On the evolution of mental health systems
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Introduction
The closure of mental hospitals was closely associated with policies of deinstitutionalization and the implementation of legislative changes that were introduced to advance the rights of mentally ill persons, specifically regarding commitment laws. These were highly touted initiatives that were the backbone of mental health reform policies implemented in many countries by the middle of the last century. Regardless of the benefits of these initiatives and policies, commentators have often considered them as reasons for the increasing demands for forensic psychiatric services, the juridicization of psychiatric practice and the criminalization of those mental patients whose lot has been ‘to serve their illness’ in correctional institutions [1–4]. The real problems, however, may not have been the necessary reforms to an archaic custodial system of care in mental hospitals or the needed legal protection of the human and civic rights of the mentally ill, but the inadequate follow-up and the lack of social structure in the community at the time hospitals beds were closed. Adequate community systems could and should prevent the backward drift of mental patients into a more pernicious form of institutionalization [5,6].

Equally pernicious in some jurisdictions is the growth in demand for forensic services that threatens the stability of and funding for regular mental health services and tends to unbalance ecological funding distributions [7]. The overcrowding in forensic units, the need to ‘download’ forensic patients into regular mental health beds and, as happens in some jurisdictions, the use of ‘hospital orders’ have started to produce a rift among forensic staff and employees in the regular mental health system who feel that funds are inappropriately funnelled out of hospitals and community care to treat ‘criminals’ in forensic units or in prisons. And yet, these are the same patients who would have come to them in the past, but for multiple reasons now cannot access the services provided in the regular system. The rift among staff is an extension of the schism of a system into two sections of what ought to be a single and wholly encompassing system of care for the mentally ill.

Clearly, better information and a closer integration between forensic services and the general mental health system are required [8]. This is more imperative now, given our knowledge that mental illness is a spectrum that covers not just schizophrenia, depression and dementias, but also comorbidities, addictions and lifestyle conditions such as obesity, tobacco-related complaints, suicide and domestic and generalized violence. The resulting financial costs to national economies [9] must also be noted.

In this editorial, a review is presented of the mental health system with the hope of contributing to the debate on mental health reform, in line with papers published in Current Opinion in Psychiatry in September 2003 and in this issue. These papers paint a picture of the varied and complex dynamics of forensic psychiatry as a subspecialty and its interactions with the general mental health system. They have been written by experts in the field and exemplify the problems and what can be done to start solving these problems in the provision of proper mental health services. Thus, hopefully changes will be made to prevent the drift of mental patients into correctional institutions within an integrated matrix of mental health services and evidence-based mental health reform.

On mental health systems
Mental health services that are fully integrated should cover a full gamut of services in and out of psychiatric institutions and in the community. Services organized in this fashion would constitute a matrix of services whereby patients flow seamlessly through agencies, including acute psychiatric units in general hospitals and institutions for medium-term tertiary hospitalization, according to the particular needs of the patient at that moment in time. Within a matrix of interactions and mutual responsibilities [10] and through the development of shared care models and service protocols, general hospital psychiatric units should develop mechanisms for interaction at all levels of the mental health system. Such units would be the anchor of the system which would incorporate close liaisons and interactions...
with all other components of the system, including government agencies and academic departments of psychiatry and epidemiology. The units would develop protocols that delineate the responsibilities and timely interventions with community mental health agencies, families and support groups and with other professionals mandated to provide curative and management services for the mentally ill, whether in hospitals, in prisons, or in the community. This follows the conceptualization of mental health as being basic to the well-being and prosperity of the population. To reach this point, four ingredients will be needed for a fully effective mental health system: (1) legislative mechanisms through appropriate national mental health plans and mental health legislation that protects the rights and entitlements of mental patients and their families; (2) adequate budgetary allocations and a proportionate sharing of national general health budgets; (3) direct involvement of clinicians, consumers and their families, and the population in general for purposes of advocacy. These should be equal pillars for the sustainability and good functioning of the system. Certainly, such a conceptualization and the close interactions within the matrix that span the whole system will not survive without (4) adequate epidemiological surveillance and monitoring mechanisms to evaluate the quality and quantity of the services provided by each of the components, and to gauge the satisfaction that clients and patients derive from the system. Data systems that measure these components are therefore mandatory to any properly functioning mental health system (Fig. 1).

