INNOVATIVE MENTAL HEALTH PROGRAMS IN LATIN AMERICA & THE CARIBBEAN

EDITORS:

José Miguel Caldas de Almeida
and Alex Cohen

Pan American Health Organization

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José Miguel Caldas de Almeida, MD, PhD
Faculdade de Ciências Medicas, Universidade de Nova Lisboa, Portugal and
Former Chief, Mental Health Unit, Pan American Health Organization
and
Alex Cohen, PhD
Department of Social Medicine, Harvard Medical School, Boston, MA, U.S.A

Pan American
Health
Organization

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> These case studies represent particular experiences in the countries. The approaches shown, and the opinions of the authors, do not necessarily reflect official policies of the Pan American Health Organization.

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INTRODUCTION
WHAT WE CAN LEARN FROM MENTAL HEALTH REFORM IN LATIN AMERICA AND THE CARIBBEAN

In the last quarter century, several projects emerged to reform mental health services in Latin American and Caribbean countries. Some did not survive the difficulties that inevitably arise in processes of change, and ended up disappearing before the intended changes could be introduced. Others, however, as shown in this publication, were able to overcome difficulties and meet intended objectives, effectively transforming the structure and quality of services. All these projects, including the many that did not survive, were part of one of the richest experiences in the transformation of mental health care worldwide - the experience of mental health reform in Latin America and the Caribbean.

Despite the conceptual wealth of reforms developed in this part of the world and the enormous creativity demonstrated in implementing new models, these reforms are little known internationally. Even at the regional and national levels, surprisingly little is known about them. This publication is an attempt to help to change that, conveying to interested readers some of the more innovative experiences implemented in Latin America and the Caribbean. Granted, it is only a first step, but one I hope will be followed by other initiatives that assess the impact and publish the results of reforms undertaken in the Region.

Each experience described here has its own history, as can be seen in each one of the chapters. Yet, all of them are part of a single reform process with shared historical roots and influences. Because a general context is important in order to understand essential aspects of the reforms, this introduction will briefly summarize the historical evolution of the mental health reform process in Latin America and the Caribbean, describing its most influential factors and its main achievements.

As proved by the experiences included in this book, a great deal can be learned from mental health reforms in Latin America and the Caribbean., On the one hand, each initiative developed truly original and innovative solutions for some of the problems usually encountered in the reform processes. Obviously, many of the innovative solutions can be applied in those countries that are at a similar stage of development as the Latin American and Caribbean countries where the reported experiences took place. However, many of these innovations also can be useful to any country interested in reforming its mental health services, regardless of the country's degree of development. I also believe that the reform of mental health services in Latin America and the Caribbean—given specific aspects such as the dynamic following the Caracas Declaration and the impact of international cooperation—help us to better understand the real importance of some factors, such as social and political aspects and international cooperation, in implementing mental health service reforms.

EVOLUTION OF MENTAL HEALTH REFORMS IN LATIN AMERICA AND THE CARIBBEAN

The first attempts at reforming mental health services in Latin America and the Caribbean took place in the 1960s, when the early effects of the community mental health movement in the United States and the psychiatric reform experiences in Italy and other European countries began to to reach this region (1).

From the 1960s through the 1980s, the Pan American Health Organization (PAHO) promoted several international conferences to help improve mental health care in the Region's countries. These conferences significantly contributed to define appropriate reform strategies for Latin America and the Caribbean, and called attention to the need to integrate mental health into primary care and to find alternatives to the hospital-based mental health care model.

Several countries (Brazil, Honduras, and Nicaragua, among others) developed experiences of community mental health services and programs during this period. In some cases (such as in Nicaragua), these experiences were part of a national mental health policy, but in most cases, the projects were merely local efforts that depended on circumstantial political support. Despite the localized and ephemeral nature of many of these experiences, they clearly played an important role in disseminating new ideas about community mental health (*1*).

The Caracas Declaration, adopted at the Regional Conference for the Restructuring of Psychiatric Care in Latin America (*2*, *3*), held in Caracas, Venezuela, on November 11–14, 1990, was a landmark in bolstering mental health care reforms in the Region, particularly in Latin America.

The Declaration proposed integrating mental health into primary care and local health systems, and defended the need to remove the psychiatric hospital from a central position in the psychiatric care system. According to the Declaration, psychiatric care should be provided by community-based services, which offer accessible, decentralized, comprehensive, participatory, and continuous care and prevention. Another key aspect of the Caracas Declaration was its firm pledge to protecting the human rights of people with mental disabilities.

In the words of one of the two main promoters of the Conference (*3*), several factors formed the basis of the Caracas Conference.

First, there were clinical and ethical-legal factors. Experiences and assessments in different sites led to an awareness that mental health care was woefully insufficient in most places, and in some cases, in violation of the patients' human rights.

Second, there were epidemiological factors. Although undertaken with major methodological shortcomings, several countries began to conduct studies of psychiatric morbidity that laid to rest the false notion that mental health problems occurred exclusively in developed countries. These studies also revealed that the spectrum of mental health problems was much wider than previously thought, including problems associated with violence, disasters, and other social factors (highly prevalent in Latin America and the Caribbean).

Technical factors also played an important role. The search for alternative models to the psychiatric hospital in the United States, in Europe, and in some places of Latin America led to the establishment of community-based care models, which proved to be not only better at respecting patient rights and promoting rehabilitation and integration into society, but also to be clinically more effective. Finally, the influence of political changes in the 1980s in Latin America cannot be ignored. In fact, in the late 1980s, the end of several political regimes that violated human rights, and were especially averse to anything having to do with mental health, caused a reemergence of democratic governments that brought new attention to human rights, both politically and in civil society, as well as in the field of psychiatry.

Not every Latin American and Caribbean country formally committed itself to the Caracas Declaration. In fact, conference participants included only eleven Latin American countries and three European countries that were particularly committed to support psychiatric reform in Latin America. It should be noted, however, that participants included, in addition to psychiatrists and other health professionals, members of parliament, government officials, patients, and journalists. At stake in Caracas were not only technical changes, but also the search for new social and

cultural models. In order to achieve these changes, not only were policies, laws, and other top-down initiatives needed; also needed were bottom-up initiatives. The Conference took place at a critical moment. According to Itzhak Levav (*3*), "the opportunity offered by the conference helped countries establish a reference framework, outline an action program, and effectively mobilize resources from Latin America and from countries outside the region."

In order to implement the Caracas principles, PAHO promoted a technical cooperation initiative—the Initiative for the Restructuring of Psychiatric Care in Latin America (*2*, *3*)—in which mental health units and centers from the countries that attended the conference participated to promote changes in psychiatric hospital care, implementation of community services, and improvement of mental health information systems. The initiative also promoted research activities, training activities for professionals in community mental health services, technical assistance in revising legislation, and support in mobilizing local, regional and international resources.

The Initiative for the Restructuring of Psychiatric Care in Latin America led many countries to undertake measures designed to reform mental health services following the principles of the Caracas Declaration. It also promoted the establishment of national mental health policies and legislation in many countries.

One important aspect of the newly implemented mental health policies in several countries was the integration of mental health into primary care. After Caracas, many countries, including Brazil, Chile, Cuba, El Salvador, Guatemala, and Panama, made significant advances in this regard. The Cuban experience, as can be seen in the pertinent chapter in this publication, was the first to include mental health in primary care as the basis of the new mental health system, and to implement this strategy at the national level. The existence of a network of primary care covering the entire population was certainly a factor that greatly facilitated this strategy, but it would never have been implemented if there had not also been a detailed mental health plan, which made it possible to train professionals, create specific mental health programs, and develop new mental health facilities in the community. The strategy followed in Chile (reported in this book) was different, to the extent that development of specific programs was favored in primary care to target problems identified as priorities, such as depression. Chile's effort to assess its program is worth mentioning, because it was the first attempt, as far as we know, to assess a national mental health program in the Region. Early on, the Central American countries (for example, Nicaragua, Panama, and Guatemala) promoted the integration of mental health services into primary care, stressing prevention and health promotion. In Brazil, countless mental health projects in primary care were implemented, especially after the end of the 1990s, when new perspectives were opened with the creation of the Family Health Program, a national program aimed at providing comprehensive family care for the entire population (*4*). The experience in Sobral, Brazil, as described in this publication, is a good example of these comprehensive projects and of how, in some places, they grew to be an important piece in the mental health service reform.

The development of comprehensive, community-based mental health services that could guarantee mental health care to a given population and that would replace psychiatric hospitals was the main objective of several national and regional projects throughout Latin America and the Caribbean.

The reform in Argentina's Río Negro Province, an experience that from the onset had both enthusiastic supporters and relentless critics, was one of the first reforms to successfully implement an integrated mental health system with no psychiatric hospital in a large territory, with a significant component of psychosocial rehabilitation and extensive patient participation.

Strongly influenced by the Italian principles of community psychiatry at the beginning, the Río Negro reform had its own unique features that responded to the province's characteristics - a vast territory with widely scattered pockets of population. Some of Río Negro's responses to its particular problems can definitely be applied in other places that have similar problems.

Another influential experience, both domestically and in neighboring countries, was that of Santos, Brazil (*4*, *5*). The Santos reform, which was also influenced by Italy's democratic psychiatry, was in a way a laboratory for mental health reform in Brazil, providing a conceptual basis that came to inspire and guide many later projects. The Santos reforms proved that in countries such as Brazil it was possible to create a community mental health system that could replace psychiatric hospitals with evident advantages. The later evolution of this reform eventually revealed, however, that mental health reforms with a marked ideological component and extremely dependent on charismatic leaders are especially vulnerable, given the possible changes in leadership and political powers on which they depend.

Deinstitutionalization has always been a key issue in psychiatric reforms. After the pioneering experiences of Santos and Río Negro, reform projects with a strong de-institutionalization component began to be implemented in many other places. Their impact was especially felt in Brazil, where the number of psychiatric beds dramatically decreased. This significant change resulted from a strong national policy designed to correct trends seen in the 1960s and 1970s, during which military dictatorship governments supported an explosive growth of private psychiatric hospitals (*4*).

The experiences in Campinas, Brazil, and Hidalgo, Mexico, both described in this publication's chapters, also were especially significant in the area of de-institutionalization. Campinas was certainly one of Brazil's sites where more advances were made in developing a comprehensive community system with facilities adapted to the different needs of persons with mental health problems: CAPS (psycho-social community care centers), group homes, rehabilitation programs and workshops, and others. An important issue arising from the Campinas experience is the importance of the management model in implementing new services. Contrary to what is usually seen in other reforms in Latin America and the Caribbean, in Campinas the mental health services, while a recipient of public financing, are managed by a very flexible and autonomous nonprofit nongovernmental organization, which naturally leads to the question: to what degree was this management model a decisive factor in the success of a reform that required creating new types of services, new operative models, and new forms of distribution of power among team members?

Hidalgo's reform, which conceptually drew strongly from the Leganes Madrid model, had several features that drew a lot of attention, both in Mexico and elsewhere in the Region. First was the speed with which the psychiatric hospital was closed and an important set of group homes and rehabilitation programs were set up. A process that usually takes many years here took little more than three years. Second was the decisive and systematic way that the directors took advantage of the news media to disseminate information on the reform. Hidalgo's experience, as do all controversial experiences, sheds light on many important issues: what are the costs of closing hospitals so quickly (for example, in terms of trans-institutionalization); what are the limits and costs of charismatic leadership; how can a compromise be found between a reform's more ideological component and a scientific and evaluative component that cannot be overlooked?

In the Spanish-speaking Caribbean countries, the main influences in terms of mental health reforms were similar to those seen in Central and South America. The same was not true in the English-speaking Caribbean countries, where services are structured more like those in the

British model and are traditionally more subject to influences from the United Kingdom and Canada. Among these countries, Jamaica was definitely the first to attempt mental health reform at the national level. As can be seen in the chapter on this experience, several innovations were instituted, such as the creation of a national network of mental health officers that provided mental health care in the community and treatment of psychiatric disorders in the general medical units of the district general hospitals. These were pragmatic strategies adapted to the specific conditions of the country, which led to clear advances in the provision of care in Jamaica and could be successfully applied in other English-speaking Caribbean countries such as Belize.

Despite the progress made by these experiences, it was evident by the end of the 1990s that, if general intended changes were to be implemented, much more was needed. This observation was the cornerstone of several international initiatives that began to arise to place mental health on the list of priorities on the international public health agenda. This new phase coincided with the major World Health Organization (WHO) 2001 initiatives, World Health Day and the *World Health Report* (*6*), both of which covered the subject of mental health, and with the launching of several other WHO initiatives.

Thanks to mobilizing efforts undertaken in 2001, a new wave of reforms emerged in many countries. It is still early to fully evaluate these reforms. We can see, however, that some have already led to results that merit special mention. Barbados and Saint Lucia, for example, made important advances in the preparation and implementation of a mental health plan, which improved conditions at the psychiatric hospitals and led to the launching of alternatives in the community. Belize also progressed in creating alternatives to the psychiatric hospital and reinforcing the community service network. Guyana developed a plan to train health professionals and improve psychiatric services. El Salvador, Guatemala, and Nicaragua implemented several innovative projects designed to bring mental health services to the community (*7*). In Mexico, treating mental disorders was included in popular health insurance and, based on an assessment of services in the country, a reform movement began to take hold in some Mexican states. In Paraguay, a reform process started, based on using human rights as an instrument to change services (*8*). In Peru, an assessment was done of the human rights of people with mental health problems and a national mental health program was created. New community services were implemented in the province of Buenos Aires, Argentina; several new experiences helped deepen reforms in Brazil and Chile (*9*).

LESSONS LEARNED

The first lesson to be derived from the Latin American and Caribbean experiences is that good will and enthusiasm are not enough to successfully implement a mental health service reform. Today, reforming mental health services is a complex task that requires strong political support and the ability to implement comprehensive strategies in several arenas (e.g., legislation, organization of services, information systems, financing, human resources). In all the experiences included in this book, improvement in the quality of services was based on national or state mental health policies and plans implemented by teams with some technical capacity.

This does not mean that a country must have many resources in order to reform its mental health services. As this publication shows - and here is the second lesson to derive from the Latin America and Caribbean reforms - it is not true that mental health service reform is a luxury only attainable in developed countries. Any country can significantly improve its mental health services if it includes this goal among its public health priorities and successfully ensures that those factors that experience has shown to be essential are present. Clearly, countries with more

resources and greater critical mass—Brazil and Chile, in Latin America and the Caribbean, for example—can more easily implement ambitious national policies. But significant reforms can also be achieved in countries with fewer resources, as long as strong political support for mental health reform exists: as it happened, for example, with the reform in Cuba that integrated mental health care into primary health care, or with the reforms in Río Negro or the state of Hidalgo in creating community-based systems.

Based on the Latin American and Caribbean experiences, what are the essential ingredients for successful reforms?

First, there must be a mental health plan or, at least, a policy that defines priorities in the organization of mental health services. A reform brings with it so many difficult changes that it is impossible to achieve without a clear definition of which are the top priorities and which are the strategies chosen to reach them. All the experiences included in this publication arose from the process of implementing a mental health policy: in some cases at the national level (Brazil, Chile, Cuba, Jamaica); in others, at the state or provincial level (Hidalgo, Río Negro).

Second, there must be a mental health unit in charge of coordinating the implementation of the new plan. This unit, usually part of the ministry of health, can operate under various names, such as the directorate of mental health services, the mental health unit, or the coordinating office of mental health reform. What is important is not its name, however, but the functions it performs, the authority that it has, and the technical capability of its team. It can be said that the closer to political power and the greater the authority over operation of services, the greater is the capacity of these units to effectively coordinate the reform. All the countries that succeeded in making significant progress in improving mental health care in Latin America and the Caribbean had mental health units within the ministry of health overseeing coordination of the transformation process.

