

OUTSIDE INSTITUTIONS MODELS MANAGEMENT OF ADULTS WITH MENTAL DISORDERS AND THE IMPACT ON ARGENTINA DESINSTITUTIONALIZATION

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ABSTRACT

The aim of this work is to characterize and evaluate organizational design and models of deinstitutionalization in developed countries in the West and its impact on surgery in Argentina. It is described the structure, configuration, decentralization and liaison positions of Mental Health organizations. Service networks was observed with varying degrees of regional autonomy and decentralization. In Argentina was described a multiplicity of approaches and treatments implemented in an irregularly and discontinuously way. Existing projects pose a dichotomy between two health care systems: hospital work and work in the community, which prevented a common work, that would enhance the actions between hospitals and conducted in society. Results are not measured in terms of actual product of professional work (health status of patients) but in terms of nominal product (services provided). A common feature observed in the models analyzed was the timeliness of the different experiences subject to political vicissitudes, low budget allocations for grant programs, systems failure in ex-post evaluation and disadvantageous competition with other groups for the allocation of housing, employment and social security.

KEYWORDS: Psychiatric Deinstitutionalization; Mental Health; Professional Bureaucracies; Management outside institutions.

INTRODUCTION

Mental disorders are a growing health problem, representing in the world 13% of the disease, reaching 22.2% in the region, and experience an accelerated growth compared to the 8.8% of years of disability-adjusted life (DALYs) reached in 1990 (Cohen, H., 2009).

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In Argentina, as in the rest of Latin America, Mental Health is not usually considered a priority, despite the scientific evidence on the burden of mental problems for a country. Therefore, the development of attention, and much more rehabilitation, should faced shortcomings, limitations and difficulties.

Macrosocial and macroeconomic factors affect and impact on mental health, in greater level in low socioeconomic strata, for which the services are scarce, and only a minority that needs attention, receives it effectively (WHO, 2003).

Paradoxically, this situation leads to an appreciation of the psychiatric bed and patients, or their family, refuse to be externalized even when they are capable of being discharged. Frequently, the family can not resolve their needs, especially when it is organized under the productivist model, constituting this, one of the first ring system of social oppression (Kraut, AJ, 2006).

Mental Health is a fundamental human value and in the case of institutionalized patients protected for the State it is your obligation to protect social rights by promoting actions of social inclusion and work.

In the presence of ineffective and economically inefficient hospitals, it is proposed the restructuring of psychiatric care in Latin America (PAHO / WHO, 1990). In Argentina the National Mental Health Act promotes the prohibition on the creation of new mental hospitals, public or private institutions monovalent (Law 26657, chap. VII, Art. 11).

The strong stigma that represents mental health, the conditions of the organization and management of services can be considered as the main obstacles to carrying out the process of desinstitutionalization. The strong asymmetry in the relationship of the patient with the family, with the health system and the judicial system, is an addition to the weaknesses and shortcomings of the institutions in most countries.

The desinstitutionalization has the objective of creating new effective and efficient devices, to keep the patient in the community and not the mere closing of psychiatric hospitals. The term is discussed by different authors, for whom it would be more correct to speak of De-hospitalization, because not all hospitals were asylums and not all patients stopped relying on an institution (Curlee, M. et al., 2001).

This work adheres to the naming of desinstitutionalization as a process whose end product is the outside institutions and socio-professional reintegration of the patient to avoid traffic transinstitutionalization or patients outside the institution without changes in routine, in an attempt to free unsustainable.

Programs currently operated outside institutions add additional units of variable factor work applied to a fixed amount of physical resource and capital. The product (socioprofessional reintegration patient) decreases, even if increases the total amount expressed as activities of the labor incorporated; determining a marginal underperformance against biosocial limitations.

The aim of this work is to characterize and evaluate organizational design and management models operated psychiatric deinstitutionalization in some developed countries in the West and its impact as an antecedent of the process in Argentina.

