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Clinical management and management of processes in the mental health setting

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The emergence of new management models into the health care setting is not the consequence of economic or financial needs but of a profound transformation in the supplying of the services (doctors and health care workers), citizens (patients) and the state administration.

In recent years, there have been radical changes in the nature of the patient-doctor relation which entail new ethical demands for the professionals. The changes are a consequence, on the one hand, of the triumph of the ideas of the French Revolution and the secularization and Democratization of the modern societies. On the other hand, they are determined by the economic forces which, simultaneously, have made it possible for extraordinary progress to be made in recent decades and the universalization of care. They have introduced a third character into the doctor-patient relation. This third character, funding, is precisely that which has made it possible for the patient to go to the doctor. It takes on the form of national health services or insurance companies. What this means is that although in the past, the doctor's art and science were sufficient to practice his profession with the few citizens who had access to him, the patients are currently increasingly better informed and more experts and responsible. The professionals are more capable and better trained, the medical technology is more complex and efficient. We are now within a totally new scenario and line of argument.

The ethics of traditional medicine is that of welfare. The traditional relationship of the doctor was based on achieving patient compliance, based on the fact that the doctor did what was best in benefit of the patient, because it was the doctor who had the knowledge to do so and to make the best decisions.

In 1972, the American Society of Hospitals published the *Patients Bill of Rights*, which considered the adult individual as autonomous and free and therefore capable of making their own decisions. That is how the ethics of autonomy was born, and in accordance with this, the patient decided what was best for him/her and the doctor, being a better expert on the disease, should inform the patient about all of its characteristics, therapeutic resources and implications so that the patient can make an information-based decision. The informed consent, thus, is the axis in this doctor-patient relationship.

The fact that health has been recognized as a right, the statement that premature death or discapacity because of the disease is not only a personal problem but one that is a social burden (this being which is measured by the DALYs), converts universal coverage into an unavoidable goal. Consequently, the funding of medicine and health care economy is currently no longer a personal problem but also a social one. Until recently, only those who could pay for it went to the doctor, but nowadays the state is required to manage what is the right of the citizens, in the case of Spain supported by the existing Constitution. Limited resources, individual demands and social responsibilities can only be compatible with adequate management of resources, this being so important that it is possible to speak about ethics of management, which we prefer to call ethics of fairness, based on a distributive justice that is provided in accordance with the needs of each individual.

THE CHALLENGE OF MENTAL DISEASES

Among other things, mental diseases are characterized by their complex origin, relatively low mortality and high chronicity, their high prevalence and for being very incapacitating and stigmatizing. All of this makes it necessary for them to have a wide range of medical and psychological as well as rehabilitation resources.

Biological, psychological, and social factors intervene in the complicity of its origin. Some are genetic ones, which condition vulnerability, and others are the consequence of stressant environmental factors that intervene in the precipitation and maintenance of the chronicity and that can act as epigenetic agents. Furthermore, as in many other diseases, once they are initiated, defensive or compensation mechanisms appear. These mechanisms sometimes become

self-destructive and therefore become objectives of therapeutic intervention. There is no doubt that both pain and inflammation have great adaptive value. However, it is also true that in the clinical practice, they must be combated when their function is no longer useful and meaningful. In fact, analgesics and anti-inflammatory drugs are among the most prescribed drug groups. The same occurs with the general adaptation syndrome and the adaptation of the diseases described by Selye[1] and the great use of corticosteroids and analogue drugs.

Something similar occurs on the psychological level. Anxiety, essential for individual survival, can become a serious symptom that must be treated with anxiolytics and controlled with psychotherapy techniques. Anxiety and stress are two sides of the same coin. Bakan[2] already described the parallelism between the ideas of Selye and of Freud[3] years ago and as Freud, he had to complete his theories on the role of libido in the origin of neurosis with those of the role of death drive that became clear when studying the obsessive phenomena and recurrent dreams after a traumatic event. This phenomenon is so destructive when it is dissociated from libidinal drives that Stekel[4] called it *Thanatos*.

We also found the same on the social plane. The psychiatric establishments which, at least since the work of father Jofré,[5] arose to protect the patients from the abuses and harm infringed by persons, ended up becoming total institutions,[6] that is, they controlled all aspects of the life of the inpatients in which the patient lost their individuality and thus the possibility of recovery. In fact, something that is not generally lacking in the asylums is a cemetery in which the person in the asylum could rest in his/her final days.