Establishment of strong alliances with various stakeholders involved in mental health reform proved to be another key factor. In all the experiences described in this publication, we find alliances of different types, with other health services, with social care, with representatives of patients and family members, with the justice sector, etc. In countries where the reforms had national-level impact (for example, in Brazil, Chile and Cuba), the reform processes occurred during periods of intense social and political change, and they succeeded in mobilizing support from several social groups that proved to be key allies. Lack of support or opposition from important groups (for example, from academic psychiatry) are, however, factors that could hinder the implementation of mental health reform. A significant risk in separating those responsible for the mental health reform from the hospital sector is that two parallel systems can be created: on the one hand, community services that are separate from the general hospital and research centers; and on the other, hospital and academic services that are separate from the community and are reduced to a strictly biomedical approach. The experiences in Latin America and the Caribbean show that the best way to avoid this risk is to establish bridges between the two parts and, as much as possible, to base discussions of major reform issues on scientific evidence.

In recent years, the need for changing the structure of mental health services has been increasingly acknowledged by all parties. Thanks to advances in psychiatric epidemiology and to contributions from studies on the burden of mental illnesses, it was possible to prove the high prevalence of mental disorders and show that the burden of these diseases has been seriously underestimated (*10*). All this information, widely disseminated through 2001 initiatives dedicated to mental health, made it much easier to argue in favor of improving mental health care. Research on mental health services, in turn, has greatly increased our knowledge on the effectiveness of the different types of services and their costs. In Latin America and the Caribbean, however, much

remains to be done in this regard. Data must be gathered to more comprehensively show political decision-makers and the general public the advantages of and urgent need for mental health service reform. Data on the burden of mental disorders proved to be a powerful instrument in defense of reforms. Now it is important to obtain new and updated data to show even more clearly the costs resulting from these disorders in Latin American and Caribbean countries and prove that it is worthwhile to invest in implementing new services. Such data can only be obtained, however, if research on mental health, particularly research on services, is seriously pursued and gathered in the countries of the Region.

One of the most important contributions of the Latin American and Caribbean reform efforts has to do with using the human rights of mentally ill persons as a critical tool to improve services (*8*, *11*). The connection between reform of services and defense of human rights was already clearly articulated in the Caracas Declaration, a fact that facilitated the development of new mental health laws in many Latin American and Caribbean countries. Establishing new laws has been a key instrument in creating consensus and mobilizing society in favor of reforms. A good example of such a process is the one that occurred in Brazil, which led to the passing of the current legislation.

Mental health service reforms in Latin America and the Caribbean have received various kinds of international support. PAHO helped sponsor the Caracas Conference, where representatives from several international organizations that provide technical assistance on mental health issues to Latin American and Caribbean countries participated, mainly from Spain and Italy. One of the most innovative aspects of the Initiative for the Restructuring of Psychiatric Care in Latin America was PAHO's decision to assign a consultant to each reform initiative, in order to ensure regular technical support in the reform implementation process. Initially, these consultants were experts with direct experience in implementing reforms in European countries (especially in Spain, Italy, and the United Kingdom). With the passage of time, however, this consultancy began increasingly to be performed by consultants from Latin America and the Caribbean with experience in improving mental health services. In recent years, PAHO began to favor the promotion of subregional initiatives, in order to take advantage of potential collaboration between neighboring countries.

The balance of the various international cooperation activities in Latin America and the Caribbean shows that this is clearly an extremely useful factor in implementing mental health service reforms in developing countries, especially those in the initial phases of reform. International cooperation facilitates the dissemination of relevant information on reforms and strengthens those groups that struggle to improve mental health care and defend the human rights of people with mental health problems in each country. International cooperation also can play a key role in strengthening the capabilities of reform coordinators, in providing technical support for implementing plans and programs, and in supporting research projects.

A reform's success, as shown by the experiences described in this publication, depends, in the final analysis, on the creativity and the initiative of those who live in the country where it occurs. International cooperation, however, is often the outside assistance that, at just the right moment, comes to support efforts for change and to promote the technical capability that today is indispensable for a successful mental health service reform.

—*José Miguel Caldas de Almeida*

References

1. González Uzcátegui R. Salud mental en la comunidad en América Latina. Ejemplo de Programas. In: Levav I, ed. Temas de salud mental en la comunidad. Washington, DC: Organización Panamericana de la Salud; 1992: 291-312.

2. González Uzcátegui R, Levav I, eds. Reestructuración de la atención psiquiátrica: bases conceptuales y guías para su implementación. Washington, DC: Organización Panamericana de la Salud; 1991.

3. Levav I, González Uzcátegui. Las raíces de la declaración de Caracas. Proceedings of the Regional Conference on Mental Health Reform: 15 years after Caracas Declaration, Brasília, 5-8 November, 2005. Washington, DC: Pan American Health Organization (in press).

4. Alves D, Valentini W. Mental health policy in Brazil: from dictatorship to democrac*y*. In: Morral P, Hazelton M, eds. Mental Health Global Policies and Human Rights. London: Whurr Publishers; 2003.

5. Andreoli SB, Ronchetti S de S, de Miranda AL, Bezerra CR, Magalhães CC, Martin D, Pinto RM. Utilization of community mental health services in the city of Santos, São Paulo, Brasil. Cad Saude Publica 2004 May-Jun;20(3):836-44.

6. World Health Organization. World Health Report 2001. Mental Health: New understanding, new hope. Geneva: WHO; 2001.

7. Organización Panamericana de la Salud. Salud mental en América Central. Documentación del Foro de Políticas de Salud Mental de los Países Centroamericanos, México y el Caribe Hispano. Washington, DC: OPS; 2004. (Documento OPS/THS/MH/01/04).

8. Hillman A. Protecting mental disability rights: a success story in the Interamerican Human Rights System. Human Right Brief 2005;12:25-8.

9. Caldas de Almeida JM. Technical cooperation strategies of the Pan American Health Organization in the new phase of mental health services reform in Latin America and the Caribbean. Panamerican Journal of Public Health 2005 Oct-Nov; 18(4-5):314-26.

10. Kohn R, Levav I, Caldas de Almeida JM, Vicente B, Andrade L, Caraveo Anduaga J, et al. Trastornos mentales en América Latina y el Caribe: una prioridad de salud pública. Rev Panam Salud Publica 2005 Oct-Nov;18(4-5): 229-40.

11. Vásquez J, Caldas de Almeida JM. Salud mental y derechos humanos. Atopos 2004;2:45-56.

ARGENTINA:
WAVING THE MENTAL HEALTH REVOLUTION BANNER—PSYCHIATRIC REFORM AND COMMUNITY MENTAL HEALTH IN THE PROVINCE OF RÍO NEGRO

Pamela Y. Collins, MD[1]

> *This whole process has taught us that you can leave the asylum as is or you must close it. There are no in-betweens such as open-door [hospitals] or therapeutic communities. If you leave [the asylum], intending to reform it later, that structure once again begins to "institutionalize." Because of that, you either leave the asylum as is or you must destroy it. We opted to destroy it.[2]*

On Sunday, August 24, 2003, one week before provincial gubernatorial elections were to be held in Río Negro, an article reporting the Minister of Health's questioning of the health plan appeared in *La Mañana del Sur*, a regional newspaper published in the provincial capital, Viedma. The article described a speech the country's Minister of Health, Gines González García delivered to a large audience of professionals while accompanying the gubernatorial candidate of the Justicialista Party on the campaign trail. According to the article, the Minister "questioned the plan of deinstitutionalization that allowed the closure of health care facilities for severely ill patients." Although he did not comment on the province's health program overall, the Minister did elaborate on questions about the mental health system. He said, "I believe you have to have common sense. One must not be extremist and leave patients without attention and care. While institutions must not be prisons,...believing that patients can be cured in the city is a dogma 'based more on ideology than science.'"

The following day, the mood was somber in the office of the mental health team, as team members read the article and interpreted it as a criticism of the work and the ideology to which they were committed. How did mental health issues become a campaign priority in a sparsely populated province in Patagonia when, worldwide, mental health services have traditionally been the most neglected of all health services?

This chapter will attempt to address that question. First, it will describe the history of mental health services in Argentina as a whole and in the province of Río Negro specifically, as well as the context in which they were developed and currently function. Using observations from site visits throughout the province the text will illustrate program principles, innovations, and

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[1] Assistant Professor of Clinical Psychiatry, Department of Psychiatry, Columbia College of Physicians and Surgeons.

[2] Note: All translations have been done by the author.

challenges. Finally, the chapter will discuss the lessons that have emerged from Río Negro's experience and their relevance to the international mental health community.

MENTAL HEALTH SERVICES IN ARGENTINA: A BRIEF HISTORY

Argentina gained independence from Spain in 1816, but it would take another 40 years and decades of civil war before the leaders who envisioned a unified Argentina would emerge victorious. Fueled by the wealth of grain in its fertile central region, the country began to export grain and beef. This led to rapid economic growth and helped establish Argentina as the "granary of the world." European immigrants poured into the country, seeking new opportunities, and they shaped the character of the nation.

Historians of psychiatric services in Argentina link the flood of immigrants and the nation's increasing wealth to the development of mental health services. Mariano Plotkin suggests that as the immigrant population grew, an emerging group of new "economic and intellectual elites" threatened the traditional power structures when they established labor unions and brought new political ideas. In response, the State built institutions and enacted legislation that helped to establish a public health care system, which eventually ended up marginalizing certain sectors of the population, such as people with mental illness.

The psychiatric hospitals that the State established as early as the 1860s evolved into overpopulated and understaffed facilities. Care was inadequate and inmates were poorly nourished; families often were reluctant to send their relatives to these institutions for care. Human rights violations were the norm. Patients were admitted to and discharged from the hospital for psychiatric reasons, but admission to a hospital also had to do with a lack of legislation to protect vulnerable groups—the poor, recent immigrants, and the mentally ill. Psychiatrists recognized the problems in the asylum system, and attempts at reform began in the late 19th century, but meaningful and lasting reforms were elusive and would remain so over the next century.

Under Juan Perón's administration in the late 1940s and early 1950's, advocates of mental health reform within the government called for the "demolition of the old urban asylums" and the establishment of new acute-care facilities, outpatient clinics, and psychiatric services in general hospitals. Conditions did not improve substantially, however: in 1955, the national Neuropsychiatric Hospital for women had 223 patients and only 100 beds. The ousting of Perón by a military coup in 1955 ushered in a period of transformation of mental health services. The government established the National Institute of Mental Heath (INSM), whose goal was to provide "the mentally ill [with] the maximum opportunity for cure and reincorporation into society, or when this is not medically possible, to be housed in the best conditions for their rehabilitation and care." Over the next several years, INSM supported the establishment of psychiatric services in other general hospitals and opened a day hospital in Buenos Aires' men's hospital. Some of these settings had multidisciplinary treatment teams, and were well integrated with other services in the hospitals.

Radical psychoanalysts and psychiatrists established therapeutic communities and other socially conscious treatment experiments in the 1960s and 1970s. The writings of Thomas Szasz, Erving Goffman, David Cooper, and Franco Basaglia, which viewed mental hospitals as "agents of social control" likely influenced many leftist mental health professionals. Basaglia's vision and the development of a community-based psychiatry in Italy that gave priority to the reincorporation patients with their families and communities and included the individual's social context in the care, presaged later psychiatric reforms in Argentina. The conservative psychiatric

establishment, however, remained powerful, and professionals were polarized along political lines.

In the 1970s, during the presidency of Isabel Perón and the subsequent military dictatorship, the government attacked the field of mental health, persecuting providers and dismantling progressive treatment programs. Many therapeutic communities were closed, and the military assumed control of the administration of hospitals. Providers were arrested; some were murdered. By the end of the 1970s, aside from wealthy, conservative psychoanalysts in private practice, the traditional asylum remained the main option for care. An investigation conducted after the reestablishment of democracy in 1983 reported, "The 35,000 beds in psychiatric hospitals represent an unjustifiable *cronicario* (a place where patients stagnate and deteriorate), a punishment whose collective horror is difficult to imagine, and a flagrant violation of human rights.". In the 1990s, investigations in two hospitals near Buenos Aires revealed a record of abuses, including malnutrition and extremely high mortality rates. In the words of one observer, Argentina's psychiatric institutions were a place "where patients, lost to the outside world, simply…vanished behind asylum walls."

HISTORY OF RÍO NEGRO'S MENTAL HEALTH SERVICES

Río Negro is one of the northern provinces of Argentina's Patagonia region. The province extends 212,000 km², reaching from the Atlantic Ocean in the east to the Andes in the west. Some 600,000 people live in the province, concentrated in the cities of the northwest, along the southern border with the Andes, in and around the city of Bariloche, and, on the Atlantic coast, in and around Viedma, the capital. Much of the province is sparsely populated, and, outside of the northwest, vast distances separate the larger cities. The cultivation and export of fruits, especially apples and pears, contributes significantly to the economy, particularly in the north. In the province's southern region, ranching and livestock production are important sources of income. The mountains and lakes of the Andean cordillera attract large numbers of tourists.

Río Negro's current mental health program blossomed in the wake of Argentina's democratic resurgence in 1983. At that time, the national government began to develop new health policies, including a plan for mental health that focused on managing patients in psychiatric hospitals, creating therapeutic communities, and developing mental health services in general hospitals. Although competing national priorities related to reconstruction after the dictatorship generally stymied reforms, the plans for mental health care in Río Negro advanced further in this process, for several reasons (Hugo Cohen, personal communication). First, the National Director of Mental Health, Dr. Vicente Galli, supported Río Negro's efforts. Further, the absence of a medical school and an attendant power base of conservative mental health professionals, the new sensitivity to human rights after the dictatorship, the province's sparse population, and the long distance from the capital may have worked together to permit large-scale reform to proceed with little opposition.

The energy behind the psychiatric reform movement in Río Negro is generally attributed to Dr. Hugo Cohen, a psychiatrist and the founder of the current mental health program in the province. Cohen completed his residency training in psychiatry in 1984 at the Hospital de Lanús in Buenos Aires—a site renowned for the successful integration of psychiatry into the general hospital. He was a politically active chief resident who founded and led a large national organization of medical residents (Comisión Nacional De Médicos Residentes, CONAMER) during the dictatorship, serving the needs of about 5,000 trainees and enduring all of the risks

connected with such a position. Cohen also worked with the country's Ministry of Health in the new democracy to revise the training curriculum for psychiatric residents.

Dr. Juan Pablo Abadie, advisor to the National Mental Health Director, offered him the position as Chief of Mental Health in the province of Río Negro. Cohen arrived in Río Negro in May 1985, and became the first director to take responsibility for mental health in the province from *within* the provincial ministry of health; a psychiatrist colleague directed the psychiatric hospital, the Neuropsiquiátrico de Allen. Traditionally, the provincial director of mental health had also served as the director of the psychiatric hospital. The separation of the post from the hospital paved the way to consider the provision of mental health care as more complex than hospital-based care. Ultimately this separation permitted the asylum to be marginalized and alternative mental health care modes to be developed.

Cohen began to develop the first course in public mental health in Córdoba University. The course focused on mental health services administration and mental health policy and was used to train personnel to administer mental health programs.

Under Cohen's leadership, and with the collaboration of many colleagues, two major events changed the character of mental health services in Río Negro. The first was the closure in 1988 of the province's only public psychiatric hospital, the Neuropsiquiátrico de Allen, which employed 54 of the 64 mental health workers in the province. The process of closure occurred gradually. As human rights concerns gained prominence in mental health at the end of the dictatorship, professionals in Río Negro began to re-evaluate asylum-based care and the traditional management of patients. Two significant meetings of mental health care providers in 1984 and 1985 led to concrete efforts to form mental health teams with coordinators in each administrative zone of the province in anticipation of the hospital's closing. Once the groundwork had been laid for providing outpatient care, the process of discharging patients from Allen proceeded in earnest, and beds for psychiatric patients were opened in general hospitals around the province. As in other parts of the country, the traditional psychiatric establishment resisted these changes.

The second major reform was the passage of the Law 2440, the Law for Health and Social Promotion of Persons with Mental Disorders (Ley de Promoción Sanitaria y Social de Las Personas que Padecen Sufrimiento Mental), which was presented to the provincial legislature in 1989 and passed in 1991. Advocates viewed the law as one of the greatest accomplishments of the mental health reform movement in Río Negro, although it also was controversial. The legislation's first article delineated the goals of the provincial mental health program: "The province promotes a health system that, in considering the person as a whole, guarantees the treatment and rehabilitation of people of any age who suffer from a mental disorder." It went on to state, "The restoration of the identity, dignity and respect of a person with mental disorder, expressed in terms of his or her reintegration into his community, constitute the ultimate goal of this Law…." The law required all providers (public and private) to conform to its principles.