In this context, this paper discussed in Section II, a description of organizational design and management features. It will describe the characteristics of organizations and outside institutions operated models, as well as coordination of the units, the human resources involved and the source of funding. Finally in Section III, we conclude with a discussion that allowed a comparison of common critical aspects of the models developed and their impact as part of deinstitutionalization in Argentina.

DEVELOPMENT

Structural characteristics of the organizations for mental health care

Organizations that operate models outside institutions, adopt professional bureaucracy settings. Core operations are the key part of the organization and the coordination mechanism is the standardization of knowledge and standard skills outside the institution. It works like a standard program package or repertoire of skills, applied to situations known calls contingencies (alteration of mental health), also normalized (Mintzberg, H., 2002).

The Professional has the basic routine of categorize or diagnose the patient needs based on contingencies. The organization seeks to engage a predetermined contingency normalized to a standard program to whose output is applied the patient externship for labor reinsertion.

The technical structure is minimal and hierarchy midline has broad spans of control over professional work. The support staff, focused on meeting the core operations activities is large and directed from the apex, coexisting machine enclaves within professional settings. Spaced parallel hierarchies appear, a bottom-up democratic for professionals and top-down mechanically to the support staff.

Decentralization is horizontal. Professionals do not only control their own work but gain collective control over administrative decisions that affect them and to protect their interests. This raises a democratic structure within the bureaucracy, but with a work requirement like coordination by mutual adjustment, equipment and standing committees, and in some organizations the inverted pyramids abound.

The grouping base of different units is the function aided by the scale process and interdependencies (Mintzberg, H., 1991). Specialists (psychiatry, psychology, social work, etc.), under the supervision of another of the same class, promote specialization within their unit. This situation is conflicting and requires a multidisciplinary approach with real methodological interdependence approaches.

These clusters limit the perspectives, favoring the emphasis on the meaning, in the sectorial scientific paradigm of each unit and not on purpose. Liaison positions should use the power of persuasion and negotiation to coordinate directly the units involved and treat residual interdependencies.

In general, organizations for the treatment of mental disorders describe a permanent design matrix structure, where units and the people working in them are relatively stable.

Models of deinstitutionalization

A. Experience in the U.S.

In 1953 started a movement of des-manicomilization taking in count the high rates of people with chronic conditions in psychiatric institutions -339 chronic patients per 100,000 inhabitants (Thorncroft, G., 2004). That situation produced an active participation in the reform of the health system, such as the formulation of the Mental Health Act called Kennedy (Braun, P., Kochansky, G., 1981).

The purpose of the plan was to prevent inappropriate admissions in psychiatric institutions, seeking community alternatives to return and insert patients in the community, and organize and maintain support systems for non-institutionalized persons who are receiving services in the community.

The de-hospitalization caused high impact savings for the state, a significant reduction in psychiatric beds and a decreased dependence on conventional psychiatric services.

The institutionalized population decreased at a rate of 6% per year and in the decade of the eighties, the recorded values boarding a rate of 0.5 per 1000 habitants (Thornicroft, G., Bebbington, P., 1989).

Inadequate management of alternative care systems produced consequences that caused damage, as helplessness of adults with severe mental problems, high turnover of patients due to lack of medical care and lack of structures for treatment services and support for the patient and his family, which accompanied unsustainable social insertion (Kraut, J.A., 2006) (Geller, M., 1982).

The current legislation, inspired by a paternalistic paradigm, legalized the exclusion of people with mental illness and forced patients to choose between options like: total freedom derived from the rejection of involuntary internation / absolute confinement in asylums restrictive and oppressive system (González Duro, E., 2009).

Thornicroft, Bebbington, Bachrach, Talbott, (op cit) reported significant changes in the lifestyle of users successfully externalized. Others noted resistance to the inclusion of patients with severe pathologies in Mental Health Centres, provision of precarious housing, and lack of alternative devices (Lamb, R., 2000).