What has the response of psychiatry been to these challenges? Or more specifically, that of psychiatry, medicine and society in general, as the responsibilities are shared. The response was the traditional one , as we have already seen, nosocomial, which was abolished, at least officially, in the 1970's with the processes of deinstitutionalization[7] and psychiatry reform.[8] However, the advance supposed by such a radical change was soon blemished by the emergence of conflicting positions, arising from and nurtured from the old anthropological roots and with combative spirit, meriting better causes, which gave rise to different "psychiatries:" biological, psychodynamics, behavioral, systemic or social. The underlying fight for power is revealed if we take notice that some of these "psychiatries" are linked to care devices or forms: of "general hospital," "community," "referrals," etc. None of the pseudo-disciplines have been able to respond to the needs of the patients and even less so to those of research. This should be recognized. Allow us to give some examples.

The medical model, or better said, the already expired medical model, links mental diseases to an organ, this being of course, the brain. However the failure of neuropathology over many decades was shocking. Thus, it could be said that "endogenous psychoses are the Delphic Oracle of psychiatry"[9] or that "schizophrenia is the cemetery of neuropathology."[10]

There is no doubt that which Freudian psychoanalysis has provided to the knowledge of the human being and its illness is of core importance. However, its contributions as therapy in comparison are scarce. Thus, the great critic of psychoanalysis, Thomas Szasz, has been able to state that neurosis is a religion and psychoanalysis is a cult[11] and that psychoanalytic treatment, because of its lack of specificity, is outside of the channels of medicine. It is, he states, as if a radiologist would obtain the same kind of plaque for all the patients regardless of the indications.[12]

It must be stressed that from extreme postures of psychoanalysis, from the behavioral or systemic schools of thought and from the most anti-psychiatric trends, mental illness is a myth. This leaves suffering mental disorders out of reach of all coverage regarding their health care needs. As always, every revolution leaves a trail of the sacrificed, in this case those who suffer mental diseases. It also must be said that the result of this will be that many professionals will be unemployed.

We previously mentioned that the traditional medical model is outdated and that the notion of morbid entities has been replaced by others that revolve around the model of vulnerability and stress.[13, 14] No one has been more critical of the Kraepelinian models then Kraepelin himself. His own words are:[15]

> "The method applied up to now to define the forms of diseases, considering the cause, manifestations, course and outcome, as well as postmortem findings have been exhausted and are no longer satisfactory, so that new pathways should be investigated."

In almost one century, the situation has not changed. The testimony of Hyman,[16] who mimicked the text of Kraepelin word by word, is sufficient:

> "Contrary to the optimistic expectations, the strategies for diagnostic validity based on clinical descriptions, laboratory studies, and natural history of the disease and familial aggregation have not contributed to forge a nosology based on valid nosological entities."

The Kraepelin model had another problem. For him, mental diseases are characterized by their final stage, not by their course, as is generally stated, which in the case of schizophrenia, was total destruction of the psychic life (*Zerstörung*), a notion derived from the concept of endogeneity of Möbius[17] and that of degeneration of Morel.[18] This last concept is contrary to Darwin's theory of

evolution[19] (published five years later!). This stresses the enormous severity of some diseases that destroy the most specifically human, acquired over millions of years of evolution.

Kraepelin himself indicated new roadways in the mentioned work. These included a proposal of functional classification, not very different from the current approach of Wakefield[20] and the need to distinguish between predisposing factors and deteriorating ones, something which needed to be recovered. It must be stressed that this functional approach revolves around the concept of harmful dysfunction, which clearly invades two essential aspects in nature of mental diseases: the world of values and the social aspects.[21]

CURRENT MANAGEMENT OF PSYCHIATRIC SERVICES

Behind all this, there is a human being in need who is the axis of the medical action. This entails the need to manage complex situations and the so-called managed care,[22] that deals with the coordination of resources, of the consensus on interventions and outcomes, teaching communication and continuity of cares. Managed care requires the incorporation of a different dimension that broadens the setting of action of the administrators and professionals.[23]

This is how *Patient Focused Care*[24] arose in which care is the final objective. It tries to provide the patient more adequate and satisfactory services, to assure continuity of cares over the course of the disease, to assure excellent quality, which responds to their needs and expectations. It also attempts to facilitate the daily work, reducing the variability and introducing clinical management strategies, all at an optimal cost to assure sustainability and increase the value of the service provided.

The financial aspect is important, as we read and hear daily. However, that referring to the values of the current society among those who have the right to health and to receive health care is no less important. The 2010 World Health Report focuses precisely on this. It is entitled: "Health systems financing: the path to universal coverage."[25] One of its sections is on "Promoting efficiency and eliminating waste." In this, strategies are mentioned to ensure that the resources are used effectively, to get the most out of technologies and health services, to improve hospital efficiency, to get care the first time, by reducing medical errors, to eliminate waste and corruption and to critically assess what services are necessary. This report has made a worrisome but hopeful mention, since it is a challenge and an opportunity: about 20-40% of the resources spend on health are wasted.