The law's second section outlined the activities of the mental health team and the role of others (e.g., the courts) who were instrumental in treating and rehabilitating people with mental disorders. The law included families, friends, and neighbors as critical participants in the person's recovery, but also called for creation of intermediate or transitional facilities for care. These facilities included halfway houses or hostels (*casas de medio camino; hostales*) for users of mental health services that had no home or who were in need of shelter, and housing for users who had committed homicides or other serious crimes or who were not competent to stand trial (*casas inimputables*). The program limited lodging in halfway houses and hostels to 15 days, at which time the user's situation could be reevaluated and residence extended. These spaces did not exist at the time of the hospital closure; many communities still lack them.

Perhaps the most controversial aspect of Law 2440 was the banning of public or private asylums that did not comply with the law. According to the law, admission to any psychiatric facility should occur only as a last therapeutic option. When admission was absolutely necessary, the goal of admission must ultimately be to reincorporate the person into his or her community. Psychologists and psychiatrists in private practice had to collaborate with the provincial mental health program whenever their patients needed admission to a general hospital, as the law mandated. Proponents of the law saw this as progress: the law protected people with mental illness from the potential abuses of the asylum and from the alienation of long admissions. Opponents of the law viewed this measure as an extreme and potentially dangerous removal of orthodox psychiatric treatment. In short, the psychiatric care that the medical establishment was most familiar with had been forbidden. The hospital's closure forced the medical community and the population at large to confront or support people with serious mental illness. In doing so, the psychiatric hospital as *cronicario* had been forbidden, but the law also removed the familiar safety net of long-term inpatient care for the psychiatric patient.

THE CURRENT CONTEXT OF MENTAL HEALTH SERVICES
At the National Level

Although other provinces have pursued their own mental health reforms in the last two decades, most public mental health services in Argentina remain hospital-based. Taxes, social insurance, private insurance, and out-of-pocket payments finance mental health costs. The country's mental health program and policy date to 1957 and focus on mental health promotion, prevention of mental illness, treatment, and rehabilitation. In practice, the national plan does not appear to carry much weight. Provinces exercise the right to determine their own health priorities, and resources allocated to mental health care differ from province to province. The structure of services (including the presence or absence of services) varies widely. Both the province and the city of Buenos Aires have a strong hospital presence mixed with community mental health services. People with mental health problems can access care in outpatient programs or private practices, through psychiatric services in general hospitals, or in psychiatric hospitals. Private services abound. In the mid-1990s, 1 of every 200 Buenos Aires residents was a psychologist in the mid-1990s. The abundance of private and public services diminishes as one leaves the Buenos Aires. Other provinces, such as Neuquen, though equipped with inpatient psychiatric beds in the general hospital, historically have not had any large psychiatric hospitals. Santiago del Estero, Tierra del Fuego, and Salta lacked public mental health programs at the time of this writing.

At the time of the current study, a new national mental health plan had been drafted and was being revised. The draft plan identified the goal of mental health services as facilitating general well-being and improved quality of life for all members of society. Using language reminiscent of Río Negro's Law 2440, the writers of the plan recognized that current socioeconomic problems in the country contributed to mental suffering, as evidenced by high rates of alcoholism, domestic violence, and risk behaviors among adolescents. They also acknowledged that mental health care that centered on being admitted to the asylum, where patients were isolated from family and friends and could suffer from human rights abuses, did not promote health. At the same time, the plan's drafters agreed that outpatient care in overly crowded primary care services did not adequately meet the needs of people with mental illness.

National mental health leaders considered the lack of national statistics as a critical deficit if services were to be developed in accord with demand for care. The plan proposed to develop epidemiologic surveillance of mental disorders, a national mental health law, and the promotion of strategies for primary mental health care. Other priorities included placing mental health in the

public policy agenda, promoting cost-effective interventions, developing community-based programs, and extending the reach of psychiatric reforms that involved deinstitutionalization and reincorporation of people with chronic mental illness into their communities.

In Río Negro Province

The author visited the province of Río Negro in August of 2003. The trip was organized by the Pan American Health Organization and the directors of Río Negro's mental health program in Río Negro, Lic. (a university-trained psychologist who does not have a doctorate) Daniel Bikauskas and Dr. Alberto Lucio, who made arrangements for and accompanied the author on a two week tour of selected mental health teams throughout the province. All interviews and conversations were conducted in Spanish. Many hundreds of km were covered in the course of the visits, eight services were visited, and meetings were held with staff from 10 of the of the province's 20 mental health teams.

Argentina's new president at the time, Nestor Kirchner, had been in office for only three months. Kirchner represented the country's new hope after the financial and political turmoil of the preceding few years, when the government defaulted on its IMF loans; the currency—once tied to the US dollar—was devalued; millions of people lost savings, pensions, and jobs; and half of the population plunged into poverty. The severe economic crisis led to high rates of unemployment, decreased resources for mental health services, and increased social problems that mental health providers were often called upon to address. Some of the towns we visited had witnessed looting and violence at the height of the chaos. The demand for public mental health services grew in many places as the population suffered from anxiety and depression. Families who formerly paid for private services could no longer afford them. By August of 2003, high unemployment rates persisted in most of the communities we visited.

For provincial employees, the financial crisis led to reduced salaries and resources: less access to telephones and e-mail, and shortages of paper, pens, medication, and gasoline. The community-based mental health services had retreated to the general hospitals in some settings. Given the instability of all the public institutions, establishing collaborative projects with other institutions in the community became much more difficult. Team members sometimes felt discouraged by the incessant socioeconomic troubles that they saw as the root of many mental health problems.

Río Negro was preparing for provincial elections at the end of August. Supporters of Law 2440 awaited the outcome somewhat anxiously. The incumbent party, the Radical Party, remained in favor of the law, but supporters viewed the opposing Justicialista Party as a threat to the survival of the law and the reforms, as seen in this chapter's opening paragraphs. There was a sense that the program's existence was precarious, partly because maternal and child health and nutrition had become greater priorities at the Ministry level since the economic crisis. In addition, professionals could interfere with the smooth functioning of the program. An unsympathetic judge (required to discharge involuntarily admitted patients even from general hospital wards) could easily thwart efforts to treat patients in the community by not permitting discharge from a hospital ward. Other medical professionals, on whom the program relied in general hospitals, could either ease or stress the relationship of the mental health team with medical staff by helping to manage psychiatric patients or by neglecting them. As a hospital administrator explained,

> *The program has many enemies. The problem is that the law is a cutting-edge law. You encounter resistance from the fact that it's new and progressive and not everyone in the government understands its philosophy, and they don't agree…There's no commitment from the province and*

the government to help sustain this law. These [bridges] are hard to cross…The banner of the revolution of mental health is flagging.

The program had many critics. They claimed that the hospital closure had occurred precipitously, without adequately preparing the community and other health care facilities. They asserted that families had not been prepared to receive their relatives, and that some users found themselves on the street. Others believed the program lacked a clear model of care, and they attributed this to the absence of a unified plan from the central administrative team. They said that each team operated independently, that the providers were insufficiently trained, and, as had the Minister, they asserted that the program was based on ideology rather than evidence. Provincial reforms were frequently compared with Italy's mental health reforms, which led to the passing of Public Law No. 180, which legislated community-based mental health services. A criticism frequently directed at the program was that deinstitutionalization might work in settings with ample resources, but not in poor settings such as Río Negro. The mental health program would not be able to fully comply with Law 2440, because the province lacked resources (and perhaps the political will) to provide transitional living facilities, hire adequate staff, and support enough rehabilitation and income-generating projects.

Staunch reform supporters acknowledged the need for the ongoing development of services, but had little patience for criticism of the process. One provider commented,

I've heard criticism that the law works, but it's difficult to implement. They say it's pretentious, that there are no resources. Then you could question the Constitution as pretentious because it guarantees education, health. The law is a tool. We use it to prioritize the intersectoral work we do….

Principles

The mental health program based its activities on a central aim: "[to restore] the identity, dignity, and respect of the person suffering from a mental disorder." The program's multiple goals were consistent with this aim and were as follows: to recover the individual's personal resources for health, to work in the context in which emotional crises are produced and have meaning, to work in an interdisciplinary team in the general hospital, to foster community participation, to ensure that therapeutic activities promote, in every way possible, the protection of the civil rights and needs of the person, to use admission to the hospital as a last therapeutic resource, to reintegrate the patient into the community after discharge, and, ultimately, to modify the social representation of insanity. Mental health services firmly rooted in the community, as prescribed by Law 2440, constituted the best way to achieve these goals.

Recruitment. Río Negro's mental health program attracted psychologists, social workers, and, to a lesser degree, psychiatrists from other parts of the country who sought a work environment that prioritized community mental health within a provincial health system. Likewise, the program's directors attempted to recruit employees who shared the values that underpinned the program. However, as employment opportunities diminished over time, mental health professionals sought work in Río Negro for survival, and they did not always share the program's ideology. Some teams experienced friction as newer colleagues entered and expressed opposing views about care and rehabilitation. Senior providers often linked their commitment to the mental health program to their identity as militants and to their personal experiences of suffering during the military dictatorship.

The residency in community mental health was an innovation that aided recruitment. The residency program admitted doctors, nurses, psychologists, and social workers, training them in the establishment of community mental health services and in the implementation of the goals of the provincial program. In the first year of the residency, participants learned to conduct a study of the community and to arrive at a "diagnosis" of mental health problems in the setting. In subsequent years, residents worked in the targeted communities to implement interventions. The residency served as a pool from which new provincial mental health employees could be drawn. In 2003, residents trained with nine of the twenty mental health teams.

Language, medicine, and stigma. The program used language carefully in documents that described the services in an effort to de-medicalize and de-stigmatize their activities. Patients were referred to as users (*usuarios*). In the past, the program avoided the use of diagnoses. They viewed diagnostic guides, such as the American Psychiatric Association's Diagnostic and Statistical Manual, 4th Edition, as tools misused by many mainstream psychiatrists to justify institutionalizing patients. Since DSM-IV diagnostic criteria linked certain diagnoses to chronic manifestations of the conditions, doctors who used these criteria were likely to expect (and possibly facilitate) chronic illness in their patients. In the early days of the program, the term "mental suffering" was used in lieu of a diagnosis. The rationale was that everyone experienced "mental suffering" at particular times, so people with mental illness were no different from everyone else. Similarly, providers used the term "crisis" for acute episodes of illness to reflect the fact that everyone had emotional crises from time to time. However, conflicts had arisen, even among members of the mental health team, from the lack of a use of standard psychiatric diagnoses. A provider stated, "We're very good at social problems, etc. I believe we also need the medical diagnoses. Otherwise how can we make a plan? How can we talk about the patient? These [diagnostic] systems are universal. Anyone knows what I'm talking about when I use them**."**

The province did, in fact, loosen its insistence on avoiding psychiatric diagnoses. Provincial mental health directors recognized that they would be better positioned to evaluate their services and share their experiences with national and international mental health communities if they used one of the accepted diagnostic systems. They worked with a Chilean epidemiologist to develop a simple system of coding based on the ICD-10 diagnostic categories. While the coding is used for the purposes of documentation, the old ideas about diagnoses linger. Language also served to counteract ingrained professional hierarchies. To remove distinctions between professionals, the program used the term "mental health worker" to refer to all providers in the province.

Team and hierarchy. The multidisciplinary treatment teams formed the core of the service. These teams comprised psychiatrists, psychologists, social workers, community mental health residents, and *operadores*, lay health workers from the community with specialized training in mental health and who often have other expertise, such as being an artist or craftsperson, or personal experience with addiction. Teamwork highlighted the unique contribution of each professional and minimized professional hierarchies. Discord arose when team members could not relinquish the indoctrination of their disciplinary training. In fact, most of the professional team members faced the conflict between their training in specific schools of psychology—very often psychoanalytic—and the mental health services provided in the province. Indeed, several team members viewed faithfulness to professional hierarchies and identities as a primary obstacle to mental health reform in Argentina.

Structure of the Services

Río Negro is divided into public health zones that roughly correspond to the province's six geographical regions. Distributed throughout these zones are 28 hospitals that are linked to 178 peripheral health centers; 20 hospitals have mental health teams. One hundred and fifty-six providers, based at the 20 hospitals, worked for the mental health program (Table 1).

The program's central administrative team (CAT) operated from offices at the provincial ministry of health in Viedma. The program had an administrative division, a research division, and a division of mental health promotion. Daniel Bikauskas, a psychologist, led the team. Dr. Alberto Lucio, a psychiatrist, was the Coordinator of Mental Health Promotion. Bikauskas reported to the Director of Epidemiology and Health Promotion. The CAT also included a sociologist who oversees the research division, an educational psychologist who oversees mental health promotion activities, the chief resident of the residency in community mental health, and an office administrator.

The CAT communicated with hospital directors and chiefs of mental health services for the 20 mental health teams in the province. Chiefs were usually psychologists, sometimes psychiatrists, and they directed teams ranging from 1 to 26 mental health workers. Teams were based in local hospitals, but staff also worked in users' homes and in peripheral health centers. In addition, they collaborated with community-based organizations and municipal government sectors in order to provide comprehensive services. Teams met annually to discuss their experiences, solve problems, and try to increase the effectiveness of services. In 2003, the teams developed a system to more systematically document the services that they provided in inpatient and outpatient clinical settings and in the community.

Private Mental Health Services

There were private mental health services in Río Negro, and some part-time employees of the provincial mental health program also worked in private practice. A psychologist from the small town of Catriel explained that she was able to maintain a private practice because most of the members of her community were employed by petroleum companies and thus had health insurance that partially covered the cost of private care.

In addition, two private mental health facilities in the province—the *Clínica Psiquátrica* and a residential facility (*hostal*) in the city of General Roca—provided a total of 80 beds and one lock-down unit. The town of Cipolleti also had four apartments that each housed two-to-three people with mental illness. The provincial mental health team (and private practitioners) could refer users to these facilities if the users were able to pay for them.

Budget

The mental health program does not have its own budget; it receives funds from the provincial health budget based on demand. The annual health budget for the province in 2003 was $108,474,295[3]. The country's Ministry of Health provides nine fellowships to support professionals entering the community mental health residency program, and the province supplements this funding. In the past 10 years, the program also has received external funding from the Friuli Venecia Julia region of Italy, as well as training and other materials from PAHO/WHO for the development of social enterprises (*empresas sociales*), one of the program's rehabilitation projects that allows people with mental illness to form income-generating enterprises.

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[3] Amount (in Argentine pesos) provided by Río Negro Province's Department of Mental Health.

Budget allocations for the mental health program did not adequately meet the needs of the services. Teams operated with insufficient funds for telephone service and fuel, and with unstable supplies of medications. Employees sometimes used their own vehicles and petrol to visit users at home.

TABLE 1. Mental health teams in Río Negro's general hospitals.

Cities	Nurses	*Operadores*	Admin.	Social workers	Educational psychol.	Psychiatrist	Psychol.	Residents	Sociol.	Total
Viedma	2	13	1		2	3	6	3		30
Sierra Grande							2	2		4
S.A. Oeste		1				1	3			5
Valcheta		2					1			3
Gral. Conesa							2			2
Río Colorado		1					4	2		7
Choele Choel		1				1	2	3		7
Chimpay							1			1
Lamarque		1					2			3
Villa Regina		3				1	4	5		13
Ing. Huergo						1	1			2
Gral. Roca		13				1	5			19
Allen	6						2			8
Cipolletti		3		1		2	3			9
Cinco Saltos		5					3	3		11
Catriel							2			2
S.C.Bariloche		9	1			4	7			21
El Bolsón		5				2	3	2		12
Ing. Jacobacci							3	2		5
Maquinchao		1					1			2
Los Menucos				1			1			2
Guardia Mitre							1			1
Luis Beltrán							1			1
Depto. S. M.			1		1	1	1	1	1	6
Total	8	58	3	2	3	17	61	23	1	176

Despite the limited resources, a new service was initiated in early 2003, bringing the total number of teams to 20. When a city identified a need for services, local officials could begin the process to secure services. Communities that were able to demonstrate a demand, could formally request the services, and the head of the program would discuss the request with the state's Secretary of Health. If funds were approved, a new mental health service was launched. Justifying the need for these funds could be difficult, since sections of the province still lacked primary care services.