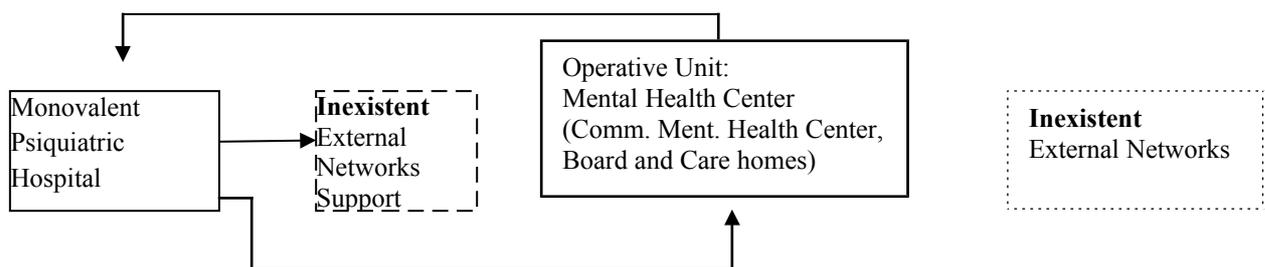


Chart N° 1. Organizational structure and routes from the patient
Source: Own Elaboration

Coordination: vertical decentralization at executive level. Admission laws authorized the medical director the inside or outside involuntary hospitalization of patients. Until the seventies ruled the hands off doctrine: the judges felt that internal problems were institutional competence of management.

Human Resources: Professionals: psychiatrists, medical clinic and specialties, nurses, psychologists, occupational therapists and nonprofessional assistants.

Funding: Federal state-hospital structure (MEDICAID) and supplemental security allocation.

B. Experience in Italy

The post industrialization produced in Italy the expulsion of people not considered suitable for their disease to productive social growth. The most relevant Italian experience of de-institutionalization was materialized with Basaglia Franco in 1961.

Defined as a theoretical model, organizational culture with a good anti-institutional position that stood in anty psychiatry and psychiatry as a subsystem of politics and economics. With a history inscribed in Marxist and communist philosophy, considered the mental illness as a result of economic marginalization.

In 1971 Trieste replaced closure with therapeutic locations in open places (departments and collective location). He proved his hypothesis of asylum uselessness and cruelty classic pharmacological activities and defined a theoretical model and organizational culture from a new general framework: working with patients as individuals and with the institution (Basaglia, F., 1989).

Privileged personal and social relations among users, grouped by nationality, with the ability to recover some of their history and identity. By sharing nationalities, patients decreased prejudice, kept language, customs and discussion from one cultural perspective.

To achieve outreach and visibility of the problem, favored a two-way movement, partnership approach of hospital to the community and the outside activitites of patients on the community.

To contribute with subsidies led patients to go to live in a community. This modified the role of institutional actors, with a fundamental shift in the role of the nurse in the escrow position to assistance and support. Modified labor relations transforming the concept of occupational therapy, considered a therapeutic activity, in social cooperatives where patients can play an active social role with other members of the community.

In 1978 Italy penalizes law reform and psychiatric hospitals suppression and restoration of patients with mental disorders in general hospitals or therapeutic communities.

It is the general framework for the gradual closure of psychiatric hospitals, the prohibition of new admissions and building new hospitals, opening of Community Mental Health Centers (CMH), focus of the new model of care, psychiatry sessions in general hospitals and connections with other sectors of medicine within the National Health System.

Following the Mental Health Plan (MHP) 1998-2000 from the Ministry of Health filled the gap since the reform policy, provided routines regarding services and defined the closure in all the country of Italy (Pasquale, E., 2011).

This defines accurate directions to organize the Department of Mental Health, unique public network of structural or functional utility with specific resources and addresses only divided into operational units such as the Community Mental Health Centers as core programs, day center for post-crisis, sheltered homes for the disabled, cooperatives work for vocational rehabilitation.

