

# Mental health policy developments in Latin America

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New assessment guidelines for measuring the overall impact of mental health problems in Latin America have served as a catalyst for countries to review their mental health policies. Latin American countries have taken various steps to address long-standing problems such as structural difficulties, scarce financial and human resources, and social, political, and cultural obstacles in the implementation of mental health policies and legislation. These policy developments, however, have had uneven results. Policies must reflect the desire, determination, and commitment of policy-makers to take mental health seriously and look after people's mental health needs. This paper describes the development of mental health policies in Latin American countries, focusing on published data in peer-reviewed journals, and legislative change and its implementation. It presents a brief history of mental health policy developments, and analyzes the basis and practicalities of current practice.

**Keywords:** Latin America; mental health; health policy, trends; health policy, history.

*Voir page 488 le résumé en français. En la página 489 figura un resumen en español.*

## Introduction

Latin America is composed of 22 countries — the two largest being Brazil and Mexico — which occupy the Andean zone, the Southern Cone, Central America, and the area known as the Latin American Caribbean. Political and international health agencies consider other Caribbean countries like Barbados to be part of the region. Most of these countries have been politically independent for less than 200 years; a few became sovereign nations only in the first decades of the 20th century. In 1999, the total population of all these countries was nearly 600 million, with a growth rate of about 40% in the last 30 years (1, 2). Almost three-fourths of the population have settled in urban areas, while indigenous groups have been reduced to less than 10% of the total. Nominally, 90% of the population is Catholic, even though the vigorous growth of other Christian denominations is noticeable. The region is composed of a multi-ethnic and multi-racial mosaic, with unique social, economic, political, and cultural characteristics, which have produced marked differences in health and economic development.

Average life expectancy in the region is close to 63 years, with women living about 4 years longer than men do. However, there are two competing tendencies. On the one hand, a decline in death rate

in some areas — reflecting reductions in infant mortality and in the prevalence of infectious diseases — has increased life expectancy up to 71 years. On the other, deaths related to cerebrovascular disease, homicide and cirrhosis have increased by more than 50% in the last 15 years, particularly in the non-Latin Caribbean countries, and in the Central American and Andean zones. The increase in violent deaths, largely among the male population, surpasses the potential years of life lost because of cancer and gastrointestinal infection (2).

This paper describes the development of mental health policies in Latin American countries, focusing on published data in peer-reviewed journals, and legislative change and its implementation. It presents a brief history of mental health policy developments, and analyzes the basis and practicalities of current practice.

## Current mental health situation

In a comparative study on the morbidity of mental disorders in Latin America and the Caribbean, Levav et al. calculated that at the end of the 1980s, 88.3 million people were diagnosed with mood, anxiety, and substance-abuse disorders, schizophrenia, and significant cognitive deterioration secondary to drug and alcohol abuse (2). This represented a 48.1% increase in a period of 15 years, or 28.7 million new cases, with some notable variations, for example, an increase of 69.8% of cases of schizophrenia in Mexico, compared with 53.1% in the rest of Latin America and the Caribbean. The same trend was seen for cognitive impairment and anxiety disorders.

Human resources for mental health programmes in Latin America have always been scarce.

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Training programmes in psychiatry produce less than 600 new graduates a year, some with only limited technical skills and inadequate training. Less than 10% of psychiatrists in Latin America devote time to educational activities (1, 3). Other mental health professionals — possibly large numbers of them — do not find appropriate employment and end up choosing second careers or may practice in a limited fashion. Multidisciplinary teams, sectorization, community services, and primary care programmes have varying levels of success (3, 4).

There are between 130 000 and 140 000 psychiatric beds, approximately 10–15% of all beds, distributed in about 600 hospitals and 1000 outpatient clinics. Out of more than 300 000 physicians, there are 11 000 psychiatrists with varying levels of competence; 80% of these psychiatrists are concentrated in metropolitan areas with high-density populations (more than 100 000). Community participation has followed an irregular pattern, mostly due to economic restrictions and limited knowledge of mental health issues.

There are four main sectors that traditionally assume responsibility for mental health care in Latin American countries. The public sector, led by the Mental Health Division in the Ministries of Health (there are about 19 such divisions at the present time), is notable for a significant lack of financial support from government budgets (1). The social security system is widely mentioned, but it covers between 10% of the population in some countries to up to 55% in Mexico.