Pathways to Care
People in need of mental health services could gain access to care through hospital-based emergency rooms, through referrals from primary care doctors or nurses, or by directly requesting an appointment with the mental health team at a peripheral clinic or at the general hospital. At the time of this writing, the province did not have data that reported on pathways to care. In the event of a crisis, a family member or the police could escort a person with acute

psychiatric symptoms to the emergency room of the general hospital. The nurse or physician on duty would then notify the mental health professional (psychiatrist, psychologist, or social worker) on call. In non-crisis situations, nurses in the peripheral primary care clinics who suspected a mental health problem in a patient referred individuals or families to the mental health worker who served the clinic. Referrals were also made through the courts, the school system, or other community organizations. Community members also sought services directly at a team's office in the general hospital or in the peripheral health centers.

Once users contacted a provider, the mental health professional evaluated the social situation, the family, and the individual's symptoms, and developed a treatment plan. This could include a home admission (where the person is confined to the home, rather than the hospital, and the team makes home visits) or admission to the general hospital's medical ward. A departmental document explained that if the crisis was precipitated in part by socioeconomic or other problems in the person's environment, the relevant community institutions were called upon to participate in the intervention (e.g., social services or pension administration). After the crisis is resolved, the person could be referred to a therapeutic group, to individual therapy, or for psychopharmacological interventions at a community health center, their home, the hospital's outpatient mental health offices, or in a halfway house. The range of activities and services provided by the mental health teams is summarized in Table 2.

TABLE 2. Mental health activities.

A. Individual assistance	B. Group activities
- Psychopharmacology evaluation - Home care - Consultations - Evaluation interview - Individual consultation - Emergency interventions - Examinations and contacts for Administrative reasons	- Psychopharmacology groups - Substance use/Addiction groups - Evaluation group - Therapeutic groups
C. Institutional activities	D. Community activities
- Interdisciplinary and Intersectoral Activities - Training of the Mental Health Team - Mental Health Team Meeting - Teaching and assessment - Administrative Work - Referrals - Rounding in sites where there is no team	- Case management - Home visits - Cultural Promotion - Work Promotion - Social Promotion - Other interinstitutional activities - Promotion of self-help activities
E. Admission activities	
- Individual treatment - Consultations from other services - Emergency interventions - Rehabilitation activities - Examinations and contacts for administrative purposes - Accompaniment	

SITE VISITS

This section describes the site visits made to several mental health teams in the province, highlighting: 1) the structure and activities of a large mental health team, 2) the development of collaborative relationships with community organizations and local government, 3) issues dealing with the collaboration with medical staff, 4) the residency in community mental health, 5) access to medications, 6) community development and mental health activities in a small mental health team, and 7) innovative programs in behavioral medicine and community rehabilitation in El

Bolsón. Each summary is meant to provide a feeling for the challenges and the accomplishments providers face in their various settings.

The Viedma Team

Viedma, Río Negro's capital is a city of almost 48,000 persons. The city sits on the banks of the Río Negro, not far from the river's mouth at the Atlantic Ocean. Boats cross the river to the picturesque town of Carmen de Patagones in Buenos Aires Province.

The teams dispersed throughout the province varied in size but had similar service structure and activities; the Viedma team was an exception. Hospital Zatti, a 73-bed tertiary care hospital, occupied one square block in Viedma, a ten-minute walk from the provincial Ministry of Health. The recently renovated long, white bungalows were aligned in neat rows. The mental health team's office was located along a dark inner corridor on the ground floor. The office served as a meeting place for the Viedma team, and mental health users in the hospital stopped by freely to inquire after their discharge dates or to consult their providers.

Organization of Services: The Mental Health Team

Viedma's mental health team, one of the largest in the province, consisted of six psychologists, three psychiatrists, nine workers (*operadores*), one social worker, two educational psychologists, and three residents in community mental health. The chief of the hospital mental health service, Dr. Diana Jeréz, was a psychiatrist who had worked for 15 years in the province. As had many other mental health professionals, she had trained in Buenos Aires in a traditional psychiatric setting where treatment was centered in the psychiatric hospital. She explained that traditional psychiatric training led to narrow views of mental health and resistance to the community-based care in Río Negro. In her view, professionals often became so focused on determining a diagnosis and its implied prognosis that they could not recognize the user's potential for improvement. In fact, when an individual diagnosed with schizophrenia improved, the traditional provider questioned whether the person truly had schizophrenia.

Mental Health Activities

The service gave priority to the treatment of psychoses and addictions. On average, one or two people entered the mental health service system daily. In the hospital, mental health providers received eight or nine requests for consultations per day.

Inpatient Care. Admissions to the hospital typically occurred when a user decompensated and had no family to care for him or her outside of the hospital, when a user had conflicts with the family and needed a place to recover, when there was danger of self-harm, or for withdrawal syndromes. These admissions were usually brief. People with mental illness who were admitted to the hospital stayed on the general medical ward. Nursing staff on one side of the ward managed patients who required intensive, one-to-one nursing care. Less acutely ill patients inhabited the adjacent corridor, where one nurse cared for four patients, on average. Patients with psychiatric symptoms were admitted to this ward and cared for by the general medical nursing staff and the mental health team.

Outpatient Care. Team members visited the homes of users after discharge to administer medications and follow their progress. The team also conducted therapeutic group sessions and other rehabilitation activities. Psychologists led two family groups for adolescents. Three groups focused on addictions—one group met in the prison and two in the community. Another group

supported people with neuroses. The team also offered a children's group and a group for people with psychoses, along with a multi-family group for their relatives. Over the past few years, as the province witnessed increasing rates of substance abuse, the mental health team trained people to conduct self-help groups for persons with alcohol dependence. In accord with Law 2440, the Viedma team also provided a halfway house that catered primarily to people with psychotic disorders.

Challenges and Accomplishments

The Viedma team struggled to maintain cohesion. Newer members did not always share the program's values, and these differences created tension. One of the team members expressed his concerns about the provincial mental health services, and what he perceived as an insufficient response to certain kinds of severe psychoses. "There needs to be a middle ground. Some people continue to deteriorate all their lives. These are chronic illnesses. You can't cure them. What about human dignity?" He explained that people in the community did not like to see users urinating or defecating in the street. "They're not in an institution, but is this a life of human dignity?" WHO recommendations on mental health legislation and human rights state that "legislation should strike a fine balance between the individual's rights to liberty and dignity on the one hand and society's need for protection on the other". How and where to strike that balance were issues of contention in the Viedma team. The provider agreed that asylums were terrible places: "They're just warehouses. I know. I've seen them. The work [we do] in the community is good. I'm not here to denigrate the system or the work that people have done in the past, but each person needs to be evaluated separately and his needs taken into consideration."

Despite the tensions, the team worked with its multidisciplinary members in creative ways. Psychologists, as well as psychiatrists, slept in the hospital on overnight call and handled admissions and consultations in the emergency room and from other medical services. When a non-physician was on call for the mental health team, a designated primary care doctor in the hospital wrote the medication orders. This arrangement appeared to run smoothly.

Viedma's team was one of the few that organized and sustained an income-generating rehabilitation project for users. The program taught a small group of users to farm and to market the produce locally.

Community Collaborations: Successes in Choele Choel

A three-hour drive north of Viedma, through an expansive landscape covered with low-growing brush in muted shades of green, gray, and brown, lay the small town of Choele Choel, population 10, 832. The Choele hospital, a 52-bed facility, was at the center of the Valle Medio region. The hospital, a two-story white structure, sat on the central square amidst other municipal buildings.

Work in the community—both with individual users and with other sectors of city government—distinguished mental health care in Río Negro. In Choele Choel, the team and the city had mastered the art of intersectoral collaboration. This was evident one afternoon when meeting with the mayor and with representatives of the city government, the police, and the court system. Meeting participants discussed the ways in which municipal services collaborated with the mental health team. Many users of mental health services were poor, and the city helped to provide them with housing and jobs. The city also sponsored the distribution of food rations and, each weekday, a lunchtime food kitchen that served children 3–12 years old, people with mental illness, and pregnant women. On weekends, the hospital provided meals. Given the region's overall poverty, resources were scarce and housing, especially, remained a challenge.

Both city workers and the mental heath team agreed that the town had initially resisted the development of community mental health services. They recalled that doctors did not want to treat psychiatric patients. Medical teams immediately referred anyone with a history of mental health problems to the team, even if the current complaint was medical. A psychiatric user admitted to the hospital caused discomfort and chaos for the staff. Community members also were uncomfortable encountering visibly mentally ill people outside of the hospital. They described a citizen of the town who had been brought back from an asylum in another province to live in Río Negro.[4] The user had several psychotic episodes that were witnessed by residents, and many of them wanted the user returned to an institution. Instead, the team worked to discover how this individual could function productively in the community. The team psychiatrist, Dr. Hugo Reales, asked the user a critical question, "What sort of work can you do?" This opened the door to appropriate treatment and rehabilitation.

A woman from the mayor's office commented,

To me the Law [2440] seems fantastic. But even today this isn't everyone's opinion. Some have great resistance. For some of us, it's great. We try to work together. But there is still fear. This thing of what's going to happen with this mentally ill person in the street? It's the idea of danger. They are waiting for some patient to do something, so they can say, "I told you so"' It's the idea that if the patient had a crisis once, he will always be ill.

The intersectoral work required the training of staff in other institutions. The mental health team conducted workshops on human rights, professional ethics, and management of acutely ill users on the street, so that, for example, police were better able to handle users in crisis. The result was that police no longer carried disturbed citizens directly to the hospital, often taking the person home instead, and calling the team for an evaluation.

Similarly, the judicial system's management of mental health issues changed. The province enacted a domestic violence law, which required that a mental health evaluation be conducted on all victims of physical or emotional violence. In cases of domestic violence, the mental health team, the justice of the peace, and the police formed a network that developed a management strategy for each case. The mental health team also evaluated people who committed serious crimes. "We don't have mental health professionals in our system, so we rely on the mental health team," noted a court representative. Forensic psychologists worked only in the larger cities of Viedma, Bariloche, and General Roca.

Members of the team and city employees specifically talked about the need for more resources to adequately serve the community: shelters for battered women and resources to focus on prevention of mental illness and to sensitize community members to mental health issues. The focus on prevention went against the grain of community expectations. The group agreed that the community had become accustomed to specialized care rather than prevention. Those providers whose roles centered on prevention and mental health maintenance (usually the *operador*) faced the most criticism by outsiders. One psychologist commented on the *operadora*'s experience of criticism. "This happened …[when] she didn't go to the house with an injection or pill: she wasn't *treating* them."

The team struggled with a sense that their approach to mental health was not valued by the larger health care system. One worker explained that the health department was concerned

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[4] When Law 2440 was passed, mental health workers from Río Negro visited some of the neighboring provinces to bring home any patients known to be hospitalized in asylums there.

with productivity: the number of injections or the number of procedures performed. Mental health was, by comparison, a low-tech specialty in which providers spent many hours talking to users or their families and coordinating arrangements with social support services. As a result, mental health workers saw fewer patients. The team members felt pressured to more accurately document the various tasks they performed. A psychologist noted thoughtfully, "We need time in our work to reflect, to write. It's a problem of products. We do things that are valuable—we need to show it."

Despite their need for more human and material resources, the team members recognized the value of the intersectoral collaborations. "At the beginning of the services in Choele Choel," the team's chief, Lic. Yanina Bruno, explained, "We were few. If we didn't do the follow up [with users] no one did. We were responsible for the whole area. Now we have follow-up everyday. Now we can prevent crises. Before, crises came looking for us."

Collaboration with Medical Staff: Challenges and Successes

Whereas collaboration with community organizations and the city government was often a successful feature of the mental health team's work, the quality of relationships with other medical staff varied from site to site.

Río Colorado is a small town with a population of about 11,000 in the Valle Medio region, surrounded by small farms and orchards. The small mental health team, based at a 39-bed hospital, was notable for its cohesion and its positive relationships with the hospital-based medical team and the community providers.

The team set aside two rooms in the medical ward for mental health admissions. They relied a great deal on the family to fill the gaps in human resources. On the day of the visit, there was one patient with schizophrenia in the hospital. Family members hovered around the room, taking turns staying with their relative in the hospital, so that he had constant supervision and care. Fully aware of the low threshold for strained relationships with the nursing staff, when the family wasn't able to be present, a member of the mental health team stayed in order to keep the nursing staff from being burdened by the full responsibility of care.

Providers in the community health centers welcomed the mental health team. When asked about her opinion of the provincial mental health program, one nurse said, "I have not heard anything about problems with the [mental health] system. When I suggest mental health, people don't refuse." We talked about the fact that people in other provinces often were referred to psychiatric hospitals for treatment. She innocently asked, "But that couldn't be good for them, could it?" These providers rarely dealt with acutely ill patients, and they perceived the mental health team as accessible and responsive. The site visit included several of the health centers. In one community, the nurses explained that, initially, mental health services had been highly stigmatized. One of the nurses admitted that she herself had feared users, but eventually learned how to calm their anxieties as well as her own. The nurses at the center asserted that they now felt comfortable treating people with psychiatric disorders. If a problem arose they felt adequately supported. "We just call them [the mental health team] and they come. We resolve whatever issues arise." Typically, they did not witness mental health crises at the clinic because the families of users usually called the mental health team directly or took the family member to the hospital.

A nurse at another clinic described how she referred patients to mental health services. During a routine clinic visit a woman might refer to her husband, saying, "He's good except when he drinks." The nurse would probe, and as the woman gained confidence she shared more information about the relationship. A community health worker would visit the home to further assess the situation. The woman might reveal that she had been abused, or information gained

from the home visit might suggest a problem, and so the nurse and the community health worker would refer the woman for mental health evaluation. The health center team gathered for a weekly team meeting to decide how to approach such problems.

In general, community medical providers viewed the mental health teams more positively. Some clinicians on inpatient units resented the mental health service. In Villa Regina, a city in the Valle Medio, the head nurse on the medical unit complained about the care he and his colleague were forced to provide. "We are the ones who have to spend time with these patients." The other nurse elaborated, "You need people who are trained to work with these patients. They're different from patients with other problems. I don't feel adequately trained." Both agreed that they would prefer to see the mental health patients separated from the others, preferably in a separate mental health ward.

In Bariloche, a large Andean city on the shore of Lake Nahuel, the tertiary hospital admission wards were arranged by acuteness. There was an intensive care unit, an intermediate care ward, and minimum intensity ward reserved largely for patients preparing for discharge. Mental health patients were admitted to the minimum intensity ward when they were acutely ill. The arrangement fueled conflict with the nursing staff. A physician attempted to explain the relationship of the medical staff to mental health patients,

> The loco *bothers us. The patient looks physically fine. In general our training is with the patient lying in a bed who can't walk, doesn't talk. There are conflicts when mental health patients are admitted….There are no intermediate spaces, like the half-way house. We also do not have private psychiatric facilities.*

These spaces for patients described in the law were absent in Bariloche, and the hospital absorbed the need.

During visits with the team as they did their rounds, conflicts were apparent. The male pre-discharge ward was a large, bright room with blue and white walls. Low walls divided the room into three or four sections, and in each section, approximately six beds faced each other in rows of three. The far sections of the ward held beds for mental health users. In fact, of the 32 ward beds, mental health patients occupied 8. Of these, one patient with schizophrenia had been in the hospital for several weeks; two had been there for 15 years, and, due to their symptoms and their social situations, could not be discharged. Team members later explained that some admitted patients would be best served by a neurology service; however, there was no neurology service, so the mental health team assumed responsibility for them.