Table 1 **Health Care costs (% of the GNP) and Life Expectancy (years, countries selected) in 2009 (Data from the OECD)27[27]**

Country	Health Care Cost[1]	Life Expectancy[2]
USA	17.4	78.2
Sweden	10.5	81.5
France	11.8	81.0
Germany	11.6	80.3
The United Kingdom	9.8	80.4
Spain	9.5	81.8
Japan	8.5	83.0
Luxembourg	6.8	80.7

[1]http://www.oecd.org/dataoecd/26/24/48406859.pdf
[2]http://www.oecd-ilibrary.org/social-issues-migration-health/life-expectancy-at-birth-total-population_20758480-table8

In 2010, the cost of brain disorders (mental disorders plus neurological disease) in Europe was 798 billion € the direct costs accounting for 60% (37% direct health costs and 23% non-medical costs) and 40% are indirect costs due to loss of productivity of the patients.[26] The problem is that lack of resources for health care is inevitable, since health per se requires investments in other areas such as education, protection of the environment and of the family. On the other hand, there is no correlation between health cost (measured as % of the Gross Domestic Product or GDP) and general health[27, 28] (considering life expectancy as index) (Table 1).

We have already stated that the financial aspects are important, but that they are not the only ones. Medical management has to include management of resources (economic and human), management of knowledge and of values.[29, 30] The former is measured in activity and costs, the second according to the scientific evidence. The third revolves about the needs felt, the expectations, and has a high affective component since it moves the foundations of the existence itself of the patient (Figure 1). In each one of them, the weight of the medical decisions is different (Table 2).

Health care management basically consists in having and organizing the elements and resources of a health care system to achieve the best possible results in the health state and quality of life of the patients and users.

Medical care given in any health care system is strongly determined by the decisions made by the doctors. This has a repercussion on the quality of service provided to the

Table 2 The weight of the clinical decisions

Type of Ethics	Responsible person
Traditional (of charity)	The physician
Of Autonomy	The patient
Of equity (of management)	Health Care Administration
	The physician
	The patient

patient. However, as the doctors obtain an increasing greater influence in the allotment of health care resources, their influence grows in the administration decisions. Consequently, they demand greater autonomy and responsibility in health care policies. This results in a new management frame that permits them to development their projects and aspirations from the perspective of professional ethics and commitment with the values of public service.

However, not all physicians are the same and in keeping with that stated above, it is possible that the greatest disparity is found between psychiatrists and even more between mental health care professionals. It should be remembered that the rule in many community resources has been, and perhaps continues to be, allotment of professionals according to their arrival: first for the psychiatrist, second for the psychologist, third for occupational therapist, and successively. This is what has been called *unwarranted variation* of John Wennberg[31] in the providing of health care services. This type of analysis deals with the differences that cannot be explained by a disease, medical need or scientific evidence. The causes of the variability are complex, but in general are due to not correctly applying that which research dictates, to decisions of a patient who is not sufficiently informed or of a care structure not based on real needs and on evidences on whether they are adequate or not.

Therefore, the fight against unjustified variation has been made on three fronts: 1) scientific, that is, in accordance with evidence-based medicine or on facts; 2) the personal that concerns, above all, the patient and the patient setting in accordance with value-based medicine and 3) that of management, in accordance with the principles of *Patient Focused Care* and with the development of consensus-based care strategies between the different agents: state administration, professionals, user associations and civil societies in general.

The needs for multidisciplinary and teamwork, participation of a large amount of resources involved, and coordination between services and the fact that neither patients nor diseases understand specialties make the management of the process an essential requirement for good health care organization.

Traditional clinical services have some characteristics that do not allow them to handle the needs of the current clinical management. They have a pyramidal structure. Their organization chart is rigid. Initiative and control, when they exist, go from above to below and their culture is that of submitting to a unilateral model. The consequence of all of this is that many times the goal is not the patient but rather that of serving the model, to protect and expand it.

Emphasis on the patient and not on the system and also not on the disease itself has led us to design a management of processes based on statistics, since the needs, goals, interventions, and professionals and resources involved are different in different evolutionary moments.

Methodology of management of processes is based on the systemic analysis of the sequence of the activities which include a care process and its graphic representation. To do this, it is necessary to define all of the activities and to analyze their quality characteristics. It means defining what is going to be done to satisfy the expectations and needs of the patients. It is very important to include indicators to measure and analyze systemically the results obtained and their tendency over time and to be able to establish new priorities.[32] In the Institute of Psychiatry and Mental Health, we have used the European Foundation Quality Management (EFQM) model as the scaffolding to structure the processes, with the added intention of extending the culture of quality and its measurement to all of the members.