The private sector has experienced significant growth in the last decade. Unlike previously, it now reaches a large segment of the population even though mental health coverage is still uneven. The charity sector has lost ground in many countries with the implementation of policies that hold health as a right rather than as an expression of public compassion. Finally, the folkloric sector, although vaguely defined and a source of continuous controversy, embodies the informal care systems whose assessment is extremely difficult (5, 6).

Psychiatric hospitals exist mostly as public facilities for housing large numbers of chronic patients, homeless and other institutionalized people. Private clinics have multiplied, while psychiatric units of general hospitals have diminished. Outpatient clinics have expanded although day hospitals and day treatment programmes with recreational and occupational activities are conspicuous by their absence (1, 7). Even though in the last decade most of the countries of the region increased their health-related expenditures, overall health-related budgets have deteriorated owing to the economic crisis. Health-related expenditures for Latin American countries vary between 3.1% of the gross domestic product (GDP) in Peru and 9.5% of the GDP in Argentina, with an average of 6.2% for the region (8). The allocation of resources for mental health purposes is significantly more limited.

## Brief history of mental health policies in Latin America

A significant tradition of high quality epidemiological research exists in Latin America (9–11). Two Seminars on Mental Health in the Americas, organized by the Pan American Health Organization (PAHO) and held in Cuernavaca (Mexico) and Buenos Aires (Argentina) in 1960 and 1963, respectively, were the first official expressions of interest in mental health policy-making by international organizations. In 1968, the first Conference on Mental Health in the Americas took place in San Antonio, Texas (USA). The *Bulletin of the Pan American Health Organization* devoted topical issues to mental health in 1976 and 1985, and highlighted other activities such as the Seminar on Perspectives of Mental Health in Latin America held in Cali (Colombia) in 1978, the meeting of the Advisory Group of the Regional Mental Health Program of PAHO in Panama in 1985, and the Working Group on Primary Care and Mental Health in the Americas in Washington, DC, in 1980. The Declaration of Alma Ata (1978) strengthened the message and the impact of these activities (12–14).

The 1990s opened favourably with the Declaration of Caracas in 1990 (15, 16). This emphasized primary mental health care within local systems of health, and appropriate provision of resources and programmes. It also encouraged a reduction of the dominant role of traditional mental hospitals in exchange for a more defined community emphasis. And urged legislation that would ensure respect for human rights and promotion of community organizations for the assistance of the mentally ill. An International Conference on Mental Health in the Americas, sponsored by the American Society of Hispanic Psychiatry in New York City in 1996 (17) introduced the concerns of Hispanic populations in the USA and North America. They were experiencing similar conditions, in terms of mental health care, as those living south of the Rio Grande.

The Decade of the Brain, sponsored by the US National Institute of Mental Health, and the Year of Mental Health decreed by the United Nations in 1997 set the stage for a meeting of the PAHO Governing Council in Washington, DC, in 1998. This meeting urged Member States, for the first time in 20 years, to formulate national plans focusing attention on and boosting resources devoted to mental health programmes as an integral component of large-scale reforms of their general health systems (18). The final document of this event recommended to “intensify support for efforts to reorient mental health services from an institutional to a community approach.” It advised a move towards including mental health services “in every health insurance or payment plan and every health care services program,” with particular emphasis on the management of affective and psychotic disorders, and epilepsy. The resolution also committed the countries to create programmes to enhance the psycho-

social development of children, to design courses in public health schools that would train students to manage mental health programmes, and to work towards passing legislation protecting the human rights of people with mental disabilities. The reform and upgrading of mental health services was recognized as a strong subject for cooperative efforts between the public and the private sectors.

## Bases for mental health policies

The increase in psychiatric morbidity in the 21st century will have important repercussions for the social development of Latin American countries and in the planning and provision of health services. The complexity of psychosocial factors in the causation and triggering of mental health disorders calls for the establishment of clear policies for prevention, education, and rehabilitation (2, 4, 5). Broadening of services may be based not only on demographic growth but also on the increase in prevalence rates. While affective disorders may increase less than schizophrenia, alcoholism, or anxiety, the aging of the population and factors such as nutrition deficiencies and infectious diseases will increase the burden from diseases that cause cognitive impairment. Furthermore, differences in economic growth, industrial development, buying power of the population, and access to information will have a bearing on mental health (10, 11).

