Bridging experience and evidence in mental health care reform

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The US Community Mental Health Act of 1963 led to a deinstitutionalization process which proved to be a mixed failure, particularly when community services were not available in the catchment areas. Ten years later, John Talbott (1) reported that hospital readmission or "revolving door" was a significant problem and that nearly half of it could be prevented with minor improvements of existing services. In spite of this early evidence, "revolving door" effects followed psychiatric reforms in many countries. Thirty years later, Talbott published the "ten commandments" of community mental health care, and summarized the reasons for the problems created by deinstitutionalization in four main factors: lack of consensus about the movement, no real testing of its philosophic bases, the lack of planning for alternative facilities and services, and the inadequacies of the mental health delivery system (2).

The paper by Thornicroft et al uses an expert knowledge approach to frame community care on common sense and to describe ten key challenges to implement it and to improve balance of care. The paper is mainly focused on the challenges of care reform at individual services (microlevel). A number of comments may be added to better understand the current trends of decision making and planning at the upper side of the Thornicroft and Tansella matrix (3): the regional or national care system (macro-level).

Mental health care in the real world performs as a complex environmental system characterized by multidisciplinarity, high dimensionality with ill-structured and nonlinear domains, and high uncertainty with heterogeneity of data and imprecise information (4,5). Complex care systems demonstrate other identifiable characteristics such as embeddedness, self-organization, or unpredictability. Under these conditions, evidence cannot be generated using the designs and statistical methods of evidence-based medicine. New health technology assessment tools include outcomes management, decision support systems and knowledge discovery from data (KDD). KDD is a hybrid of statistics and artificial intelligence which incorporates implicit expert knowledge into the data analysis. In the analysis of complex systems, expert opinion is not a source of bias but a key component of the knowledge management and the development of mathematical models. Thus, experience is incorporated into evidence-base mental health care planning (5).

The classical debate between hospital and community psychiatry is already closed. Today´s mounting evidence delivers a simple and clear message: traditional psychiatric hospitals are part of an outdated system of service provision which should be abandoned or entirely transformed. Although failures exist and they replicate at a stubborn pace, psychiatric hospitals have been successfully closed in several countries or regions, whilst in other areas these services have been changed into integrated health care systems (6). On the other hand, the closure of a psychiatric hospital produces similar social resistance and unrest as any other service in obsolete economic sectors, particularly when the hospital is a major source of employment in what are often isolated communities (7). Surprisingly the staff´s needs and the social dynamics are not handled in a similar way to other economic sectors. Involving other ministries or national agencies may favour deinstitutionalization in middle income countries. As Thornicroft et al put it forward, the reform of psychiatric hospitals should be led by experience and common sense as much as by values. Bulgaria and other Eastern European countries provide a good example of the complexities of hospital reform. Criticism raised against the World Bank policy to fund "improvement" of the Bulgarian psychiatric hospitals confronts the reality of emergency crisis and human rights of people living in these institutions. The balance of care approach may facilitate a better appreciation of these problems.

Classical community psychiatry put major emphasis on closing psychiatric hospitals and on developing specialized community services, mainly residential and intermediate care for severe mental illness. During the last years, a new balance of care model is providing a broader view of the mental health system. Person-centered approaches and longitudinal perspectives are key to this new framework. It takes into consideration the equilibrium between residential and community care, primary and specialized care, or health, social and forensic

care within an integrated (multi-sectoral) approach to the delivery of services (7). A special focus is provided on the transitional arrangements needed during the process of re-balancing care for people with mental health problems, or on the outputs at later stages of this process. For example, re-institutionalization has been identified as a worrying trend of well developed community care systems in Western Europe (8).

To date, mental health systems have been extensively described by system characteristics, macro indicators of system development and the specific focus on deinstitutionalization and community psychiatry. However, little information has been provided on the financing of mental health systems until very recently. Care financing studies are concerned with the flow of expenditure throughout the care system. The Mental Health Economics European Network has described the financing systems of 17 European countries and identified commonalities and differences (9). A thorough information on the financing system of a number of these countries have been published separately (10,11). Assessing and comparing financing systems represents a "follow the money" approach which may provide a more accurate information on the care system than other traditional description methods. The World Health Organization has also provided a framework to produce standard reports on mental health financing (including pooling, context, mapping, resource base, allocation, budgeting, purchasing, and financing analysis). Financing is a main policy tool to lead mental health reforms (12,13).

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