During rounds that began in the nursing office of the men's ward, a nurse soon interrupted the discussion of patients, and began to speak angrily:

> *There are two nurses on the ward and the mental patients come and stay….What should happen is that they come for 2–3 days for acute management and then get managed at home. They show up on the ward and no one comes to help—not the doctor, not the psychologist, nor the* operador. *I thought it was the job of the* operador *to accompany the patients. I don't know what her job is. I don't know what they do. They should be here….*

The nurse listed her complaints— that she must manage these psychiatric patients, that they occupied needed beds, and that she did not have help in managing them. She explained that she needed an endangerment leave (*licencia de peligrosidad*), leave granted to nurses working in stressful medical or surgical subspecialties. Nurses caring for psychiatric patients had been denied

the leave. The mental health program directors had requested the additional leave for the nursing staff and had always been turned down. The province responded that the hospitals were already working with only 60% of the normal nursing staff, so they could not afford to allow more leave.

A few of the Bariloche team members spoke about the angry ward nurse, expressing their own frustrations with providing services. One psychologist lamented the lack of financial resources for mental health services, but believed that the socioeconomic situation had to improve before anything else could improve. Other providers spoke about the ingredients of the mental health services that were missing locally, such as a halfway house. One commented, "We had a halfway house for a time, but lost it. We are missing these intermediate spaces…. We spend lots of time looking for things—time and more time. You find a place, they stop paying the rent. It's hard to find these spaces through which to integrate [users]."

The challenge of discharging users from the hospital was not solely determined by the availability of intermediate spaces. Involuntary admissions required a court order. An administrator explained, "Before, hospitals didn't have norms or criteria for admission. So, courts could order an admission. It was easy. There were no barriers." A judge's approval was also required for discharge, and discharges were sometimes delayed by this process. An example was given: If a user was admitted for an act of aggression, the judge ordered the admission, and the judge must grant the discharge. In order to be discharged the judge might ask the mental health care provider whether the person was at risk of repeating the act. If the provider could not assure the court that the person would not repeat the act, the person remained in the hospital. The lengthy admissions increased tension in the hospital and alienation of the mental health team.

Training the Next Generation: The Residency Program in Community Mental Health at Villa Regina

Villa Regina is a town of approximately 40,000 residents located in the Alto Valle. Lic. Ricardo Rojkind, a psychologist, directed the mental health team at the 60-bed hospital, a modern, five-story brick building.

The team trained a large number of community mental health residents. At the time of the visit, six residents worked in Villa Regina: five psychologists and one primary care doctor. The team began with one resident in 1996 and added one per year. Dr. Debora Jadzinsky, a psychiatrist, directed the training program. Residency training included both theoretical and clinical training. Residents attended classes twice a week, and during the remainder of the week they worked as clinicians within the mental health service.

First year residents functioned as *operadores*. They learned about the community, the health system, and how the team functioned. They learned to do a community-level diagnosis and they presented their findings in a written report. In the second year, residents worked in the same community to address the problems they identified during year one. During the third year they learned how to plan mental health services at the primary care level, secondary and tertiary care levels.

Residents admitted users to the service, provided individual therapy, and did consultations in the hospital. In their second year they began to manage patients on their own. Team members supervised residents, and the senior residents paired with junior residents to conduct therapy jointly. The three-year program prepared professionals to join one of the province's existing teams or to establish services in a new site. Selection into the residency was based on the subjective assessment of the applicant's ability to empathize, shared values about community mental health, personal traits, and objective performance on an exam.

Most of the residents had an interest in community mental health and had sought the specific training experience offered in Río Negro. The majority came from provinces where the asylum remained an important part of mental health services. Río Negro lacked resources and available positions to hire most of the residents upon completion of the program, but they believed the skills they acquired would be useful regardless. One psychologist explained, "There are lots of opportunities for work because we can go to NGOs, factories, anywhere." Others nodded their heads in agreement. They believed the broad training they received made them more marketable. Although other provinces did not have the same mental health system, their training would be valued.

The bulk of the treatment in Villa Regina is individual, and usually includes a form of psychotherapy and medication when indicated. Upon inquiring about the kinds of psychotherapy administered, it was unclear whether providers used formal therapies, solely supportive care, or offered counseling. A resident responded, "We listen to what our supervisors do. It depends on the user. Most of us have psychoanalytic training, [but] it's not appropriate here. We are free to choose the method of psychotherapy…. We have to do brief therapies, sometimes the treatment depends on time."

The residents and the author discussed a hypothetical case of a woman with severe depression, but no suicidal ideation. Such a woman would be evaluated in the office, and if she appeared well enough, would be sent home and asked to return the following day to continue the evaluation. In terms of medications, Dr. Jadzinsky said that fluoxetine, sertraline, and anaphranil were all options that would be considered, depending on whether the woman was anxious, not eating well, had disturbed sleep, or other medical problems.

When asked what happens during therapy, a resident replied, "Well, we'll chat to find out what's going on." When asked if they were aware of short-term psychotherapies such as interpersonal psychotherapy (IPT) that have been shown to be effective in reducing depressive symptoms, residents asserted that, although they were not familiar with that particular psychotherapy, they did focus on interpersonal issues in their therapy. The residency director added that they didn't use manuals or protocols for treatment; rather, they focused on how to mobilize social support for the user and, he explained, that much of their work involved reassuring users that the provider would be with them, that they wouldn't have to suffer alone.

Access to Medications: Financial Struggles and Temporary Solutions

In addition to psychotherapy, psychopharmacologic interventions were a mainstay of treatment, but at several sites lack of financial resources consistently challenged the team's ability to provide optimal care. For example, the hospital in Río Colorado functioned with a budget of US $2,000 per month. When funds arrived late, patients had to be referred to other hospitals, though at times the hospital also lacked money for gasoline to transport the patients. Medications also arrived irregularly. In 2002, medication costs increased after the peso's devaluation, and prices fluctuated widely. When the hospital pharmacy ran short of medications, a local pharmacy provided drugs and allowed the hospital to purchase them on credit. Costs were prohibitive. Whereas the hospital normally paid 17 pesos for a month's supply of haldol, the local pharmacy charged as much as 83 pesos. The fluctuating prices made it impossible to predict account balances. The hospital did manage to keep medication available for the emergency room, even if they could not do so for ambulatory care patients. In an effort to cut costs, in 2002 the government passed a generic drug law that required doctors to prescribe generic versions of drugs.

The mental health team responded to the constant threat of medication shortages in creative ways. Within the hospital, the team kept a supply of medications in a small office. In case

the hospital pharmacy ran out of drugs they had some on hand. In the event that this supply was exhausted, the team had access to a small box with samples from pharmaceutical companies, a crowded jumble of bubble-packed tablets and capsules. Although the providers joked as they showed me their supplies, the half-empty packets of picked-over pills testified to the gravity of the situation. Any unused drug could be valuable in a crisis situation that demanded medicine. They stored the backup supply in a shoebox, hidden and locked away separately from the other supply.

Team members in Villa Regina emphasized their willingness to use their own resources when money was tight. One provider commented, "One of the questions about the program is 'How do you do this without money?' We do it on our bicycles, we use our own cars." This commitment extended to procuring medications also. When the hospital pharmacy was short on medications, rather than referring patients to the municipality to seek help, they attempted to solve these problems, asserting that these were the team values.

Small Teams and the Broader Notion of Mental Health: Maquinchao

The village of Maquinchao lies along Línea Sur, the route through the cold, desolate desert that dominates the southern portion of Río Negro. The paved roads that carried travelers south from the Alto Valle and onto Línea Sur ended miles before Maquinchao, and gave way to gravel and dirt, slowing travel considerably. The author arrived at night. The outlines of houses, their simple angular profiles, square flat roofs were visible as they lined the broad dusty streets. An icy cold wind blew clouds of dust and debris and accentuated a sense of vulnerability and the loneliness of the surrounding countryside.

Maquinchao's population numbered approximately 2,700. As in many other remote villages in Patagonia, most of the community's professionals came from elsewhere in Argentina. Locally, unemployment was high—estimated at around 30%. Sheep farming employed the majority of residents, who participated in all aspects of the industry, from tending animals to preparing wool for sale. Sheep-raising set the rhythms of the community. Men left the region in the fall to take the flocks south to colder climates for the winter, and they returned in the spring to the warmer climate where the animals gave birth. Women remained in town with their children. Families were large and often isolated from one another by long distances. The harsh climate hampered travel. During the long winters families concentrated on finding fuel for heat and keeping adequate food supplies on hand.

The mental health team was new to Maquinchao, and consisted solely of the chief, Lic. Marcela Salgado, a psychologist who arrived in January, 2003. She based the service at the small, 28-bed general hospital, but focused most of her energies on collaborative activities in the community with the city and local agencies.

The visit included making a call on a greenhouse project that the mental health team had developed. On a plot of land adjacent to the hospital stood a structure supported by wooden beams and covered with heavy plastic. Inside, a vegetable garden had been planted. Behind this structure sat mounds of manure mixed with straw and soil. A Mapuche official had secured earthworms to produce fertilizer to create rich dark soil. The sandy, gray, dry soil of the region did not support many crops. Salgado and others viewed the project as a means to provide users with a useful skill and raise income generating crops. The income would be used to buy clothes, medicines, and other necessities for users seeking care at the hospital. Ultimately, she hoped to include this initiative as a project part of a federal program that provided a small subsidy to heads of households. The plan required recipients to put in at least four hours per day of work

accompanied by skills training. Salgado guided us to other agricultural projects in the community that she hoped to help expand and sustain.

How did community projects begin? What was the role of the community in initiating these projects? The mental health service itself provided an example. The justice of the peace found himself repeatedly managing cases of domestic violence. He understood that the town needed a psychologist to help meet the needs battered women. After six women with the same problem sought his help, he decided to act. Similarly, town officials felt ill-equipped to adequately address the problem of alcoholism. They wanted a mental health professional to assist. The justice of the peace and the hospital's director addressed a letter to the mental health program in Viedma, requesting that a provider be sent. Bikauskas and Lucio secured funds from the province; in January 2003, Salgado arrived. Prior to her arrival, they referred people to the mental health team in the town of Jacobacci—approximately two hours away. The team from Jacobacci made regularly scheduled rounds every few weeks to see mental health users.

Interestingly, the concern about lack of mental health services arose from community leaders, rather than from the community members themselves. A group of leaders explained that one of the difficulties in working in Maquinchao was the community's reticence. A local development expert explained this cultural trait in terms of the long history of exploitation and submission of the Mapuche people (one of the indigenous groups in the region). The expert said,

> *People are dispersed. Working together as a group is not usually done. There is also a lot of distrust for outsiders. People have been deceived by outsiders. Mapuche communities are now mixed in with the others. They say whites took everything and left them with nothing. Legally, they're still trying to resolve this. Whites are still considered dangerous. There's a history of exploitation.*

Health care professionals and others came from the outside, developed relationships, and typically left after four or five years. "It's an abandonment," commented another member of the group.

The question of how to involve local folks in solving social problems arose again with respect to the above-mentioned greenhouse project. Salgado explained, "When we started this greenhouse project with a few people from the alcoholism group and a few chronic patients, the community really wasn't interested. They watched to see what was going to happen. Gradually, they came a little closer." She noted that the community's experiences had led to an expectation of negative outcomes or failure. Emblematic of the lack of community cohesion, there were no shared spaces in the community, not even a public space for athletics.

I asked Marcela Salgado about her objectives for the mental health program. She replied without hesitation: "Reintegration into the work force and social integration. I'd like to develop this approach of working as a group—helping people see how they can accomplish things if they work together."

Innovations in El Bolsón: Behavioral Medicine and Rehabilitation in the Community

The author traveled from Maquinchao to the town of Jacobacci, and then on well before sunrise to make the six-hour journey to El Bolsón. The trip shortly reached the foothills of the Andes, and gradually climbed into pine-covered mountains. Snow had fallen that morning, and the scenery was stunningly beautiful. The road was again paved with asphalt signs of tourism began to be seen: Swiss-style inns and log cabin shops selling local preserves. The destination—El Bolsón, population 16,187—had been reached.

Dr. Analia Broide, the team leader, was a psychiatrist who arrived in El Bolsón in 1979, fleeing the perils of the dictatorship. There was no mental health service when she arrived, and she worked with the gynecology service. In 1982, Broide began to divide her time between mental health and gynecology. She took calls with the primary care doctors and evaluated users in need of mental health services; thus, she was always part of the medical team and had always maintained good relationships with the other services in the hospital. In 1983, the current mental health service began.

At the time of the visit, the team had twelve members: five *operadores*, two psychiatrists, three psychologists, and two residents. The team's activities reflected Broide's grounding in medicine. Primary care residents spent a two-month rotation on the mental health service, and the mental health team joined the medical team for daily hospital ward rounds.

The team successfully worked with the medical staff in creative ways. At the time of the visit, the mental health and primary care services were collaborating in the development of a behavioral medicine program called Center for Programmed Health Care (*Centro de Atencion Programada de Salud*), known by its Spanish acronym, CAPS. An internist came up with the idea, noting that most disease prevention activities focused on maternal-child health. He wanted to include adult medical patients in disease prevention, and empower them to maintain good health. As a first step to developing such a program, the providers gathered for regularly scheduled meetings coordinated by a health education specialist. The meetings were central to the evolution of the project because they encouraged the providers to examine their own health behaviors and ideas. One provider explained, "In the last few months we've been working on our own values, doing role-plays… What emerged was the hegemony of medicine. We had to get off the [high horse] and put our feet on the ground." The group envisioned that the program would be especially useful for people with hypertension, diabetes, and obesity. Patients would be referred from the primary care clinic to CAPS. They would be evaluated by the physician for the medical problems and referred to a group coordinated by a psychologist and a doctor. The groups would address emotional issues related to health behaviors and ultimately, behavior change.

The team successfully made its presence known in the wider community through several rehabilitation and economic enterprises that catered to all citizens of El Bolsón. They secured a transitional living facility (a large house near the banks of the river that was used for temporary housing) for recreational activities, which has served as a soup kitchen during the economic crisis. The team built a gym for women in one of El Bolson's poorer neighborhoods. They offered classes and babysitting services. The large structure had two apartments attached that were currently inhabited by an *operador* and a visiting psychologist. A service user occupied a cabin in the garden and assisted in maintaining the premises.

The visit included an evening call on a community sports center and gym that the team managed. This one-story building bustled with activity. We entered a lounge area complete with small tables, pinball machines, and a bar. Directly in front of the entrance, double doors opened onto the athletic field where a group of young men played indoor soccer. When the city made the space available, the mental health team placed the winning bid for the facility. Sports teams and other groups paid a small fee for use of the space. The mental health team charged low rental fees to ensure that all who wanted to use the space could afford it. Mental health service users staffed the bar and kitchen. The small income generated from this gym paid the users' salaries.

SUMMARY OF SERVICE EVALUATION

Service evaluation is ultimately concerned with quality of care, and can be defined from various points of view:

From the perspective of persons with mental disorders, good quality means that they receive the care they require and that their symptoms and quality of life improve. From the perspective of family members it means that support is provided and that help is given for the preservation of family integrity. From the perspective of service providers or program managers it means that effectiveness and efficiency are insured.

The mental health program has not conducted a formal evaluation of the services by measuring symptoms or quality of life as outcomes among users. Data are available that describe the admission and discharge statistics and the distribution of diagnoses. The observations that this author was able to make are based on brief visits to a subset of the services, hand-selected by the program directors; they may not adequately depict the program as a whole. The summary that follows highlights key aspects of mental health services in Río Negro.

Accessibility of Services

Overall, since the beginning of the mental health reform in 1983, the mental health program has grown tremendously, increasing the accessibility of services overall. Table 3 summarizes changes in the provision of services from 1984 to 2001.

TABLE 3. Changes in service structure, human resources, and patient visits, 1984 to 2001, Río Negro, Argentina.