It also explicit standards of service every 10,000 inhabitants (1 bed for acute, 1 day bed for subacute, 1 bed in sheltered homes) and professionals (1 per 1500 habitants), therapeutic continuity with individual plans, integration with Regional and Municipal Services duties at the level of subsistence and housing for vulnerable users, professional training and evaluation system services.

The purpose of the model was to decentralize the decisions of the Ministry of Health, that were considered political, relocating physicians transferring from offices to hospitals and community centers, develop psychiatric areas close to patients to ensure the continuity of treatment.

The critical point of the model was the underestimation in the design of programs intended by the government policy, the budgets for grant failure, ex-post evaluation, professional training and competitive disadvantage with other groups to the allocation of housing, employment and social security.

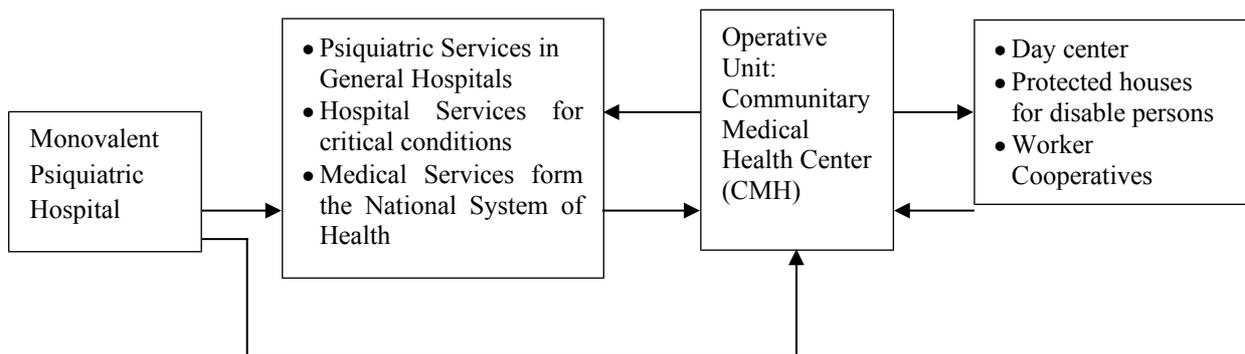


Chart N° 2. Organizational structure and routes from the patient
Source: Own Elaboration

Coordination: One network of public services, Department of Mental Health, with a unique management divided into operational units with horizontal decentralization, are integrators of different areas and competitors with regional and municipal units.

Human Resources: Professionals: psychiatrists and other medical specialties, nurses, psychologists, social workers, occupational therapists and assistants nonprofessional.

Funding: State Funding.

C. Experience in France

In 1945 a psychiatric policy is introduced and was called psychiatry sector. Mental Health assistance is organized in specific and geographically sectors, with multidivisional structure and link matrix by market served and a multidisciplinary team under the direction of a psychiatrist.

Each sector has internment units and crisis centers for emergency care with hospitalization in intensive care for brief periods. There are also hospitals at night, night care and during weekend and therapeutic departments for limited stay with intensive tasks of rehabilitation and social reintegration (Auvergnon et al., 2006, Gabay, P., Fernandez, BM, 2011).

The political and social power evolution to a capitalist concept makes the psychiatry sector fail because they are not supported by the administration or by the technical core, which tend to private activity and for this the 80% of the fields of psychiatry remained depending on psychiatric hospitals (Foucault, M., 2005).

In 1992 a survey of psychiatric care in France, described three types of structures: neo-asylums, inpatient services with full employment and prevalence of long-term support; semi-open that constituted a modern alternative for those requiring prolonged monitoring and open structures implemented in the general hospital (Massé, G., 1992, Gabay P., Fernandez B., M., 2011).

The National Health System that covers most of the population still has a curative assistance, with the hospital predominantly as a central institution and its funding is detrimental to the creation of outpatient services.

