From Hospital to Community: Case Management and the Virtualization of Institutions

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Until recently institutions and institutionalization were one of the main means by which the apparent organization of collectives and society was achieved. Devices which divide and collect flows of things and persons that pass through them, creating routes and stable habits and situations. Then, we are used to think of them as an important condition in the consecution of social order. Stabilisation and repetition are in fact a good way of conserving and avoiding events which could destabilise order.

Nevertheless all around us we see that an important change is made from institutions towards *community* or *open programs*. A “showy” example of this comes from the prison system and the continuous attempts to find penalties on substitution at least and for the moment for “soft” crimes, and the use of electronic bracelets (tagging) to provide a transition for these selected prisioners from prison into the community. In fact, technoscientific innovations make possible to think of some “open prisons” or “walking prisons” to manage risk out of the institutions walls.

We can find another good exemple of this new openess in mental health, within what is known as the move from an institutional psychiatry to a communitarian one.

Looking at some of the initiatives and programs borned from within this aim to create a community care system we can see how this traditional device concieved for gathering, stabilizing and controling patients is loosing preeminence. While some people call this process and its subsequent treatment in the community deinstitutionalization, we think it can be better understood in terms of virtualisation.

From Hospital to Community

In the past 30 years there has been a significative contraction of traditional institutional settings and a concurrent movement towards community psychiatric services in the developed world. Old psychiatric hospitals seem now inefficient relics of a past age of failured institutional care: they were supposed to be expensive, iatrogenic, stigmatising...

Deinstitutionalisation was one of the most controversial answers given to the failure of a system centred in the psychiatric hospital. Given that it was not anymore a good place to be, the inmates were externalised. Probably, for being able to think about the externalization one of the key points was the advent of psychotropic medications for treatment of severe mental illnesses (mid-1950). The old

treatment models viewed patients as hopeless cases who needed to be stabilized with hospitalization. The heavy, tranquilizing effects of those new drugs made management of patients out of hospital walls easier (without rapidly "decompensating" or becoming a danger to themselves or others).

Nevertheless, deinstitutionalisation has been presented in most cases more as a problem than as a solution. This process has been largely discussed since the expansion of community-based services was neither achieved or successful in most cases.

It is clearly cheaper for the state to discharge someone from an inpatient facility than to keep the patient there indefinitely. But by and large, most “communities” didn’t provide the kind of integrated, comprehensive, mental health care required to sustain these individuals.

Two of the prior handicaps appreciated in community care when compared with hospital care was that patients had less *supervision* (and sometimes not at all) and that there was a lack of *coordination.*

The aim of coping with these problems implied the development and conceptualisation of innovative strategies and mechanisms for coordinating fragmented systems of community care of chronic mental patients. These programs are focused on the need to maintain contact with patients and to maintain a treatment plan across different services and settings of care through improvement engagement with services and community resources. *Case management* is the current name of one of these new approaches to provide mental health services, born with the aim of remedying the lack of coordination, supervision and other deficiencies of the community mental health services developed in the early years of the deinstitutionalisation. There have been articulated different models of case management but all forms share the aim of *help[ing] patients to survive and optimise their adjustment to the community* (Tirado 1997).

It is a common place to think about this processes in terms of institutionalization-deinstitutionalization. But our aim here is to understand this neither as deinstitutionalization nor as the end or extinction of this institution. Rather we think **we are being witnesses of the virtualisation of it.**

That is, we are going to see how an object, the psychiatric hospital, looses its actuality (it is not a solution anymore) and, by virtue of this, we are discovering the general question to which it relates and we see how a problematic field appears in front of us. We do not face a way of creating a stable solution but a way of managing continuous change.

Following Lévy and Serres we want to characterise virtualisation as a dynamic through these main points: being out of there (deterritorializing), the creation of new speeds and new spaces or what Serres calls space-time heterogeneity, and the passage from interior to exterior and from exterior to interior, or maybe the end of the interior-exterior distinction.

