinics and the introduction of community provisions point towards a humanistically-oriented perspective in mental health care. The source of the institutional world of values is the fundamentally social nature of the human being; geographically easily accessible provisions that are free from stigmatizing – these are the preferences of all involved clients. The sectorial nature of the network of outpatient clinics have been determined by the monopoly of the medical profession whereas the welfare nature of community provisions has been characterized by a non-medical monopoly. Community provisions could actually serve as a means to delegate competencies to those who suffer from missing competencies: their aim is providing psychosocial support that is geographically easily accessible and thereby attenuating major sufferings. Outpatient clinics also provide topographically accessible care; these are, however, mainly medical procedures.

The socializing of medical care. As far as no professional competencies for deciding welfare issues are provided by universities of medicine it is only to be hoped that a welfare extension of Western medicine will take place. Community provision of mentally disturbed patients can be regarded as one of the experiments toward such an extension. Provided that community needs of clients cannot be satisfied by decaying natural communities such artificial, legal means are a useful way if they can be based on good and succesful ideals. Communities can learn from each other. Are there scientific evidences and/or factual grounds for such a utilization of public funds? The methodology of communal and easily accessible mental health procedures has been based on these issues. From a methodological point of view this is neither an analysis of the mind, nor a military regime based on punishment; methodologically the procedure is both suited to the needs of the conscious human being and is capable of overcoming sedative-based confinements. The European Committee supports cooperation of professional and client organizations, telecommunication and mobility as well.

Methodological provisions. Pastoral healing and the professional support of clients' aims; self-governments and meetings of recovered, rehabilitated, putative or real clients, users, ex-users; civil control exerted by them and like in the case of medical healing resorting to business societies; all this would pave the way towards multidiscipline social cooperations. „Love and Laugh" cooperative social movements and networks of abled and disabled people will be supported by the majority society within the framework of a kind of social planning actually operating it like a universal service. Professional supporters coming from the medical, employment, priestly, special education, welfare and judiciary professions can make up the team of community and welfare provisions. The idea of easily accessible mental health outpatient clinics is no alien concept either although it is articulated into the traditional health care hierarchy.

Welfare and cooperative jobs are largely missing in Hungary, there is actually no universal job rehabilitation and only a few foundations can boast with results in the field of job rehabilitation. Let meg, however, remind you in this respect on a marvellous social reformer, Robert Owen (Newtown 14 May 1771 – 17 November 1858).

As a European relief and rehabilitation fund is still missing would job rehabilitation of psychiatric clients remain a utopia? The problem hasn't been solved by the rehabilitation rent community provision either. The establishment of a national rehabilitation authority, government office and national institute will certainly mean an important acquisition but the member states of the UNO Treaty of the Rights of Persons with Disabilities

(CRPD) alone do not seem capable of solving the problem of psychiatric and psychosocial rehabilitation. (In some countries they don't even want to.)

Could we propose to afford adequate relief funds to CRPD and make sure the clients will control their use? Until this has not been done many things will remain in the realm of utopias and illusions.

POSTSCRIPT

We express our gratitude to benevolent providers (this was the majority) and first of all the patients for their cooperation.

The analysis of the monitoring will be distributed. Our responsibility lies, however, in revealing and acquiring information; we can also make proposals but we are no decision-makers whose responsibility lies in making adequate decisions and we don't have the necessary funds either. 22 years after the change of the system and 14 years after the establishment of PÉF our existence still depends exclusively on foreign funds. This is how our country honors and appreciates our activity. Who knows? Perhaps this also will change. When? When someone who is int he position to make important decisions will be affected as well. We always greet new governments with great expectations and this is only the beginning of the government period anyway. The situation of the patient is always awful for heÍ/she is exposed to the will of others. Nothing is stronger than the pains of a disturbed soul. And to become succesful our nation would need intact souls..

For information see our website: www.pef.hu

According to the (biased) opinion of Mental Health Interest Forum the following professionals (mainly psychiatrists) are worthy of being called reform psychiatrists. We are aware of the fact that our knowledge is finite: we cannot know everybody. This is why please do not hesitate to inform us about other such professionals.

Special mention should be due to:

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The list will be continuously extended and reflects exclusively the „biased" opinion of clients

Budapest, 14 January 2012