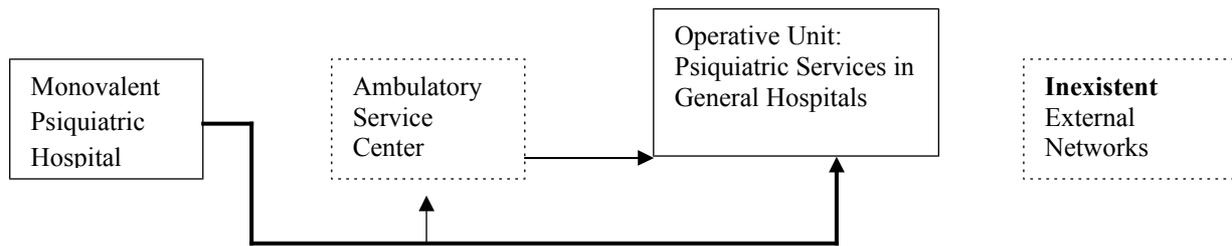


Chart N° 3. Organizational Structure and distances from the patient
 Source: Own Elaboration

Coordination: limited vertical decentralization at National Health System level with the hospital as the central institution. Horizontal decentralization in care services and facilities. Internal agents of the new ORG failed to control the environment, in front of an active external coalition.

Human Resources: Professionals: psychiatrists and other medical specialties, nurses, psychologists, social workers, and other non-professional auxiliaries.

Funding: State Resources.

D. Experience in Spain

The organizational model, influenced by the Italian experience was based on the recognition of regional autonomy. From the regional framework and therefore decentralization of powers, it has allowed the different regions to have issued regulations, including healthcare, with different transit planning and different experiences.

Psychiatric reform started in 1985 with an epistemological change in the way we understand and address mental health problems. Units were organized in Peripherals care centers, outside the hospital with a core professional team (psychiatrists, psychologists and social workers) every 50,000 beneficiaries in primary care. It establishes the need for Psychosocial Rehabilitation Centres, Day Centres, Community Support Units, Residential Units (Lafuente, LS et al, 2007).

Spain is one of the few countries that in their Constitution includes an explicit right for mental patients to received protection, assistance and legal protection from the public administration. However, the Constitutional Court makes itself the social roots of the association and cure madness and danger / safety sanity and order the compulsory

admission to psychiatric patients to behavior deemed inappropriate, blaming community psychiatry.

Despite the changes made, the Spanish model, indicates weaknesses as an overly biological approach, lack of coordination mechanisms between levels, lack of criteria in the formulation of objectives and goals, weaknesses in network integration with general health, absence of unified registers that allow design responses to meet the demands, implementing precarious residences, inadequate psycho geriatric population programs, teen and children (AEN. Mental Health Professionals, 2001).

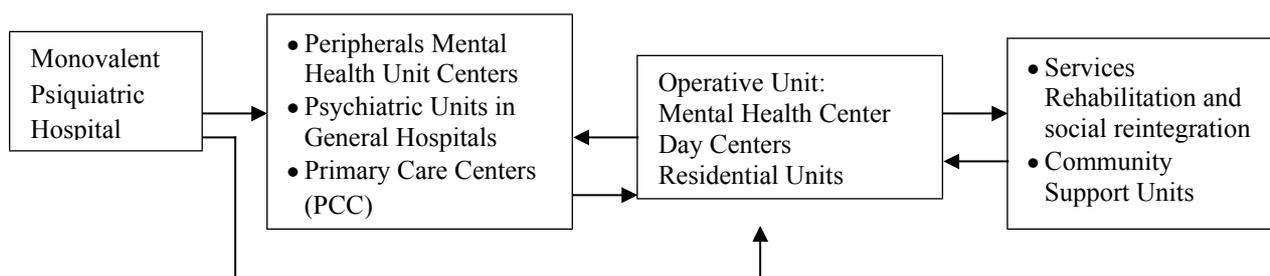


Chart N° 4. Organizational Structure and distances from the patient
 Source: Own Elaboration

Coordination: Vertical Decentralization: National Health System. National Mental Health Plan. Horizontal Decentralization: decentralization of powers in the different regions.