The process of mental health reform
It has taken a long time for mental health systems to have reached this stage through a process of trial and error and the application of policies that, often, have been based more on ideologies than on hard data and the realities of what really works best for persons affected with mental conditions. The history of the mental health system and the process of reform in the province of Ontario (Canada) may be used to exemplify this point. Presently, it could be said that mental health reform in Ontario has entered its third wave, having started the process of change practically from its very beginning in the early 1800s when a custodial and institutionally based model of care was put in place (Fig. 2). Mounting evidence about the deleterious health and social impacts of institutionalization [11], however, led to the deinstitutionalization model that commenced in the 1950s and that instituted the discharge of large numbers of patients from mental hospitals, resulting in the closure of the corresponding beds in many of these hospitals.

It did not take long to bring home the message that deinstitutionalization without adequate community systems was an utter failure and a major assault on the well-being of mental patients. Deinstitutionalization was not a panacea, judging by the plight of mental patients in the community and the levels of homelessness and criminalization, as well as the growth of a parallel system of forensic psychiatry (Fig. 3).

Fortunately, over the past decade, the deinstitutionalization maintenance model has started to give way to a recovery model [12]. This is based on the conceptualization that mental health systems should not just aim at ‘management of the illness and maintenance of the patient’, but the focus should be on maximum recovery and as much social reintegration and participation as possible. In order to survive in the community and to be able to reintegrate into society, the mentally ill require community networks that protect their civic rights and
provide basic entitlements such as housing, employment and prompt access to medical interventions (Fig. 4). These are the civic rights and legal entitlements that were forgotten when legislative reforms were made in the last century, possibly out of blindness to the barriers to reintegration and to the levels of stigmatization mental patients faced from the general population, providers of mental health services, legislators and policymakers alike. The recovery model will deal with the clinical needs of the patient in a less restrictive manner, while respecting their autonomy, empowering them to make their own decisions, but expecting them, quid pro quo, to manage their illness and to be active participants in their rehabilitation and reintegration.

In an evolved mental health system, psychiatric interventions that are hospital based should deal with the immediate problems caused by serious psychopathology, be symptom specific and of short duration. As a result, a barometer of appropriate hospital services would be the average length of stay of patients admitted to acute psychiatric units in general hospitals. These units treat patients, on average, for no longer than 15 days, while vigorously tracking longer stays and outliers to find suitable community arrangements for follow-up and accommodation. Similarly, the system is required to prevent admissions, highlighting the importance of setting up workable and active psychiatric emergency programs. These programs work in close association with emergency clinics and community mobile crisis teams, which in turn work with community components, namely local police departments, district schools, the court system and the office of the public prosecutor.

These new arrangements clearly relate to tenets of mental health reform whereby patients are at the centre of the intervention, not the clinicians or the institutions. This system should be rooted in the community and provide integrated and seamless levels of services, while respecting the human rights of patients and advocating for their basic legal entitlements. At the same time, the system should be evidence based, information driven and accountable to patients, to funders and to the community as a whole (Fig. 5).

**Data systems and service accountability**

As exemplified in Fig. 1, where the trunk of the tree is composed of epidemiological data, surveillance of epidemiological indicators and evidence-based interventions, the multiple and varied service demands on an evolved mental health system require accountability systems at different levels: from measurement of levels
of admissions per year, in order to compare numbers of treated patients with levels of need in the community, to analysing the functioning of psychiatric units. Data monitored should include types of pathology by gender, age, county of provenance, and length of stay by diagnosis and by physician so that case mix models can be developed to carry out cost analyses. There should also be effective monitoring of the integrity of the data, data capture and quality that spans the catchment area or health district.

Information from these data systems should be available on request and used routinely for administrative purposes, system monitoring, and measurement of staff performance and output. Thus, systems should contain fields that indicate the type of intervention provided and the therapeutic response, as well as levels of functioning of the patient on entrance and on termination of the health event as assessed by an individual practitioner. Furthermore, arrangements for follow-up and length of community tenure need to be logged. Thus a unique identifier number per patient across the system would be required. The data system would also need to assess patient satisfaction and levels of protection of rights provided in cases of involuntary admissions.

In addition to treated prevalence data and quality performance monitoring by clinicians, community data should include incidents of violence and special cases of morbidity and mortality (homicides and suicides), as well as levels of police intervention and criminalization.

A data system is the server of accountability. A well developed system can serve as a watchdog, monitoring mental health in the community and measuring to what extent the community needs are being met. Only a system so integrated and accountable that aims at recovery and full community integration of mental patients can tackle the many issues that are affecting their legal rights and that, eventually, will prevent them from drifting into criminalization and imprisonment [13].

References