Change category	1984	2001
Structure	4 mental health services 1 psychiatric hospital	19 multidisciplinary community mental health teams 1 central mental health department 6 halfway houses 6 income generating projects several consumer and family organizations 3 homes for the care and rehabilitation of people incapable of standing trial. 1 community mental health association
Human Resources	70 Mental health workers (85% at the Allen Hospital) • 10 professionals • 45 non-professionals • 15 administrators	150 mental health workers (distributed in 20 out of 28 provincial hospitals) 60 mental health *operadores* 90 professionals (social workers, psychologists, sociologists, doctors, and educational psychologists Residency in Community Mental Health 1994-2001 8 residency positions 1 chief resident 40 professional alumni of the program
Hospital admissions & outpatient visits	Crisis admissions per year: 195	Crisis admissions per year: 1,350
	Average length of stay: 6 months	Average length of stay: 11 days Percent re-admission: 15%
	Ambulatory care visits: 14,000	Ambulatory care visits: 133,000

In the sites that were visited, the population typically accessed mental health services through outpatient offices in the hospital, through the emergency room, or by referral from

peripheral health centers. Schools and courts also referred people for evaluation. In most sites, inpatient and outpatient hospital-based services were readily available. Once a user entered the service system, however, the specific treatment and rehabilitation opportunities varied greatly from site to site. They depended upon the size of the team and the team's chosen focus. In Río Colorado, for example, group therapies and structured psychosocial rehabilitation activities languished, whereas individual treatment occupied most of team's time, and relationships with users were strong. Financial difficulties limited the teams' access to transportation to make follow-up care visits with users in several settings. It is likely that users also lacked resources to travel to hospital or clinic sites.

At least one team in the province's northwest section, the most densely populated region, had experienced deep divisions at the time of this evaluation. That site was not part of the round of visits. Comments from providers in the contiguous province suggested that access to services in that region of Río Negro was problematic, and some users sought care elsewhere.

Availability of Medications

At the time of this evaluation, every sector of the public health system, including mental health services, had experienced lapses in the supply of medications due to the fiscal crisis in the country. The provincial medication program, Zonal Medication Program (Programa Zonal de Medicamentos), known for its Spanish acronym, PROZOME, had a relationship with a pharmaceutical company (*El Laboratorio Productor de Medicamentos*), which supplied most of the medications for outpatient and inpatient care. According to the director of pharmacy at the Ministry of Health, however, the company did not make psychotropic drugs. The PROZOME drug formulary included traditional neuroleptics, such as haloperidol and chlorpromazine, as well as atypical neuroleptics such as risperidone and olanzapine. Likewise, the list included tricyclic antidepressants (amitryptaline, imipramine) and selective serotonin reuptake inhibitors (SSRIs) (sertraline and paroxetine). Presence on the list did not guarantee that the province supplied the drugs. Each hospital controlled its own budget and determined, independently, how to purchase psychiatric drugs, and ordered medications according to local needs. Larger hospitals could buy drugs directly from other pharmaceutical companies, pharmaceutical wholesale suppliers, or local pharmacies.

One site complained that medications allocated for use by the mental health team were also used by other hospital departments, such as surgical service. As result, supplies of certain benzodiazepines and antidepressants were often exhausted by the end of the month, leaving the mental health service with insufficient supplies. These shortfalls created tension between the mental health service and the hospital administration, as the mental health team repeatedly requested more funds for medications on a regular basis. Sites emphasized the lengths to which they went to maintain supplies of medication when they were not available through the hospital pharmacy, such as purchasing from local drugstores or seeking funds from the municipality to assist patients with payment for medication.

Interventions

Teams use conventional psychiatric medications to manage symptoms in users with psychoses and affective disorders. From the descriptions heard, psychotherapy was typically supportive and oriented toward the resolution of immediate problems. Teams selected psychotherapy forms that were amenable to their settings. For example, rural populations were not accustomed to psychoanalytically oriented treatments, and brief psychotherapies, which have been shown

efficacious in the treatment of depression (interpersonal psychotherapy, cognitive behavioral therapy), were either unfamiliar to most providers, not used, or both.

Psychosocial rehabilitation activities were available to users in most of the sites that were visited. These projects varied in size and longevity; their lifespan depended upon available resources and interest on the part of users and providers. In Viedma, a few users with chronic psychotic illnesses participated in a nearby farming project. In Bariloche, some elderly users were actively involved in the Teatro de Brotes, an award-winning local theater group, in which participants were people with serious mental illness and that addressed issues relevant to their lives. In some communities, however, where high unemployment persisted, users also were unemployed and often idle. Therapy groups were available in the larger cities, and these ranged from self-help groups for people with alcoholism, multifamily groups for people with psychoses, adolescent groups, and groups centered on a particular activity such as reading, weaving, or theatre. Smaller communities struggled with confidentiality concerns, and ongoing therapeutic group activities were limited.

A Focus on Human Rights

The mental health program considered the issue of respect for human rights was at the core of its operations. Each site emphasized the themes of dignity and respect for users. What was not apparent, however, was the involvement of users in the planning and development of the program. The hosts said that a very active user group existed in Viedma, but the author did not have the opportunity to meet its group members. At none of the sites was the inclusion of users in determining the team's priorities apparent.

Outreach and Follow-up Efforts

Community outreach and follow-up activities were essential components of the provincial program. The long-term personal relationships established with users, their families, and community organizations with which users were involved enabled mental health workers to know when a person was better and when he or she showed signs of acute illness. These activities allowed the provider to utilize community-reincorporation resources to help support users' health and recovery.

At most sites, follow-up entailed making home visits to users to deliver or administer medications, or simply to check up on them. Rising fuel costs and limited access to vehicles curtailed the ability of some teams to do regular outreach. Teams responsible for providing services in neighboring communities (e.g., those based at area hospitals) had the most difficulty due to the distances they were required to cover. Of the two urban teams visited, outreach appeared to be more of a challenge in Bariloche than in Viedma. This may have been related to availability of vehicles, differences in team management and cohesion, and the number of full-versus part-time employees.

Staff Training

The mental health program held an annual meeting during which teams from throughout the province convened to share experiences and tackle specified projects. During this meeting, program directors trained providers according to their needs; however, providers did not appear to receive ongoing education on a regular basis. The teams had limited access to professional journals, although some team members did attend professional conferences.

Pharmaceutical advertising permitted the ready dissemination of advances in psychopharmacology. The psychiatrists that were interviewed kept abreast of these

developments, even if they did not have access to all of the newest medications. Access to information about developments in non-pharmacological interventions was more difficult to attain, and program directors admitted that this was one of the program's weaknesses.

Mental health teams also were responsible for training other hospital staff on mental health topics. During conversations with hospital-based nursing staff, these staff members complained of inadequate training. One nurse called for structured, systematic training in mental health. Most felt they lacked the skills to manage acutely ill psychiatric patients; however, at least one mental health provider told me that hospital staff attendance at mental health training sessions was often poor.

The lack of training of hospital-based medical staff helped undermine the reduction of stigma, a goal of the program. These staff members likely endorsed the same stigma held by the broader society toward people with mental illness, but frustrating experiences in the hospitals provoked them even further. Inpatient medical providers resented mental health service users in part because they felt unequipped to manage psychiatric illness, and it is likely that users perceived the hostility of staff in the hospitals.

Coordination of Services

Beyond the requirement to comply with Law 2440, the 20 mental health teams varied considerably in their emphasis on specific mental health services. El Bolsón's team was much more integrated with the hospital's medical services, whereas the psychologist in Maquinchao preferred to pursue diverse community projects. The teams functioned relatively independently, and each chief of service influenced the team's focus.

Some people have criticized this aspect of the program, insisting that it pointed to a lack of organization, rather than reflecting the different strengths of individual teams. After observing a variety of sites, the need for variety and flexibility of approach is easily appreciated, since local settings differed in terms of population size and cultural composition and in which social problems were the highest priority. A basic set of goals and objectives should be maintained across sites, however, as should uniform standards of care. This appears to be what the program was currently trying to accomplish.

The relationship of individual mental health teams to the medical services at their sites also varied. Overall, staff in the peripheral health centers viewed the mental health teams positively and appreciated the services they provided. In hospitals, although relationships varied from site to site, the demand for mental health services remained high, despite sometimes strained relations. Strained relations grew out of the nursing staff's sense of neglect and inadequate support from the inpatient-ward teams, a valid complaint. An agitated patient with bipolar disorder required very different management than a post-myocardial infarction patient. The teams varied in their sensitivity to these relationships. All teams were faced with making decisions about where to direct their resources, but some teams made the relationships with nursing staff a priority.

In addition to working with medical staff, the teams had to forge strong relationships with local judges. Judges and providers worked together to determine when involuntarily admitted users could be discharged. The teams needed to develop and apply risk management procedures in order to facilitate the discharge of users at high risk for relapse. Such procedures would insure the safety of users and of the community and would ease the sometimes adversarial relationship between providers and judges.

Most teams highlighted the improvement they had observed in attitudes toward mental health care over the years. One team described its eventual acceptance into the community.

Initially, the medical services resisted the mental health service. The hospital asked, "What are they doing here? Why do we need them?" The community also didn't understand their purpose. Today, they are recognized as a valid service with committed providers. Some of this success seems to have come from the fact that the team removed the burden of caring for people with mental illness from other medical services. In many medical settings around the world, primary care providers feel ill-equipped to manage psychiatric illnesses, and they dread the amount of time required of them to evaluate, diagnose, and treat psychiatric patients. Perhaps in Río Negro medical professionals increasingly valued those teams that freed them from this "burden" of caring for people with mental illness.

Public versus Private Services

The provincial mental health program had no statistics on the number of available private mental health services, but there were private mental health services in many towns in Río Negro. In some sites, like Catriel and Bariloche, providers worked part-time for the public mental health program and part-time in private practice.

With the exception of private practitioners who perhaps opted to refer patients to other provinces for private inpatient or residential services, collaboration between public and private services occurred by default, since the vast majority of inpatient mental health services were in the public system. There was no organized means of communication between private practitioners and the public mental health system to service needs or gaps.

Some providers in the neighboring provinces of Buenos Aires and Neuquen insisted that the province either did not or was not able to take responsibility for all of the mental health needs in Río Negro, because many of its residents sought mental health care outside the province. Río Negro's mental health directors did not have any data illustrating the extent to which this occurred, and they explained that they could not dictate where people sought services.

Prevention Efforts and Health Promotion

Providers in the mental health program viewed their relationship with patients, community outreach efforts, and follow-up activities as prevention activities. Most sites emphasized that users experienced few relapses, but there was little data to support this claim. However, what was apparent during visits to users' homes and in conversations with users at various sites, were the strong connections and warm relationships that many providers in Río Negro had developed with service users.

Providers often established rapport with communities by conducting health promotion and disease prevention workshops in the community and in the school system. Many focused on reproductive health, sex education, or parenting. None of these interventions had been evaluated. One team described the workshops to prevent teenage pregnancy that the psychologists conducted in the schools, but noted that rates of teen pregnancy continued to rise.

Community-level Benefits of Intervention

The clearest benefits of Río Negro's mental health program were seen in the influence it had policies, community institutions, and, sometimes, public attitudes. Law 2440, despite its controversy, served to keep mental health care on the provincial agenda. The issue of mental health needs had been integrated into other legislation (e.g., the Domestic Violence Law). The program's emphasis on utilizing community resources catalyzed collaboration with multiple community institutions, and, in some cases, probably changed attitudes toward mental illness. In Choele Choel, members of the police force changed the way in which they managed acutely ill

psychiatric patients. The program operationalized mental health services more broadly—not by medicalizing social problems, but, rather, by bridging social services and mental health services.

Providers and Communities

Few professionals were natives of the communities in which they worked. This was especially true in rural areas (e.g., Maquinchao and Jacobacci). Often, the decisions these professionals made about social interventions were based on their own ideas, and had not been organically developed with the community. Clinically, similar issues arose at times. In Jacobacci, the providers listed epilepsy, anxiety, alcoholism, and developmental disorders in children as prevalent mental health issues. Yet, they received complaints about locally defined illnesses that combined physical and emotional symptoms and did not always correspond to medical diagnoses. One of these, *aflijimiento*, for example, could indicate palpitations or anxiety, depending on the context.

Remaining Question for Long-term Facilities

The mental health teams must decide how they will manage the problems of users in need of long-term care who do not have families to provide housing. As of this writing, general hospitals function as long-term facilities in communities that have no other alternatives. During the process of deinstitutionalization in some international settings, planners anticipated that a subset of the deinstitutionalized patient population would require intensive support lest they overburden acute-care settings. Some form of supportive housing would be essential for seriously ill patients. In an evidence-based review of modern mental health services in low-, medium-, and high-resource settings, include long-term community-based residential care as one of the service components that should be present in medium-resource settings.

In Río Negro, the lack of such facilities increases tensions among the medical staff and leads to demoralization of the mental health providers, whose vision of community mental health does not include homeless people with mental illness. It forces users who need care to live publicly in insufficient housing. There also are implications for stigmatization. Angermeyer and colleagues showed that, among a sample of persons with psychiatric diagnoses in Germany, patients treated in the university (general) hospital setting felt more stigmatized than those treated in the state psychiatric hospital. The authors hypothesized that the public exposure that accompanied treatment in the general hospital setting increased the chances of being identified as a psychiatric patient, and consequently the risk of feeling the object of discrimination.

Accomplishments

The mental health program notes several positive developments since the passing of Law 2440:

- 10,000 users have been treated in the community without secluding them.
- There were only seven incidents of serious crime committed by users (e.g., homicide or rape).
- Referral of users to mental health services outside of the province decreased from 10 in 1985 to 2 in 1991, and have remained at this low level. These patterns have not been monitored since then.
- The courts have adopted much of the mental health language used in Law 2440, including terms such as "user," "therapeutic strategy," and "mental suffering."
- There is greater acceptance of mental health users sharing the same space as others in the hospital.
- Providers have established strong, long-term, supportive relationships with many of the users in their communities.

Lessons Learned in Río Negro

The critics of Río Negro's program insist that the program is ideologically driven. To some degree this is true. Program directors believe that the principles set forth in Law 2440 will provide the best care for people with mental illness, and are deeply committed to serving this identified population. These ideologies do not conflict with values promoted by WHO and mental health organizations, however. The question is whether the adherence to ideology harms mental health users in this context. Does it prevent the mental health teams from implementing interventions that users need, or does it allow them to promote interventions that do harm? The absence of transitional or, if needed, longer-term living facilities in communities like Bariloche deserves further consideration. Why are these fundamental pieces of community-based care missing? Political will, in part, determines the use of the province's financial resources, but so do the very real constraints imposed by economic hardship. Structural stigma (i.e., the lack of funding and other resources for mental health) may also play a role. What role is played by leadership's belief that facilities (even in the community) that house service users for the long-term will, by definition, institutionalize them? The answer is unclear.

Have the reforms in Río Negro been successful? In many ways, yes, but, the development of comprehensive community-based services is far from complete.

The 2001 World Health Report issued the following recommendations for mental health care:

- provide treatment in primary care;
- make psychotropic medicines available;
- provide in the community;
- educate the public;
- involve communities, families, and consumers;
- establish national policies, programs, and legislation;
- develop human resources;
- monitor community mental health; and
- support more research.

Río Negro's mental health program has attempted to address all of these points rather extensively, except perhaps research, and the model of community mental health services in Río Negro is consistent with WHO's goals. The program has managed to be self-sustaining in the midst of limited financial resources and recent social upheaval, and its deficits do not provide grounds for dismantling the system; rather they provide insights into where the program most needs support. The following lessons have been learned:

- Collaboration between mental health services and other city institutions can provide a safety net for persons with serious mental disorders, reducing acute episodes of illness.
- Care for persons with mental illness in the community must include attention to all aspects of the person's life.
- Mental health services can function with primary care doctors providing pharmacologic interventions.
- Cohesive, committed mental health teams can form meaningful relationships with users that help sustain them in the community.

The following vulnerabilities persist:

- Law 2240 has unstable political standing. The opponents of the Law 2440 and its supporters seem to agree on many of the areas in which the mental health program is lacking (e.g., the lack of transitional housing, resource shortages, staff shortages); yet, they have not been able to fruitfully bridge those differences. As a result, the supporters of the law fear that it may be overturned with every provincial election.
- Current economic difficulties have not only reduced resources, but increased levels of distress in the general population and the demand for mental health services.
- A lack of cohesion can limit a team's effectiveness. Generational differences, for example, can pose problems. Team members from the older generation self-identify as militant, having suffered real losses during the dictatorship, and having fierce commitment to the team's ideals. The younger generation comprises a group with mixed motivations and mixed views of mental health care. Larger services are particularly vulnerable to conflict, as team leaders insist on a degree of loyalty and support of ideology that all members of the team do not share.
- Teams must remain up to date with advances in mental health care. High quality services should attempt to "[build] quality improvement into clinical practice through evidence-based practice, clinical practice guidelines…and continuing professional development." The program must develop methods for accessing and staying current with information on best practices.
- A program of research and service evaluation could help the team to objectively identify areas of success and weakness.
- Greater dissemination of experiences regionally and internationally would allow more opportunities for feedback and growth.
- Facilitating greater involvement of users in service delivery decisions would operationalize human rights ideas that underlie the program.
- The need for supportive housing solutions must be addressed realistically, taking into account the objective needs of each community.