Recognizing the fundamental value of mental health in the overall assessment of public health — that the efficacy of prevention and treatment programmes rooted in population-based public health are well documented — will reduce the neglect of mental health issues in public policies (19, 20). The emergence of consumer and family movements, assessment of mental health throughout life, protection of confidentiality, and recognition of cultural factors constitute other foundations for the development of progressive mental health policies. Such policies should also have cost benefits (21–23).

Sound definitions are as important as any other component of mental health policy. It is not only the appropriate definition of mental health, mental health services, mental health agencies, and mental illness that is crucial but also programmes, direct services, recipients, activities, functional impairment or disability, and other concepts should be clearly defined too. Boundaries may become blurred in the bureaucratic arena (24). This is particularly true in efforts to integrate psychosocial and biomedical components in the presentation, assessment and implementation of policies. Inter-sectoral work continues to be a problem in Latin America. The integration between primary care and general health care at the hospital and community levels must be based on rational options with respect to local needs, available resources, and the effectiveness of proposed solutions. Important elements for a continuous evaluation of policy measures are quantitative and

qualitative indicators, disability indicators, and measurement of sequelae for handicaps produced by adverse psychosocial factors and conditions (16, 22).

Quantifying the “burden of disease” has resulted in the development of disability-adjusted life-years (DALYs) to express the years of life lost to premature death, and years lived with a disability of a specified severity and duration (20, 25). This demonstrated that, of the ten leading causes of disability worldwide in 1990, measured in years lived with a disability, five were psychiatric conditions: unipolar depression, alcohol use, bipolar affective disorder, schizophrenia, and obsessive compulsive disorder. These conditions were by no means restricted to the countries with established market economies. Alcohol use is the leading cause of male disability, and the tenth largest in women in the developed regions. It is also the fourth largest cause of disability in men in developing countries. Another important cause such as road traffic accidents may also imply mental health disorders. Alcohol use accounts for almost 10% of the total disease and injury burden in Latin America and the Caribbean, a figure surpassed only in the developed regions of the world (2, 20).

By the year 2020 the three conditions projected to be leading causes of disease burden will be heart disease, depression and road traffic accidents. Furthermore, it is estimated that major depression will become the number one condition in terms of global disease burden within the next two decades in Latin America, and in women worldwide. Violence, currently in 19th place, and suicide, currently in 17th place, are both projected to rise in the same period.

## Current policy developments

In 1986, Alarcón (1) evaluated the current status of policy and service organizations for mental health in 14 Latin American countries. He also examined epidemiological research, human resources, and needs and limitations. He concluded that there was a lack of coherent mental health policy due to a variety of factors, not least the small share of budget allocated to mental health programmes. A gap between the magnitude of mental health problems in the region and the human and material resources available was pointed out, and the will of governments and official agencies to face the problems was questioned. Prevention, health promotion, training, and adoption of objective and realistic criteria for the formulation of strategies and evaluation were deemed important.

In 1994, PAHO published a series of Latin American experiences in programmes of psychiatric care to the community (26). Experiences in Argentina, Brazil, Cuba, Dominican Republic, and Venezuela with different mental health programmes in the whole country, cities, states, small communities or neighbourhoods, were compared. In the state of Mérida, Venezuela, for instance, promotion and primary prevention actions took place in urban nuclei

under the leadership of basic health teams and with the support of community groups, teachers, and patients' relatives. Coverage was expanded to the five districts in the state, training of auxiliary personnel was effective, and the management of several hundreds of patients improved. Coordinating mechanisms as well as referral and counter-referral networks were examined. The participation of the local university and payments by patients helped in the midst of state-imposed budget limitations.

This experience contrasts with that in Cuba where national policies favoured extensive community coverage at the secondary prevention level. The three Cuban examples presented were focused on hospital-based programmes in different parts of the island. It was clear, however, that the community projection of the hospital work resulted in a reduced number of admissions, expansion of outpatient actions, provision of attention in the family milieu, integration of patients into the workforce, and development of programmes of continuing professional education.

The municipality of Santos, Brazil, restructured its psychiatric services on the basis of public opinion, political will, and collaboration between patients and their families. Closure of the local hospital was part of the plan. Enlightened public opinion and the role of activists made it possible to expand services and receive about 10% of the total city budget, a rather unusual allocation figure – unheard of in Latin America.