Human Resources: Professionals: psychiatrists and other medical specialties, nurses, psychologists, social workers and ancillary non-professionals.

Funding: economic funding from INSALUD to the Health Services of the Autonomous Communities.

D. Experience in Argentina

In Argentina a multiplicity of approaches and treatments implemented in an irregularly and discontinuously way, were isolated experiences of desinstitutionalization. In 1964 there took place in Mendoza an experience that included a change in dealing with patients and asylums hegemonic conception of the departments of psychiatry.

The reform contained in the Kennedy plan was revived in the sixties in the province of Buenos Aires by Mauricio Goldenberg. The experience, which was discontinued in the seventies, marked great innovations, allowed access to other therapeutic frames as psychoanalysis, installed the multipurpose psychiatric hospital. The psychological model is

formalized in the hospital and in the care assistance in the hospital by sharing power and initiating official rivalry with psychiatry. (Kraut, AJ, 2006, p. 84)

Projects implemented include brief hospitalizations, networks attention for increasingly complex, ambulatory and decentralized assistance, horizontal communication devices and calls for social organizations and relatives of patients. The philosophy was related to favor the recovery of mental impaired through contact with the work, production and nature.

In 1985 in Río Negro Cohen H. starts a process of transformation that includes closing the psychiatric hospital in 1988 and approve the 2440 law of Health and Social Promotion of people suffering mental distress in 1991 (Kraut, AJ, 2006).

The rural and more complex operations hospital were the basis from which mental health teams tried to reconstruct the social network that included peripheral centers and their staff as the first link in the chain of consultations and monitoring of the person or who were hospitalized in their own homes.

Philosophical thought that accompanied the recovery process was social ties, which does not address the subject from intra-psychic conflicts, but from the situation of overpassing multiple crises throughout his life and from the conception of the mental health illness process.

In 1999 there runs the Program for Rehabilitation and Assisted (PREA) in the province of Buenos Aires, to promote community reintegration in patients without clinical justifiable reasons and lack of financial resources or family to accompany the integration.

The assisted outside institutions involves the passage of these patients to a social life with exercise of civil rights, with the assistance of a professional technical team. Users live in groups of three to five, in houses rented by the hospital or in family houses that wish to rent rooms for one or two people.

In 1993, in San Luis, Pellegrini JL implemented institutional transformation models; It starts a Provincial Mental Health Plan in order to comprehensively reshape psychiatric care in the public system in the province (Pellegrini, JL et al, 1996).

Pellegrini believes that the hospital should be part of an overall strategy for the compensation of the patient, in the outcome of the crisis and continuity of care with other devices such as hospitals during the day, night, outpatient care, home care, among others.

The model set strategically in the hospital of the Institute of Economic, Social and Psychosocial Studies (IESP) with care activities and knowledge production. The IESP made agreements with the Ministry of Culture Labor trying to answer from the academic conflicts

with measures such as to transform the institution into an acute care hospital, contain the crisis with the contact, reduce medication, install a network system home care.

The sanction and promulgation of the National Mental Health Law marks a doctrine change regarding care of people with mental health alterations. The Ministry of Public Health is the enforcement authority and should provide the basis for a National Mental Health Plan (Law 26657, 2010, Art.31).

The scope will be the public and private health services, regardless of the legal form they have. Attention must be conducted by an interdisciplinary team of professionals, technicians and other workers with the appropriate clearance from the competent authority, which should promote coordination with areas of education, social development, labor leading to socio-economic inclusion of patients.

The admission will be considered as an exceptional resource when it provides greater benefits than other interventions outside the hospital monovalent institution. It forbids the creation of new centers of neuropsychiatric hospitalization monovalent or public or private institutions and admissions must be in general hospitals which should have the necessary resources.