Regional Implications of the Program

Can Río Negro serve as a model for other provinces in Argentina? In theory, yes. The city of Buenos Aires has passed legislation (*Ley* 448) guaranteeing the right to mental health for its citizens that is modeled on the Law 2440. Researchers of Argentina's mental health services as well as providers I interviewed agreed that barriers to reform in other provinces are often related to professional hierarchies and the reluctance to share power.

Resources must also be earmarked for the development of community mental health services. Although specific hospitals around the country have launched reforms, provincial ministries of health have not promoted them. Greater regional communication between public mental health services may enable such reforms to move forward.

International Implications of the Program

Can Río Negro serve as a model for low-income countries? Aspects of Río Negro's program provide a useful model. The vision of mental health care that encompasses medical treatment and a holistic approach to healing the person in his or her social environment is useful. The use of the *operador* as a community mental health worker can be translated to low-resource settings, as can the management of patients by non-medical staff with the support of primary care doctors and

nurses (or psychiatrists where available). The interchange of mental health services with other social and medical services would be feasible in low-income settings. However, Río Negro's wealth of trained mental health care professionals and its emphasis on specialized care, though typical of Argentina, is more representative of medium- to high-income settings.

CONCLUSIONS

Río Negro's mental health program is far from perfect, but program employees recognize many of the flaws and continue to work to improve services for men and women with mental illness. The voices of the users are notably absent in this chapter for reasons of confidentiality. The warm exchanges I observed between providers and patients in many communities spoke volumes for the value of community mental health care. The ease and patience with which providers interacted with extremely ill patients was admirable. One provider said to me, "We don't look at the person to see whether he's cured or not, as you can with an appendectomy. Every little step is a success. We can't guarantee that he'll never relapse again. It's an evolving process."

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On August 31, 2003, the Radical Party candidate, the party that supports Law 2440, won the gubernatorial race in Río Negro. For the next four years, the banner of the mental health revolution would continue to wave.

Bibliography

Ablard JD. Authoritarianism, democracy and psychiatric reform in Argentina, 1943-83. History of Psychiatry. 2003;14(3): 361-376.

Ablard JD. 2003b. Law medicine, and confinement to public psychiatric hospitals in twentieth-century Argentina. In Plotkin MB, ed. Argentina on the Couch, ed. Albuquerque: University of New Mexico Press; 2003. Pp. 87-112.

Angermeyer MC, Link BG, Majcher-Angermeyer A. Stigma perceived by patients attending modern treatment settings: some unanticipated effects of community psychiatry reforms. J Nerv Mental Dis. 1987;175: 4-11.

Cohen A, Saraceno B. 2002. The risk of freedom: Mental health services in Trieste. In A. Cohen, A. Kleinman, B. Saraceno. World Mental Health Casebook: Social and Mental Health Programs in Low-Income Countries. New York: Kluwer Academic/Plenum Publishers; 2002. Pp. 191-220.

Cohen H, Natella G. Trabajar en Salud Mental: La Desmanicomializacion en Río Negro. Buenos Aires: El Lugar Editorial; 1995.

Departamento de Salud Mental, Consejo Provincial de Salud Pública. Programa Provincial de Salud Mental:La desmanicomialización en Río Negro. Provincia de Río Negro, República de Argentina; 2003.

Ellerman LA, Ruiz A, Solz P, Aguirre RD. Una utopía possible: La transformacion institucional en el Hospital Neuropsiquiátrico "Liniers", Provincia de Entre Ríos. Vertex Rev Arg de Psiquiat. 1999; Vol. X: 53-59.

Gobierno de la Provincia de Río Negro. República Argentina, La Desmanicomialización en Río Negro. Ley 2440 de Promocion Sanitaria y Social de las Personas que Padecen Sufrimiento Mental, República Argentina. Consejo de Salud Publica; 1991.

La Mañana del Sur, "Ministro cuestiona el plan de salud" Domingo 24 de agosto del 2003. p. 8. www.lmsur.com.ar

Lelliott P, Wing J. A national audit of new long-stay psychiatric patients. II: impact on services. Br J Psychiatry. 1994;165: 170-178.

Pellegrini JL. Cinco años de lucha por la transformacion institucional (1993-1998). Vertex Revista Argentina de Psiquiatria. 1999;Vol. X: 28-34.

Plotkin MB. Freud in the Pampas: The Emergence and Development of a Psychoanalytic Culture in Argentina. Stanford, California: Stanford University Press; 2001.

Plotkin MB. Argentina on the Couch. Albuquerque: University of New Mexico Press; 2003.

Rothbard AB, Kuno E. The success of deinstitutionalization: Empirical findings from case studies on state hospital closures. Int J Law and Psych. 2000;23 (3-4): 329-344.

Thornicroft G, Tansella M. Components of a modern mental health service: a pragmatic balance of community and hospital care. Br J Psych. 2004;185: 283-290.

Trieman N, Leff J. Long-term outcome of long-stay psychiatric in-patients considered unsuitable to live in the community: TAPS Project 44. Br J Psych. 2002;181: 428-432.

Vicente B, Cohen H, Saldivia S, Natella G, Vielma M, Santaya JC, Ianowski V. Programa de salud mental en la provincial de Río Negro (Argentina). Revista de la Asociación Española de Neuropsiquiatría. 1997;vol. XVII (64): 753-762.

World Health Organization. Atlas: Country Profiles on Mental Health Resources 2001. Mental Health Determinants and Populations, Department of Mental Health and Substance Dependence. Geneva: WHO; 2001.

World Health Organization. The Mental Health Context: Mental Health Policy and Service Guidance Package. Geneva: WHO; 2003.

World Health Organization. Promoting Mental Health: Concepts, Emerging Evidence, Practice: Summary Report/a report from the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation (VicHealth) and the University of Melbourne. Geneva:WHO; 2004.

BRAZIL:
TWO EXPERIENCES WITH PSYCHIATRIC DEINSTITUTIONALIZATION, CAMPINAS AND SOBRAL
Cassis Henry[1]

INTRODUCTION

While the creation of Brazil's original mental health care institutions and their eventual dismantling follow a pattern similar to global trends, the pace and direction of reform events in this country over the past three decades are somewhat unique. Nineteenth-century urban warehouses for the poor and mentally ill focused on a moral cure, based on the European model, in which the conflation of mental disorder and moral turpitude and the further identification of moral weakness with poverty led practitioners in such establishments to focus on attempts at moral improvement. Brazilian mental health services gradually moved from urban to more suburban settings, taking the form of "colonies" overseen by psychiatrists, in which the patient population became socially heterogeneous and treatment more democratic, since those of the lower classes received the same types of care as those from the middle and upper classes. The next iteration of services occurred during the 1920s with the development of the so-called Brazilian Mental Health Movement, a professional association grounded in the academic community and influenced by the North American interest in eugenics, and the latter's concern with race, mental illness, and interventions for improvements in human heredity traits. The 1930s saw the importation of such somatic practices as the induction of insulin coma and the use of early electroconvulsive therapy in the treatment of schizophrenia. The growth of psychiatric hospitals and their tendency to be private facilities coincided in time with the population's migration to large urban centers, the changing political fortunes of the Getúlio Vargas authoritarian regime (1930–1964), and the military dictatorship that followed. During this period, there was a strong tendency toward the hospitalization of psychiatric care, occurring largely within private institutions characterized by inadequate care quality. In 1981, 70% of Brazil's psychiatric beds were located in private psychiatric hospitals (*1*). The difficult economic and political situation during the late 1970s led to a crisis in the social security system and, despite the ongoing repression of the military dictatorship, increasing dissent—including voices decrying the prevailing ethos of mental health treatment. The predominant strain of theory and practice focused on a medical model of psychiatric illness, in which it was understood that individuals with mental disorders would be best served by long-term hospitalization in specialized institutions. Clamor in the intellectual community for the reform of clinical psychiatric treatment, at the global level as well as in Brazil, pointed to the theories and practices promoted by Erving Goffman, Michel Foucault, and Franco Basaglia and provided concrete new directions for Brazilian social theorists and activists and mental health professionals. Reports of violence and mistreatment of patients in mental health facilities during the 1980s also served to galvanize widespread social outcry, and, in turn, the necessary political resolve to overhaul and modernize the national mental health care system (*2–6*).

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[1] Department of Psychiatry, University of California, San Francisco, U.S.A.

Brazil's current mental health reform plan forms part of the broader transformations to the national health care delivery system established under the Unified Health System (known as SUS, or *Sistema Único de Saúde* in Portuguese). This public health care system, together with its private counterparts, covers, in theory, all Brazilians. By some estimates, around 60% of the population depends exclusively upon SUS for its health care needs (7). This system is regulated by laws whose principles are also embodied in the structure of mental health services: the universal right to health care; its integrated functioning at the federal, state, and municipal levels; and direct democratic participation in the functioning of health institutions by professional associations and—what is perhaps even more unique—groups of services users and their families. The SUS operational guidelines call for ongoing decentralized management of health systems and services to increase municipal control over human and financial resources and programming priorities, constituting one of the novelties of Brazil's health care structure and a source of its great promise in the eyes of those who value local creativity and believe that social participation in policy development facilitates flexibility in responding to local realities and satisfying community needs.

The Ministry of Health of Brazil has set the following targets for mental health care reform: the progressive reduction of psychiatric beds through the expansion and strengthening of the services network beyond the psychiatric hospital (community-based mental health centers, therapeutic residences [non-hospital residential services], and psychiatric beds in general hospitals); strengthening and securing the positioning of mental health services within the primary health care structure; providing comprehensive care to the population experiencing alcohol and drug abuse issues; promoting capacity-building among health care professionals, services users, and their families to enable their effective participation in mental health care interventions and the reform process itself; and ensuring humane, ethical, and respectful treatment in forensic psychiatry practices (*8*). According to Ministry of Health surveillance statistics, 3% of the population is suffering from chronic and severe mental illness and 6% of the population has been diagnosed with a serious mental disorder and concomitant drug or alcohol use. The Ministry estimates that approximately 12% of the population utilizes mental health services on a regular or occasional basis. These services comprise 2.3% of the national health budget (*9*).

This chapter examines how innovative mental health interventions in two distinct Brazilian socio-geographical settings are turning the challenges of deinstitutionalization into opportunities for enhanced social inclusion and quality of life. The goal of these programs transcends the mere administrative transfer of patients from central hospitals to smaller satellite settings by fostering a paradigm change in the experience of mental health services users, their families, and mental health professionals and redefining possibilities and potential outcomes for those with mental health problems. The information in the following descriptions is based on site visits conducted during 2003.

CAMPINAS: THE CREATION OF COMMUNITY MODELS

Campinas is an inland city and municipality located in the southeastern state of São Paulo and home to a diversified and profitable mix of industry and agriculture that makes it the world's ninth largest economy. With over a million inhabitants, the whole of Campinas—the largest city in Brazil's interior—is spread over rolling hills that give the urban setting a rural quality. Established in the late 18th century, its coffee and sugarcane production brought it wealth by the mid-19th century, and railway and highway construction and the establishment of an international airport later consolidated its base as a prominent economic hub. Campinas experienced rapid urban development in the 1970s and 1980s and is now a global market center fueled by the presence of

national and international high-tech, automotive, and pharmaceutical industries and UNICAMP, a state university internationally renowned for its technical training facilities. This development, in a pattern repeated often within Brazil, has attracted scores of migrants in search of work—from the poor Brazilian Northeast in particular—creating enormous wealth distribution inequalities and a complex mosaic of modern cosmopolitan urbanity on the one hand and extreme poverty and social marginalization on the other.

Mental health care services within greater Campinas include those overseen by the Municipal Secretariat of Mental Health and those managed by private entities. The descriptions in this section focus on strategic and practical innovations in the public health sector and in one affiliated nonprofit charitable hospital, in view of the fact that services provision by private university hospitals continues to operate within a tertiary care framework, with these facilities being geographically and ideologically distanced from community settings. The disengagement of the academic psychiatry community associated with private university hospitals is reflected in their virtual absence from the deinstitutionalization process as it has evolved in Campinas: while interns in psychology, social work, and occupational therapy can be found participating in various deinstitutionalization projects, the presence of psychiatry trainees is scant. The charitable services offered through the one municipally-affiliated philanthropic hospital through which a large number of non-psychiatry trainees circulate are funded through private and public municipal sources, with the city of Campinas financing its municipal services through monies allocated to it in part by SUS at the federal level. As is the case with Brazil's national mental health care system, in Campinas associations of health care professionals, services users, and their families participate directly in the oversight of health institutions. These associations are mixed and linked to particular hospitals or other health institutions.

In the early 1990s, Campinas had approximately 1,200 psychiatric beds distributed among five hospitals; by 2003 beds had decreased to 250, and by 2007 there were fewer than 200 by 2007. Campinas' mental health care resources historically have included Cândido Ferreira Hospital, a private philanthropic institution founded in 1924 and located in Sousas, a neighborhood on the outskirts of Campinas, as well as a number of private and state-run university hospitals. Since 1990, management of this facility has been shared by the private sector and Campinas' Secretariat of Mental Health, uniting Cândido's experience and specialization in the treatment of mental health problems with the city's funds and dedication to extending the benefits of mental health care to a larger population. Many of the leading mental health personnel involved in the Cândido Ferreira Hospital reforms had participated in or been heavily influenced by the effective deinstitutionalization efforts that took place in the city of Santos in São Paulo state (*10*). Transparency in setting priorities and in utilizing funds was ensured by the community's participation within the mental health administration's municipal health council, and at Cândido, the presence of patients and former patients on various bodies guiding and supervising the transition. The group behind Cândido's restructuring brought to its work the personal background and experiences of its individual members, as well as a philosophical identification with the work of psychiatric reformer Franco Basaglia in Trieste, Italy, during the 1970s. The new priorities embraced by the reform were encapsulated in the words of a Cândido Ferreira Hospital brochure: "Doors were unlocked, bars removed, and the straightjacket and electroshock were abolished." Since the reforms, the range of available treatments has focused on the reinsertion of patients into family and community life, with the promotion of social integration serving to foster effective citizenship.

The hospital, which provides services to approximately 1,000 individuals each month, sits atop a hill on an avenue lined by towering trees and far from the dense traffic of the rest of

Campinas' urban life. Since 1993, the Cândido Ferreira Hospital has served as a World Health Organization reference center for mental health treatment. Its facilities include outpatient care, inpatient hospitalization in a crisis unit, a clinical unit, chemical dependency units, a workshops unit, and a social and cultural center, as well as various Psychosocial Service Centers (or CAPS, for *Centros de Atenção Psicossocial* in Portuguese), which are a Brazilian version of community mental health centers, and assisted living residences. Of these services, physical access is controlled only in the cases of the crisis unit and the clinical unit, which provide care for those with the most chronic and/or severe conditions requiring close supervision; many in this group have been inpatients since before the hospital's deinstitutionalization. The principal and most historic building houses the crisis unit, whose rooms ring a well-cared-for courtyard filled with plants and trees. Clients in this unit may elect to participate in various painting, drawing, and sculpture activities, either independently or under the guidance of a former inpatient whose paintings and poetry have been exhibited and sold in São Paulo and Paris art galleries. CAPS patients are given the opportunity to earn a small wage by undertaking projects of decorative ironwork, furniture carpentry, and painting and sewing appliqués for clothing, handbags, and pillows in supervised workshops. These products are offered for sale at a small shop on the hospital grounds as well as at an upscale boutique in downtown Campinas. Other workshop activities include the production of a newspaper and a weekly radio show, whereby aspiring journalists are given the opportunity to teach university-level communications classes on community-based reporting and were able to test their skills while providing live coverage during the World Social Forum, held in Porto Alegre in January 2005.