An example of system that follows procedural norms without excessive input from established authorities is the establishment of social networks in the municipality of Medellin, Colombia (27). A good theoretical basis strengthened by an adequate translation of key clinical documents allowed the publication of a manual, conceived both as a preventive tool and a contribution to the minimization of risks in the dynamics of social interactions. At the same time, a recognition of cultural contexts and contribution from individual members and the whole community fostered a social awareness, organization, and sustained social, cultural and political action. Care and preventive programmes for different age groups also reflected the clinical and social realities of the site.

Other Latin American countries have also made serious attempts at developing rational mental health policies. In Brazil, there has been an extensive debate around a legislative initiative that responded, in part, to a massive mobilization of consumers, the first of its nature in the region. The Ministry of Health in Peru has assigned to the National Institute of Mental Health the task of developing, coordinating, and monitoring nationwide campaigns of public education and dissemination of technical information. The government of the Rio Negro province in Argentina has also developed an innovative set of policies, which are being closely followed by legislators, mental health organizations, and the public. This could become a model for the rest of the country.

## National programmes: Mexico and Chile

The recently published national plans for mental health in Mexico and Chile are, so far, the best examples of the use of more thorough indicators and scientific and technical foundations, as advocated by WHO (25) and Murray & Lopez (20).

### Mexico

The private sector made a considerable contribution in the assessment of the country's health situation prior to the presentation of the mental health programme by the Secretary of Health. Traditionally, mental health was not considered a part of public health because of other health priorities, lack of knowledge about the true magnitude of mental health problems, and a complex approach involving the intervention of other sectors in addition to the public health sector. Among the key documents anticipating the policy change was a report presented by the Mexican Health Foundation in 1995 (28), which opened a very constructive debate. It introduced basic tenets for health improvement, elements for an analysis of the health situation related to the burden of disease approach, and a strategic proposal with concurrent recommendations for reforming the system.

The report points out that Mexico is one of the countries with the fewest hospital beds per population in the region, and with an insufficient number of professionals — for example, only 87 qualified geriatricians, or 1 per 40 000 people in the  $\geq 65$  years age group. Another important piece of information was that the social security system, if it continued to grow at the average rate seen since 1943, would not cover 100% of the population until the year 2030. It was documented that Mexico lost 12.8 million DALYs in 1991 due to premature mortality and disability. The burden of disease was greater among men than women, greater in the rural areas, and significantly affected the child and adolescent age groups. For men between the ages of 15 and 44 years, the breakdown by specific causes placed injuries from motor vehicle accidents and homicide at the top of the list. Thus, violence joined other non-communicable conditions such as cardiovascular disease, neuropsychiatric problems, and diseases of the digestive tract. Alcohol abuse was the biggest single risk factor for health, accounting for 9% of the burden of disease (28).

The federal public sector provided only 2.76% of the GDP for health expenditures, approximately the same as the private sector. The report indicated that equity, quality, and efficiency were the main objectives of the reform, and proposed the development of a universal health system which would be comprehensive, anticipatory, accessible, decentralized, efficient, rational, and of high quality.

Despite this impressive collection of data, it is interesting to note that the proposed essential services in the universal package (29) included public

health programmes against alcohol and tobacco use, but no community extension programmes or even clinical services specifically oriented towards mental illnesses and mental health programmes. Unless the generic item "Treatment of the major non-communicable diseases" included these conditions. It was proposed that the government should spend more money on the health services and education in general. Public opinion polls concerning the principal means of solving the problems of the health system, however, showed that 58% of the people thought that reorganization of the existing system should accomplish it, whereas only 39% suggested allocation of more money.

Mexico has an extensive legal frame of reference dealing with health and mental health. The objectives are to promote a healthy psychosocial development of different population groups, and reduce the effects of behavioural and psychiatric disorders. This should be achieved through graded and complementary interventions, according to the level of care, and with the coordinated participation of the public, social, and private sectors in municipal, state, and national settings. The strategic lines consider training and qualification of human resources, growth, rehabilitation, and regionalization of mental health service networks, formulation of guidelines and evaluation. All age groups as well as specific sub-populations (indigenous groups, women, street children, populations in disaster areas), and other state and regional priorities are considered.