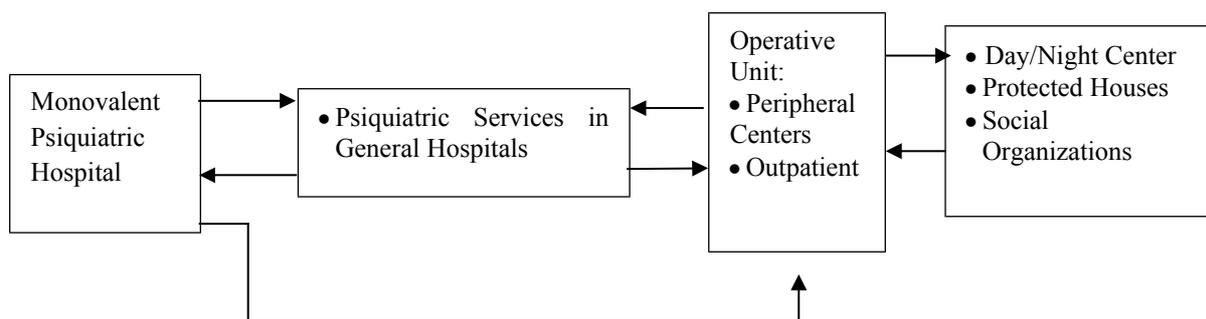


Chart N° 5. Organizational Structure and distances from the patient
Source: Own Elaboration

Coordination: limited vertical decentralization with the hospital as the central institution. Horizontal decentralization in care and service centers with multidivisional structure organizations.

Human Resources: Professionals. Psychiatrists and other medical specialties, nurses, psychologists, social workers, occupational therapists. Nonprofessional assistants: auxiliar nurses, maids, kitchen staff, cleaning and maintenance.

Funding: State Funding.

CONCLUSION

The description allowed to determine that existing projects pose a dichotomy between two systems of mental health care: hospital work and work in the community, the absence of a complementary joint work, that enhances the actions between hospitals and those that are conducted in society.

Mental disturbances were no longer standard contingencies, and loss of status as subjects of involuntarily hospitalized patients, is a critical situation that have to be reviewed. Failures in planning as a central process in the formulation of strategies and action pattern, or the design of the structure, prior to the practice of these strategies, constitute a common denominator of the models described.

Given the complexity of the case under study, by multiple determinants, the integration of health science with professionals in administration and external governmental representatives, generate value in the process to identify the need, to develop solutions and alternative selection.

Generally the plans developed and the establishment of the mission, key in the developing of strategies, were under control of individual professionals or groups of some of them, with considerable indirect power, imperfect typecasting and jurisdictional disputes. The coordination mechanisms are weak and cause cracks between sectors, a situation that leads to conflict.

Strong troubled relationship between psychiatry and psychology, causes Inter-professional rivalry in the struggle for power and in the changes produced by individual preferences, to the extent of ignoring the needs not only of the applicants but those of the organization.

A point of rivalry between the physician and the judicial system in terms of the standard, in the patterns observed, expands the powers of physicians and the called inter disciplinary team and diluted the immediate judicial oversight.

The cooperation between the health system and the judiciary is crucial to the functioning of the administrative structures of these organizations, to support global strategies and resolve conflicts. The rule do not make competing in incompetence and observed results show a cycle of dysfunction. These structures with bottom-up hierarchies

are being developed into machine like organizations top-down technocratic controls and increasing centralization.

A common denominator in Deinstitutionalization models in Argentina was the timeliness of the different experiences subject to political vicissitudes and insufficient budget allocations that limit their development, not instituted legally and are not sustainable in the long term.

The different reform models are operated for psychiatric hospital organizations integrated into a higher order, mostly public system. From the perspective of the Mintzberg hypothesis congruence, can be recognized in the ORG that operate programs for psychiatric de-institutionalization multidivisional structure configuration, semi-autonomous entities, hospitals and other healthcare facilities, coupled through a central administrative structure as Ministries, which depend from the Executive, some shared with the Judicial.