In order to illustrate some of the features of the virtualisation we are going to take a concrete example: a project for mental health based on case management that has been implemented in Catalonia by the Public Health Service, called Pla de Serveis Individualizat (PSI, something like an Individualised Plan of Services). The PSI is a proposal to organise the process of management of what is called a Severe Mental Disorder (SMD) and it is born in this climate of crisis for the conventional attendance system. If we explore one of the documents elaborated to develop the project, we can learn that the main goal of the plan, as within other case management proposals, is *to adapt the health and social services to the concrete needs of each patient as nearly as possible to their natural pattern, in order to strengthen the continuity of attendance.*

When the document explains how the necessity for a PSI arose, it states that it is as a consequence of the move in Catalonia from an institutional psychiatry to a communitarian one, a move that has created an Attendance Network that, for several reasons, is giving a limited answer to the problems of patients and their families. So, the document says that "patients that are less capable or less prone to ask for help are in risk of remaining out of the system". It is clear, then, that a priority target of the Plan is to avoid a person with a SMD remaining out of the system. The institutional way of guaranteeing this is in the process of being dismantled, and what appears instead is a new system, an extitutional one, which takes as a goal this very important characteristic: **not to leave any person out of the system**.

The plan is based on *case management*. That is, every client is a single case and he or she deserves singular management. There are specific practice principles for such case management: there should be a single case manager, the locus for attendance is the community, it requires flexibility in the frequency, length of time and place for the contacts, but firmness in aspects like medication. Programs have to get the maximum of individualisation by aiming to strengthen capacities for sanity rather than treating pathologies, and by focusing on achieving the maximum of autonomy for, and responsibility by, the client.

Then, instead of the traditional arrangement of attendance based on institutional structures and spaces, the PSI poses a processual model where every individual case can be seen as a process that passes through each of the institutions and centers involved in the program. This transformation makes us think that we can talk no more about institutions within this kind of entities, but about extitutions and extitutionalization, which is in fact a kind of virtualization. The term extitution taken from Serres (Serres 1995; Tirado 1997; Domènech, Tirado and col. 1999) is used to account for the resultant of reversing the centripetal strenghts that characterize institutions, that is, to describe the way this strengths become centrifuge: from *in* to *ex*.

Where? “Out of there”

There is no central building to refer to: the PSI crosses over many buildings (day hospital, city council, school, home, psychiatric hospital, factories, social centers) but it is not in any of them. As the document says, *the proposed programs and their corresponding individualised projects can be diagrammed, including the spaces and structures of the service-providers (the name given to hospitals, centers of work, families, centers of rehabilitation, etc.), as ordering horizontal processes which cross them over from left to right.* Then, where does the PSI have place?

One way of looking at it is by thinking on the PSI as having place only *between* these well situated buildings. Effectively, our first consideration is that the PSI is a virtual entity in the sense of being no way identified with one place.

> “A collectivity virtualized is placed out of there. This condition breaks with two logic principles: that it is impossible being and not being at the same time, and that there is no way of being inside and outside at the same time.” (Serres 1994, 140)

Every patient in his or her place is virtually in the PSI. And the PSI is virtually in every place.

How to map a space that contradicts laws of place assignment? That is, can such a space be mapped or represented? You cannot represent the virtual. The PSI is a knot of tendences we cannot map as we could with the psychiatric hospital. This does not mean that it is being dematerialised. Instead, the

institution is being "deterritorialized". Nevertheless, it is not less real. **It is, but it is "out of there"**. That is the main sense of the virtual and that is the way Serres illustrates it: *Être hors là* ("Being outside of there").

> "*Hors* indicates what is exterior, outer, remote, excluded, while *là* designates the nearby, close place: the *hors là* describes then a tension between what is adjacent, adjoining, contiguous and the distant, remote or inaccessible starting from this proximity." (Serres 1994, 64)

Inside-Outside

The main objective of total psychiatric hospitals was to include through exclusion. To set and fix individuals to avoid leaving out persons who should be in. Institutional psychiatry was a spatial solution to this problem. The building, the actuality of a shared-unified space-time was the way of ordering a multiplicity, the way of achieving a well-defined collectivity: a stable concentration. A surface capable of geometrisation which made movement heavy: there was only the inside/outside possibility and the inside meant inhabit in-stitution.