The specific psychiatric disorders to be prioritized are schizophrenia, major depression, senile dementia, epilepsy and others; among the specific psychosocial problems, addictions and violence are also singled out for interventions. Decentralization of resources, development of new models of care, the adequacy of basic health teams, strengthening of primary care, and an impetus for the social participation were the most salient strategies to reach all the objectives. The plan accounts for the risks of limiting or fragmenting the execution of the proposed actions. It calls for convergence of the different sectors civil society to make possible and perfect the mental health programme in order to improve the health and welfare of the population.

## Chile

The result of a long and sustained effort by a team of professionals, assisted by government officials, technocrats, and community agencies, is a mental health plan that recognizes the right to health. It substantiates the policy on the basis of high prevalence of mental illness, elevated social and economic costs, unsatisfied demand for services, evidence of cost-effectiveness of promotion, prevention, treatment and rehabilitation measures, and gaps in the provision of mental health services compared to the rest of health services. Some successful national experiences and the broad consensus of users, relatives, and professionals were

also influential factors. Special emphasis was placed on areas of coverage, reduction of suicide rates, the 58–80% effectiveness of psychosocial and pharmacological treatments in depression, anxiety, schizophrenia, bipolar disorder and alcohol addiction, and utilization of general health services. Priorities established were those of developmental and attention deficit disorders, post-traumatic stress disorder, depression and anxiety disorders, schizophrenia, Alzheimer and other dementias, and dependency on alcohol, tobacco and drugs. Strategies for the development of human resources and empowerment of users and their families were outlined with the ultimate goal of universal coverage, high quality, and total financial support. There were also quality criteria, technical foci, organizational support and administrative frames stimulating multidisciplinary teams and outlining the resources needed (30–32).

A substantial bibliographic support, and a well organized information and programmatic structure make the plan appealing in many ways (33). Even the political climate appears to be favourable in the light of recent developments in the country. Nevertheless, the table presenting data on resources does not include nurses, social workers, occupational and recreational therapists, and there is no mention of case managers. While the participation of institutions and organizations is evident, the financial aspects of the plan both in the public and private sectors point to the need to increase budgetary resources for mental health.

Interventions for promotion, prevention, and education are established but training programmes, availability of personnel, and outcomes of programme impact are not reported. The same may apply to the national system of forensic psychiatry whose ideal composition is presented in part of the report. The consolidation of available services and the incorporation of new ones including non-traditional networks by non-governmental organizations, self-help groups and others are advocated. The scope of mental health interventions is broad and well conceived even though cultural and spiritual needs are not mentioned by name. As for the community work, there is a trend towards adopting the intensive psychiatric approach proposed by the Wisconsin model (34). Algorithms and practice guidelines for the attention of patients with depression or schizophrenia are not explicit although the trend appears to be clear. Finally, while recognizing that the number of consultations available does not satisfy the demand, the report also mentions that the number of individuals accessing the services has been insufficient. In primary care, only a very small minority of patients consults for psychological reasons, but the report does not deal with the clinical competence of primary care practitioners or the cost-effectiveness of specialized services. The most important feature of the document is the seriousness with which the task was approached by the working group, and the frames of reference that give a much clearer view of current mental health realities in Chile.

## Conclusion

The use of new indicators in the assessment of the overall impact of mental health in the Latin American region has proven to be a catalyst for countries to update or redevelop their mental health policies. The brief historical and demographic presentation of Latin American realities shows a variety of interventions in different countries in the last decades, stimulated internally or by the work of international agencies and the private and non-governmental sectors. These mental health policy developments, however, have shown uneven results. A number of long-standing problems, and structural difficulties for the implementation of policies and mental health legislation remain. Scarce financial and human resources, and social, political and cultural difficulties in the implementation of the laws are prime examples. Training programmes as well as a presentation of research needs and plans are conspicuous by their absence (35).