From the point of view of management, a process is an action setting in which some persons, based on their knowledge and resources, carry out a series of interrelated activities, transforming an entry into an exit that provides an added value or utility for its recipient. One process may be made up of several subprocesses and different persons carry them out in accordance with a series of activities defined by a set of rules and instructions, called procedures.

A process can be a disease (bipolar disorder), a combination of them defined by administrative criteria (GRD- Psychosis) or by high comorbidity or analogue problems (stress -anxiety -depression) or caravans (emergencies). Management of processes are often carried out spontaneously and thoughtlessness in many areas of the daily life and above all in teaching and management of research projects. It is difficult for medicine to incorporate them because it is feared that this would mean a change of power forces in the area of the professionals who are dealt with as doctors without having obtained a PhD or *maîtres* in France, a degree which in Spain is reserved for the bullfighters and some celebrities in other arts.

A process consists in an entry, a typology of patients with their expectations and needs, and an exit, satisfaction, at least partially, of them with the unit's resources. These resources, once more, have a different nature (human, materials, internal structure, knowledge, tradition, etc.) and differ from one care unit to another.

It is important to indicate that the responsibilities within a process may be outside of the site of the persons involved in the organization chart of a service because the fact of having reached it does not suppose they are capable of carrying out the different procedures included in it. Management of processes means creativity beginning from the top going down, which is fluid and constantly evolving. Thus, management of processes cannot be established by an order or administrative recommendation nor can it be imported from other care centers.

Management of processes go beyond this since, due to their orientation to needs and expectations of the patients, this management is an instrument for the improvement of the care units, for the definition of priority, which necessarily will be a consequence of these needs and expectations of the population to be attended to. Definitively, they are, from our point of view, the best tool for the progressive redefinition of the view, mission and values of the organization.

Implementation of a management of processes includes a series of requirements:

1. Its development must be autochtone and not imposed or imported.
2. It requires an organizational structure of the "modern" care unit, which is not greatly hierarchized, in whose culture there is predominance of transparency, democratic management, team work, differentiation and professional qualification, and social commitment.
3. It must be progressively implemented due to the needs of its development and its implications in the structure of the care unit. It also means a profound change in the working habits, which must be assumed as necessary and enriching.
4. The processes to be introduced should be chosen by consensus for strategic reasons. Sometimes it is recommendable to choose a simple one to have the opportunity to learn. Other times, it is necessary to face a demand which, due to its dimensions, complexity, diversity of professionals, units and services involved or social relevance, is required. The proposal by the spontaneous leaders is a determining criterion as well as evaluating beforehand possible resistances to change to be able to solve them. Thus, a process map with their corresponding subprocesses is developed.

Starting from here, the development of each process requires:

1. The naming of a work group with representation of the experts in the activities proposed. This group can vary over time in size and composition.
2. The group will define a methodology of meetings, tasks and periods.
3. The writing of the Process Card. This card should include its global definition, its recipients and objectives, components of the process (activities, characteristics of their quality and professionals involved in each one of them), chart of the processes and the possible subprocesses and indicators for monitoring the results.
4. Personnel who should be assigned and percentage of their work day dedicated to the process.
5. Reference documentation: own documentation, external documentation and applicable legislation.
6. Limits of the process: start and end of process.
7. Leader of the process (in some settings, it is called owner): the leader assures compliance of the process, taking responsibility for its management and improvement.
8. Development: Sequence of activities that make up the process. It is generally represented by table, indicating the activities, quality characteristics of each one of them and the responsible persons.
9. Graphic representation of the process in form of flow charts that indicate the sequence of the activities and the relation between them.
10. Indicators: measurement tool and instruments that make it possible to evaluate and control the process. They should be measurable, understandable and controllable.
11. Registries: they collect the evidence of the performance.
12. Collection of measures necessary to carry out the continuing improvement of the processes.

The clinical management supposes significant decentralizing of the administration, responsibility and risks. Each professional contributes as an important protagonist towards the success of his/her small or large parcel, whatever profession the person has. In this work scheme, the multidisciplinary professional teams and collaboration programs between care levels acquire maximum interest as they are core to the organization of the care. The care is organized according to the needs of the patient or a profile of patients with similar needs.