There is no difference between inside/outside the PSI. Institutions, buildings, have an inside and an outside, and a boundary. Extitutions, networks, do not have an inside and an outside, they are only boundary (Domènech, Tirado and col. 1999; Tirado and Domènech 1998, 2001, Tirado 1997). There is no inside or outside the PSI, there are only elements that can or cannot be connected with it. Connected with the PSI you can appear as a client, a case manager, a relative, a boss, a diagnosis, an intelligence coefficient. PSI is not a surface capable of geometrisation, it is rather an amalgam of changing connections and associations. What matters are positions, neighbourhoods, proximities, distances, adherences or accumulation relationships.

Then we are talking of a radically different way of inhabiting: in fact it is not possible to inhabit in the PSI. Instead of this, we can see how its different elements haunt, frequent, hang about and are dispersed in an open space. And this haunting is the PSI itself. PSI is an entity which has to be thought apart from the building, that is, not as something closed but as something open; not as something to inhabit but something to haunt. In a sense, there is "**no need to go to centers**": they come to you. There is no need to leave "interiors": patients do not have to leave their homes, their habitual routes. They do not have to go to centers: centers come to them. At the same time, there remains no space outside of the extitution, outside a virtual entity: there is no way of talking of clear distinctions between interior and exterior if we are faced with entities which are here and there at the same time; inside and outside at the same time.

Open Range of Possibilities

There has to be a person that works as a coordinator of each individualised project. A coordinator (case manager) covers 10 clients/patients. The PSI in its very existence depends by large on the work of these very specialised figures. The coordinator through his/her movement, haunting, hanging around, connects the different elements of the PSI. Remember one of the coordinator's characteristics we mentioned above: flexibility in the frequency, length of time and place for the contacts. They move in a very unpredictable and discontinuous way. Maybe they are going to see a client and, then, in their

car, the phone rings and they have to stop and change direction, there is something more important to do: to visit another client, to see the boss.

If a patient complies with taking antipsychotic medication, he/she becames capable of being "out", and his/her movements or his/her life does not have to be shaped constantly. The coordinator then moves according to the different needs and events. The PSI is then a virtual entity in the sense of being an open range of possibilities.

Ordering without Gathering in a Unique Space-Time. Collectivities

The strategy for ordering human relations in the classical hospital was enclosure. A building containing patients: they are stored. Enclosures are stable stocks since they are sited in a shared unique space-time. Patients that get in are the flux, the instable flow discharged into the hospital.

When we look at entities like the PSI, to extitutions, there is no difference between what is stored and what moves to get in or out. Stocks of patients then tend to lose in volume an gain in flux. In fact, ***stock is flux*.**

> "When stock identifies itself with flux, big concentrations become dispersed into singularities" (Serres 1994, 144).

We only can see a flux of patients going through different spaces, social and medical community resources which include the patient's home or maybe a bar or a park where the case manager and the patient meet each other sometime.

At the same time, while in the classical hospital the confinement, being stored into the hospital, was a condition for examining and having information of patients, the way of individualizing and indicating his/her positions into a diagnostic, in PSI this haunting across different sites is what led to give an account of the patient as this. Movement and information are in fact the same thing in the PSI.

It does not matter where patients, the old "storage sites", are since the case manager connects them, it is not a question of being inside or outside, it is a question of being connected or disconnected. Everyone in his/her place, at home, or maybe in a bar, is virtually "in" the PSI.

Time-Space Heterogeneity

In fact, there is no way of talking about concentration or gathering with PSI in the sense we use to talk in the building. A patient forms part of the PSI through these changing connections across different buildings and services. There is no main-unique space-time to be in. The establishment, the homogeneous space-time of a unique building is far from being the solution: spatio-temporal coordinates of the collective are a permanent problem across PSI. PSI can be seen as the process of coordination and continual redistribution of these coordinates.

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Vitores,A. (2002). From hospital to community: Case management and the virtualization of insitutions. *Athenea Digital*, 1. Disponible en http://blues.uab.es/athenea/num1/Mvitores.pdf