Despite these inadequacies, there are encouraging signs and favourable developments in several Latin American countries towards the formulation of new policies based on empirical epidemiological data, while regaining the initiative in mobilizing political and public allies. One encouraging sign is the interest shown by some Latin American countries' governments, and the steps taken towards participating in the World Mental Health 2000 (WMH2000) survey. This is a "large WHO initiative which aims to obtain empirical data" and will help governments to decide how they can best deal with the increasing burden of

mental disorders in over 20 countries worldwide (36). The aim of these surveys is to obtain objective estimates of the prevalence of mental disorders, their associated disability, and patterns of treatment by: (1) assessing the global burden of mental disorders; (2) determining the psychosocial risk factors and correlates of mental disorders, with a special focus on the effects of disadvantaged social status; (3) establishing mental health utilization patterns; and (4) identifying modifiable barriers to help-seeking are other goals. From a health policy perspective, the data generated by the WMH2000 surveys will provide baseline information which can be used for health policy planning purposes on the prevalence and burden of mental disorders by the participating Latin American countries (37). In turn, these data would allow health policy planners to estimate both the societal costs of treating versus not treating mental disorders, and to guide the design, implementation, and outcome of interventions aimed at increasing access to care. The new awareness of efficiency indicators that will help policy-makers in better defining and monitoring mental health needs, as well as the rational allocation of resources, should be systematically evaluated (38, 39). A report card on mental health in Latin American countries is desirable, as is also community involvement, integration of services, and the rational, efficient use of resources. Comprehensive health policies as part of social development legislation must reflect a sincere commitment from policy-makers to take mental health seriously and take care of the mental health needs of the 600 million people in the region. ■

## Résumé

### Mise en place de politiques de santé mentale en Amérique latine

L'Amérique latine compte 22 pays, les plus grands étant le Brésil et le Mexique, qui couvrent la zone des Andes, le Cône austral, l'Amérique centrale et la zone dite de la Caraïbe d'Amérique latine. Les organisations politiques et les organismes de santé internationaux englobent dans cette région d'autres pays des Caraïbes tels que la Barbade. En 1999, ces pays totalisaient près de 600 millions d'habitants, le taux d'accroissement démographique de ces 30 dernières années approchant 40 %. La région est une véritable mosaïque ethnique et raciale dont les particularités sociales, économiques, politiques et culturelles expliquent les différences sensibles aux plans de la santé et du développement économique.

Les gouvernements ont pris conscience que leurs objectifs sociaux devaient s'appliquer à l'ensemble de la population. Le vieillissement de la population de l'Amérique latine, joint aux carences nutritionnelles et aux maladies infectieuses, augmentera la charge de morbidité responsable des troubles cognitifs. Les inégalités aux plans de la croissance économique, du développement industriel, du pouvoir d'achat de la population et de l'accès à l'information auront un impact sur la santé mentale.

Cette augmentation de la morbidité psychiatrique aura d'autant plus de répercussions sur le développement social des pays d'Amérique latine et sur la planification et la prestation des services que l'Amérique latine a manqué de ressources humaines pour la santé mentale. Pour pallier la complexité des causes et des facteurs de déclenchement des troubles mentaux, il faudra définir clairement les politiques de prévention, d'éducation et de réadaptation.

Les nouvelles directives recommandées pour évaluer l'impact des problèmes de santé mentale en Amérique latine ont incité les pays à revoir leurs politiques de santé mentale. Les pays d'Amérique latine se sont attaqués par des moyens divers à des problèmes anciens tels que l'inadéquation des structures, le manque de ressources humaines et financières, et aux obstacles sociaux, politiques et culturels qui freinent la mise en œuvre des politiques de santé mentale et de la législation dans ce domaine. Les résultats obtenus, cependant, ont été inégaux.

Se fondant sur des études de qualité, plusieurs pays d'Amérique latine élaborent de nouvelles politiques prometteuses. Ainsi, le Mexique et le Chili, au terme d'un débat public salutaire, se sont dotés de politiques de

santé mentale rationnelles utilisant des outils épidémiologiques et législatifs modernes. Un autre signe encourageant est le désir manifesté par certains pays d'Amérique latine de participer à l'enquête sur la santé mentale dans le monde 2000 (WMH2000), initiative de l'OMS dont le but est d'aider une vingtaine de gouvernements dans le monde à décider du meilleur moyen de faire face à la charge croissante de morbidité associée aux troubles mentaux. Les données issues des enquêtes WMH2000 fourniront les informations sur la prévalence et la charge des troubles mentaux dans les pays participants qui permettront aux responsables de la planification des politiques de santé d'évaluer le coût du traitement, par opposition à l'absence de traitement, des troubles mentaux.