The clinical processes are defined as a set of medical care activities and cares that are required by a specific type of patients who have common characteristics in regards to their diagnosis and therapeutic needs. Management of the processes is thus a central tool in the clinical management and quality management.[33]

Emphases on *Patient Focused Care* and our own management model, which is an Institute of Clinical Management, led us to adapt Management by Processes as a

priority objective in our organization (the Institute of Psychiatry of the Hospital Clínico San Carlos of Madrid).

The first Clinical Process we have developed is "Depressive Disorders and Anxiety." This process is characterized by including both specialized resources of the Hospital and of the outpatient psychiatric services as well as those of Primary Care of its area of influence.

The elevated prevalence of depressive and anxiety disorders and the fact that an elevated proportion of them receive treatment in Primary Care served as an argument to make this the first clinical process we designed. In other articles of this supplement, the characteristics of this collaboration program with Primary Care, the details of each clinical subprocesses, the steps for their development and implementation and the system of indicators for their evaluation are shown.

CLINICAL STAGING AND MANAGEMENT BY PROCESSES IN PSYCHIATRY

Clinical staging has a relevant role in several branches of medicine and can currently be considered a pending subject in the setting of diagnostic classifications in psychiatry.[34] Its potential utility is that of contributing to the establishment of the diagnosis of the disease and its prognosis with greater accuracy, orienting the clinician and the therapeutic strategies with greater possibility of success in each stage. The primary objective, such as that defined by PD Mcgorry,[35] is to define the extension or progression of the disease in a time cut off period, differentiating the clinical phenomenon from the initial or intermediate phases of those that are characteristic of its progression and chronicity.

From our viewpoint, this model would contribute additional advantages both in the clinical setting as well as in that of the evaluation of results and of the investigation.

From the clinical point of view, the staging model would permit greater accuracy in the prediction of the evolution (once we can identify clinical and neurobiological markers in each stage). It makes it possible to better identify the current clinical situation of a very specific individual on the *continuum* of the disease and it facilitates the choice of specific therapeutic interventions using scientific evidence according to the clinical stage, minimizing the risks. From the point of view of the evaluation of results, it facilitates the evaluation of effectiveness of the interventions oriented towards prevention (the therapeutic objective would be to achieve regression in the stages, remission, or no progression).

Within the area of research, staging may contribute to specifying and giving order to the clinical situations better, facilitating the study of the neurobiological markers of the state and traits according to the diseases.[36]

Staging of the classical medical diseases is based on the anatomical alteration and the impact of the disease on the body. On the contrary, in psychiatry, the factor of course and response to treatment is introduced as an element for the definition of the stage. Mcgorry and his group[37] were pioneers in defining a heuristic model of clinical staging for psychiatric diseases, considering that most of the disorders are susceptible to inclusion in a model of this type. As proposed by OD Howes et al.,[38] we are currently only able to partially predict results according to certain clinical characteristics, but we have a limited understanding of the physiopathology.

In the area of depressive disorders and anxiety, Hetrick[39] and the same group of Mcgorry have proposed a clinical staging model that we have adopted with some changes and that is described in greater detail in the article entitled: "Clinical Management for Depressive Disorders in Departments of Psychiatry" published in this supplement.

The interest in adopting this tentative model is based on its good adaptation to the clinical use, its simplicity and ease of understanding by the physician and above all because of its potential capacity to improve the diagnoses and clinically typify the patients better.

The subprocesses and therapeutic decision algorithms that serve as support to the clinicians in the subprocesses of the psychiatric departments have been made on the mention staging model, also including the applicability diagnostic classifications. In other words, each line of therapeutic decision is defined based on a clinical stage or sub stage.

In the Primary Care services, the clinical staging model in the Process that we are dealing with has not been included, even though it is exactly in this care setting where early detection and action on the first stages of the disease are especially important. The logical limitation of our resources because we are within the frame of the National Health System has not allowed us at present to go beyond this, although it is an objective in the near future.

CONCLUSIONS

The tools provided by Clinical Management and especially by Management by processes are especially useful for the direction of the psychiatric departments. The principal reasons are because of the characteristics per se of mental diseases (chronicity and variable need of multiple resources and professionals), by the characteristics of the Psychiatric Departments (usually formed by networks of different units) and by the demand of society (medicine based on scientific evidence, focused on the patient, that also responds to social and economic values).

In this supplement, the result of the design of a collaborative clinical process with Primary Care for the care of Depressive Disorders and Anxiety in the Hospital Clínico San Carlos and the Care Administration Center of Madrid is shown.

Our objective is to show that the design of a clinical process in psychiatry is possible, enriching it with the involvement of the Primary Care Services. Although each process should be developed according to the characteristics of each network of services, this supplement aims to explain the basic elements of the method to carry out a clinical process, showing the result of our own experience.

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