Grouping by geographic market as a design parameter is the configuration legally adopted. The technical solution using the matrix structure as a liaison between the staff of two different reporting lines, was observed in some cases applied to technical aspects and was absent in the organization, with dual flow disadvantages of authority.

The central structure assumes not only top management but most of the functions of the techno-structure, a situation which affects the poor development of this part of the organization in hospitals and care centers.

The planning-monitoring systems try to achieve coordination by normalizing the result, with mixed results. The middle line of authority, division directors, hospitals, community centers, despite the limited horizontal decentralization are vertical and parallel decentralization limiting their autonomy.

There is a contradiction in the models to compatibilize the performance control with the autonomy of the different divisions, inducing situation to continue with these divisions as closed systems, instrumental of headquarters.

The heads of the activities depend on more than one coordinator and work in more than one subproject at the same time with simultaneous functions.

The head of department or units where projects operate, assume authority regards the product line or the people who work in their unit, regardless of the function or the hierarchical structure to which they belong.

Although this way of work is relatively decentralized, these models recorded complex problems of autonomy and coordination with internal subareas (different specialties) or external to the organization (education, work, housing).

The decentralized model of professional organizations where there are predominantly horizontal relationships, where the group that makes decisions on the tasks is required to each one of them, located in each of the experiences strong rivalries within the system or with other systems involved, as the judiciary.

The divisional form adopted by the different models is not a complete and functional structure. Different functions depend on hierarchical lines set in parallel. The performance of a function by two parallel departments, as shown in the background described, involves the introduction of a foreign element in the culture of the organizations that involved in the occurrence of failures.

In this type of structure the formulation of the strategy is a bottom-up process, because the key part of the configuration is the core of operations. It is controlled first by the technical core and then by the administrative apparatus. However, this sequence of decisions contradicts the making process of multidivisional structures, that in the experiences observed with little real autonomy, are directed from the strategic apex of the headquarters.

The congruence hypothesis, configuration and extended configuration of the ORG theory, explain the functional supervision by the nature of the work of physicians, multidisciplinary staff and the relationships between the work processes of each other.

In contrast efficiency is a constraint that a major objective to accompany growth. We observed in the different models a degree of separation between the management and the technical core of operations regarding the objectives, when they were explicit, the first by a shortage of resources concerns focus on efficiency and second in the efficiency. Survival is the principal target of these closed systems because the interest of all insiders, not by keeping the ORG but to perpetuate the power configuration.

Patients with mental disorders and their families even if absent should have much influence, but for these social groups the public health system in practice becomes a natural monopoly, so that the dependency relationship makes a captive clientele.

The power of the international coalition in the health system in most of the models studied, is in senior management that with a political designation, assume authority in the absence of a strong external control. The second-level managers, administrators, have a

power delegated by the director and techno structural analysts, unit commanders, influenced though the information they hold.

By being bureaucratic the planning system-control, the activities of middle management is institutionalized. Each of the hospitals or outside institutions operating programs for social reintegration add at their bureaucratic ORG as an instrument of Direction and made operational the targets imposed by them. No results are measured in terms of actual product of professional work (impact on the health status of patients) but in terms of nominal product (services provided).

The demographic and social change requires a redefinition of the models for outside institutions and the availability of relevant alternatives to the new dominant cultural and socioeconomic context in postmodern times. Moving expulsion culture is difficult and time, there remains the tendency to reproduce the situation of separation and isolation.

The lack of planning determined models that extrapolate the past repetitive strategies or copied to other contexts under the assumption to foreseeable sectoral performances from several different scientific paradigms and welfare criteria.

While there is no universal model of institutionalization, psychiatric rehabilitation and social reintegration of patients with mental disorders have scientific basis which planners should not ignore.

BIBLIOGRAPHY

Please refer to articles Spanish bibliography.