Les indicateurs d'efficacité qui aideront les décideurs à mieux définir et surveiller les besoins en santé mentale devront être évalués systématiquement. Outre la nécessité d'évaluer soigneusement les services de santé mentale en Amérique latine, il sera souhaitable de s'assurer de la participation de la communauté, de l'intégration des services et de l'utilisation efficace des ressources. Pour répondre aux besoins de santé mentale des 600 millions d'habitants de l'Amérique latine, des politiques de soins de santé complètes devront être intégrées dans la législation sur le développement social et elles devront reconnaître la valeur fondamentale de la santé mentale dans l'évaluation globale de la santé publique.

## Resumen

### Evolución de las políticas de salud mental en América Latina

América Latina está integrada por 22 países – los mayores son el Brasil y México – que ocupan la zona andina, el Cono Sur, América Central y lo que se conoce como Caribe latinoamericano. Diversos organismos políticos o implicados en la salud internacional consideran también como parte de la región otros países caribeños, por ejemplo Barbados. En 1999 la población de todos esos países ascendía a casi 600 millones de habitantes, con una tasa de crecimiento de casi un 40% en los últimos 30 años. La región es un enorme mosaico multiétnico y multirracial, caracterizado por una serie de peculiaridades sociales, económicas, políticas y culturales que han dado lugar a marcadas diferencias en el desarrollo sanitario y económico.

Existe una conciencia creciente de que los gobiernos han de definir objetivos sociales para el conjunto de la población. El envejecimiento de la población de América Latina, unido a las carencias nutricionales y las enfermedades infecciosas, aumentará la carga de enfermedades causantes de déficit cognitivos. Además, las diferencias existentes en lo tocante a crecimiento económico, desarrollo industrial, poder adquisitivo de la población y acceso a la información repercutirán en la salud mental.

Este aumento de la morbilidad psiquiátrica tendrá repercusiones en el desarrollo social de los países de América Latina y en la planificación y suministro de servicios, debido en particular a que los recursos humanos disponibles para la salud mental han sido escasos en la zona. La complejidad de los factores implicados en la etiología y el desencadenamiento de los trastornos mentales obliga a establecer políticas claras de prevención, educación y rehabilitación.

Las nuevas directrices de evaluación para la medición del impacto global de los problemas de salud mental en América Latina han actuado como catalizador para que los países revisaran sus políticas de salud mental. Los países de la zona han tomado varias medidas para abordar viejos problemas tales como las dificultades

estructurales, la escasez de recursos financieros y humanos y los obstáculos sociales, políticos y culturales a la aplicación de políticas y leyes sobre salud mental. Estas intervenciones en materia de políticas, sin embargo, han tenido resultados desiguales.

Un dato esperanzador es que varios países de América Latina están elaborando nuevas políticas basadas en estudios sólidos. México y Chile, por ejemplo, han desarrollado políticas de salud mental racionales sobre la base de modernos instrumentos epidemiológicos y legislativos, tras un saludable debate público. Otro signo alentador es el interés de algunos países latinoamericanos en participar en la encuesta Salud Mental Mundial 2000 (SMM2000), una iniciativa de la OMS encaminada a ayudar a los gobiernos de más de 20 países de todo el mundo a decidir la manera de hacer frente a la creciente carga de trastornos mentales. Los datos obtenidos con las encuestas SMM2000 aportarán información basal sobre la prevalencia y la carga de trastornos mentales en los países participantes, lo que permitirá a los planificadores de las políticas sanitarias comparar el costo estimado para la sociedad de las alternativas de tratar y no tratar los trastornos mentales.

Deberían evaluarse sistemáticamente los indicadores de eficiencia que ayudarán a los formuladores de políticas a definir y controlar mejor las necesidades en materia de salud mental. Otros elementos deseables, además de una evaluación exhaustiva de los servicios de salud mental en los países de América Latina, son la participación de la comunidad, la integración de los servicios y un uso eficiente de los recursos. Las políticas globales de atención sanitaria deben considerarse parte de la legislación para el desarrollo social y deben reconocer el valor fundamental de la salud mental en la evaluación global de la salud pública, pues sólo así se satisfarán las necesidades en materia de salud mental de los 600 millones de personas que pueblan América Latina.

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