The oldest of the CAPS facility overseen by the Cândido Ferreira Hospital is also the only one located off-site. The three-story gated structure, with its swimming pool and open terraces and gardens, is all but indistinguishable from the houses of other residences in an upper middle class neighborhood in suburban Campinas. Cândido's projects also include a social and cultural center based in an elementary school that offers adult evening classes in basic reading and writing skills to a mostly transient population, as well as free meals and recreation classes in *capoeira*, a highly choreographed Afro-Brazilian martial arts form, and other activities for children and adults of the surrounding community. The Sousas neighborhood is also home to a number of small supervised residences for mixed groups of men and women in which hot meals are served family style in a communal dining room by a day staff.

Other mental health services in Campinas include a series of CAPS overseen separately by the Secretariat of Mental Health and widely dispersed throughout the municipality, including two specialized CAPS: one treating drug and alcohol dependency problems and the other offering services targeted to the specials needs of children and adolescents. The pleasant and relaxed physical environment of these facilities has been designed to counteract the impersonal hustle and bustle of large and urban Campinas. The interiors are decorated with original works from art and weaving workshops, and many centers contain small vegetable gardens cared for by services users. The warren of rooms opening off of the central hallway is alive with conversation and activity, revealing a computer game in progress here and a circle of chairs filled with beginning guitar players there. Interestingly, these CAPS, as well as those run by Cândido, may, from time to time, circumstances warranting, lock their doors, in apparent violation of the emphasis of the "anti-asylum" model on patient autonomy and freedom of movement. However, as members of the CAPS staff note, the purpose of this precaution is to protect the safety of services users: to guard against the unauthorized entry of those in the outside world who might wish to bring harm to those inside and to prevent individuals experiencing disorientation issues from wandering off the premises when unsupervised.

The Brazilian Ministry of Health defines the CAPS as a community-based mental health services system whose function is to care for people with mental disorders, especially those with severe and/or chronic conditions, within a defined geographical area. The Ministry's program focuses on the provision of a comprehensive response to the needs of the population with mental health problems by specially trained professional staff and the creation of a "welcoming therapeutic environment" capable of providing for the needs of all patients. Furthermore, the CAPS are additionally required to offer activities targeted to the family members of services users, with the underlying objective of achieving the patient's complete social integration back into his or her community. Within this universal definition, however, the Ministry calls on CAPS staff to respect regional and cultural differences, to take into account the input of the families and services users themselves, and to tap into local community resources outside the health sector that might serve to reinforce and strengthen the treatment's effectiveness. In other words, CAPS facilities are urged to maximize the potential of all available inputs—whether medical, emotional, social, environmental, educational, recreational, or occupational (*11*).

The mental health services managed by the Cândido Ferreira Hospital and by the Secretariat of Mental Health both share a commitment to deinstitutionalization and to the community-based provision of these services as rights of citizenship to all those who live with the jurisdictional boundaries of Campinas. However, the nature of services as one goes from one location to another may vary, due to ideological nuances which are expressed in the way users interact with one another and with the health services professionals. The most vivid and creative expression of this is to be found in a daily practice at the Cândido Ferreira Hospital: the *roda*, or talking circle, method developed by UNICAMP researcher and physician Gastão Wagner de Souza Campos, whose internationally renowned work centers on the transformation of health care models and the development of a management method that seeks to increase the democratization of services by strengthening the links between SUS services and users. The *roda* co-management concept, in turn, is based in part on the landmark teachings of Brazilian educational theorist Paulo Freire (1921–1997), whose *Pedagogy of the Oppressed* (1968) laid the foundation for what is now known as "critical pedagogy," which challenged the traditional teacher-student dichotomy and proposed that a deep and genuine reciprocity be inserted into society's notions of teacher and student. By introducing the unorthodox roles of teachers who learn and learners who teach, Freire's theory insisted on situating informal and popular educational activities in the life experiences of the participants. His innovative methods, along with his concern with the psychology of words, led to the development of new ways to define experiences and perceptions by focusing on dialogue, the building of mutual respect, and a deepening awareness of other's situations (*12*).

The daily *roda*, as transferred and adapted to the Cândido institutional setting, becomes the locus for individual and collective reaction to the nature and quality of care received as well as the verbal articulation of personal experiences and feelings.   Exchanges may become heated at times, as patients and health personnel—usually a social worker, occupational therapist, and other mental health professionals—freely challenge the statements and perceptions of other participants. The process that determines what happens at these sessions and what becomes topic of the day is a reflection itself of the quintessential *roda*: a removal of the traditional barriers separating CAPS personnel and services recipients and those setting the agenda and those obliged to accept it.

The *roda* has been integrated into the services offered at other municipal non-Cândido CAPS as well, where it is enacted in the form of a large group discussion led by mental health professionals. While it may be said that in these settings the *roda* preserves the appearance of free

expression, there is in fact less spontaneity and more control, and the process is more democratic as an ideal versus in actual practice. The difference at Cândido may be the result of a more homogenous and fluid culture of democratization that prevails there following roughly 10 years of focused commitment on the part of both health care professionals and former patients who knew first-hand the previous institutional environment within these same walls and who are dedicated to the strengthening of the *roda* concept as a pivotal symbol of the changes in which they take such great pride. These contrasts illustrate how the seemingly unified municipal movement and the progress at Cândido Ferreira Hospital in pushing deinstitutionalization in Campinas may continue to harbor doctrinal differences from one location to another which translate into distinct operational realities.

While some of the differences in emphasis emerge from the struggle over the future definition of mental health care and its possible sources of funding, it is difficult to judge whether these differences are propelled primarily by the competition for limited resources or by other unresolved issues which have prevented the establishment of common values and priorities. Cândido's goals are deinstitutionalization and social inclusion, including full social participation by users and respect for their rights by all other community residents, and the facility's ongoing transformation is being framed as merely one component in a larger municipal project geared to promote the gamut of rights and freedoms enshrined in the United Nations' Universal Declaration of Human Rights. For proponents of Cândido's self-defined humanitarian agenda, these objectives help to depoliticize their actions, thereby optimizing their resilience to changing political winds and to the unwarranted imposition of top-down course reversals. The reverberations of government elections and party changes are strongly felt at the municipal and city levels in Brazil (as elsewhere in the world), highlighting the vulnerability of health policies and health care systems to the vagaries of partisanship politics and the need to protect and sustain the incremental gains scored at Cândido Ferreira Hospital over the past decade.

The obvious question in analyzing the experience of Campinas is whether those who seek treatment for mental health problems receive care that is effective in addressing their needs and producing positive change. Taking into account the mental health care reforms currently under way here, community members experiencing a mental health disorder have greatly enhanced opportunities for increased autonomy, self-expression, and social reintegration—whether they live independently, with other family members, or in assisted living facilities—than at any moment prior to the move toward deinstitutionalization. Valuing such improvements in what might be reduced to the overused term of "quality of life" takes for granted that such changes reduce the psychic suffering caused by stigma, social marginalization, and an unsatisfied universal need for self-expression. The logic of the Campinas model of community care goes further in attempting to account for environmental triggers present in the human experience, such as homelessness, hunger, violence, and lack of family ties, which tend to further exacerbate latent mental health problems. Common sense would suggest that the residents of Campinas are comparatively better protected from the spiraling effect of these risk factors than their counterparts in other geographical areas due to the support offered by the local mental health care services network, but hard data to prove or disprove this premise are not available. Even fewer hospitalizations or shorter inpatient stays for those with mental health problems would be difficult to interpret as a reduced need for such interventions since in the view of some public health experts, this type of specialized and intensive care is overly touted, over-utilized, and at times contraindicated and ineffective. Also, the health system's traditional emphasis on the treatment of severe cases of both acute and chronic psychotic disorders (as opposed to those of individuals suffering from more generalized depression or anxiety with less visible symptoms)

may be a weak point in the system, given that the global epidemiology of mental illness demonstrates the greater morbidity associated with depression.

SOBRAL: CLOSING DISTANCES AND SERVICES GAPS

The second-largest city in the northern Brazilian state of Ceará, Sobral is the social, cultural, and economic hub of Ceará's interior and has a population of approximately 155,000. The city is surrounded by the vast arid *sertão* (hinterland), where the primary way of life in its isolated towns and villages is cattle-raising and herding. Sobral is a place of dry, unrelenting heat, old colonial churches, and quiet streets with little traffic. Mental health practitioners describe cultural life here as being traditional, patriarchal, machista, and, in recent years, punctuated by interpersonal violence, both within families and in social environments outside the home.

Historically, those with severe mental disorders in Sobral and surrounding areas who wandered into the city or were abandoned there by their families might find themselves institutionalized in the local psychiatric hospital. There, some of them would spend up to 30 days in an environment described by the staff itself as being, at best, neglectful, and, at worse, rife with physical and sexual abuse. The other mental health resource in this city, a place where Catholicism has played a central role since the days of Portuguese colonization, is the Santa Casa de Misericórdia (Holy House of Mercy). There the nuns provide free, mostly custodial, care for their patients.

As within the larger context of Brazilian psychiatric reform in general, it was in part scandal and attendant outrage that fueled the crucial burst of change in Sobral. In 2000, an investigation into the death of a patient at the psychiatric hospital revealed that he had been beaten to death, most probably by one of his custodians. The notoriety that ensued when his family pursued an inquiry galvanized the deinstitutionalization movement within the city; it also gave renewed impetus to an ongoing experiment in several smaller northern towns in the reorientation of mental health services.

The range of services provided within Sobral includes inpatient care in the psychiatric unit of the general hospital (with an average length of stay of less than 10 days), an assisted living facility, level II of complexity CAPS (CAPS II), and CAPS AD (this latter targeting alcohol and drug addiction issues).

Inside the locked door of the hospital's psychiatric unit, 20 patients or so mill around in the central lobby; the fresh paint and shiny surfaces contribute to a feeling of newness. Sunlight angling through the roof illuminates a group of patients who gather around a team of hospital staff and an arriving visitor. Suddenly one patient flies into a rage, and others run to his side. On each side of the lobby are offices and shared patient rooms, the spaces looking clean and almost sterile. The unit's goals are to manage the acute crises of patients and assist family members in reintegrating patients in the home environment as soon as possible.

In contrast to the hospital's institutional look and feel is the assisted residence facility, which aims to move patients who have been repeatedly institutionalized or institutionalized for long periods back into the community through re-socialization and training in the routine activities of daily life. The residence resembles a cozy home with its slightly ramshackle decor and mismatched furniture. It houses approximately 10 people who are transitioning into more independent living arrangements. After the first year, residents celebrated the successful departure of their first graduate. At any given time, patients may be seen hanging their laundry out to dry or relaxing in groups in the residence's small rear courtyard and garden. The residence is overseen by a nurse and several auxiliary staff during the day to ensure that medications are taken and that the residents fulfill their occupational goals.

Sobral's CAPS offer outpatient treatment only. The health care teams are multidisciplinary and include psychiatrists, psychologists, occupational therapists, social workers, and auxiliary care staff. The small physical structures are former private residences converted into community mental health centers. Patients are seen by appointment during regular office hours; emergency care outside these hours is also available. The range of services includes private evaluations and consultations for both children and adults seeking help (some of these with undiagnosed neuropsychiatric conditions), psychopharmacology appointments for returning patients, the formation or continuation of group therapy sessions for those with chronic mental health problems, and—in the case of the CAPS offering specialized services for the needs of drug and alcohol users—group and family therapy for substance dependence or abuse issues.

One of the most characteristic and innovative features of the restructuring of Sobral's mental health services is the close coordination between family health primary care providers— the foundation of Brazil's universal health care system—and psychiatrists. Elements of this decentralization of all health care include: (1) the end of psychiatric institutionalization; (2) the implementation of CAPS and CAPS AD; and (3) the forging of close ties between the mental health system and the Family Health Program, including the holding of joint consultations of psychiatrists with family health practitioners and other primary care professionals, and a strong human resources training component to ensure effective integration of mental health care interventions within the primary health care strategy. The financing of such services is, as in the case of Campinas, by city monies allocated through SUS to mental health services. In Sobral, the Secretary of Mental Health works closely with the Secretary of Health.

A variety of other outreach and prevention interventions also exist. One consists of *terapia comunitária* (community therapy) with weekly group meetings that might include such activities as instruction in massage therapy, or "talk therapy" based on sharing feelings and experiences and incorporating songs and the use of popular sayings and traditional parables to orient discussion—often around the theme of life's difficulties and how one is coping. The discussion leader—usually female—has no formal mental health training in most cases, although there is a specific course that one must attend in order to become a community therapist. The therapists' socioeconomic class usually differs only slightly from that of the services users with whom they come into contact, in contrast to the majority of those in the mental health professions. The majority of these group meetings take place in neighborhood churches in outlying areas of Sobral characterized by high density and poor populations. Most of the participants are also female, and the sessions begin with the members introducing themselves to the group, followed by the discussion leader's inquiry into new developments in members' lives since the last meeting. Then the participants engage in singing songs and relaxation techniques. The meeting usually ends with expressions of mutual caring and support. The aim of the various components in these sessions is the reduction of environmental stress and the stimulation of community-building, with the overarching goal of anxiety management and preventing the development of full-fledged mental disorders in individuals already vulnerable to this possibility.

Joint consultations, as mentioned earlier, are a central element of Sobral's mental health program and are carried out in accordance with a model of primary care and mental health services known elsewhere as collaborative care (*13*). These consultations take place during weekly trips by psychiatrists into neighborhoods and surrounding districts, where they meet with general practitioners in the latter's clinics. Psychiatrists serve as consultants in cases with an obvious mental health component, offer possible diagnoses in the cases of emerging mental health issues, and provide clinical advice that will allow family health professionals to function as points of referral into the mental health system. General practitioners see a select number of their patients—

who might include a young child with severe behavioral problems or a middle-aged adult with psychotic episodes—side by side with psychiatrists who will model for them the process of case identification and diagnosis and the appropriate use of psychotropic medications, while emphasizing the importance providing the patient a stigma-free introduction to the mental health care system. The CAPS in Sobral also include, for those already under specialized care, home visits by psychiatric and non-psychiatric staff as one of their services.

Finally, one of the most noteworthy elements of Sobral's restructuring of health services and efforts to integrate mental health into primary health care has been the development of the *Escola de Formação em Saúde da Família Visconde de Sabóia* (Visconde de Sabóia Family Health School), a training resource for Ceará and the greater Northeast region. There, students of family and public health attend lectures in a new auditorium and classrooms, benefit from a health services library and computer laboratory, and can use a satellite/video conference center, all of which are geared to inculcate in future physicians and care facility administrators a focus on the effective integration of primary and mental health care.

The thrust of mental health services in Sobral stresses deinstitutionalization, decentralization, and services that are more humanized and responsive to the needs of their users. The move to place mental health services squarely within the scope of primary health care also is part of this new framework and is promoted in the policy newsletter *Consciência Coletiva* ("collective consciousness") produced by the local network of mental health services.

However, "the demand exceeds the capacity of the system," noted Alexandre Pereira, the head of the municipal mental health services in 2003. Among the weaknesses that have surfaced during the reform period are insufficient epidemiological data regarding diagnoses, no evaluations of treatment effectiveness and efficacy, and the absence of follow-up studies. Furthermore, these deficiencies mirror those found in other parts of the country and appear to be a characteristic of the reform of national mental health services in general (*8*).

CONCLUSIONS

What do the experiences of the clinical practitioners during the restructuring process in Campinas and Sobral provide their fellow colleagues outside Brazil engaged in similar efforts? Are the lessons learned only relevant to resource-poor settings, or might they be effectively applied in a variety of communities in the Americas and beyond?

A challenge met by both of the programs discussed in this chapter is the need for the ongoing training of health professionals—principally primary care physicians, psychiatrists, psychologists, therapists, and social workers—to enable them to make a meaningful contribution to the mental health care reforms under way. In particular, professional medical associations have historically focused more on issues of private practice versus those relating to the public health arena, such as deinstitutionalization and community-based services. The monetary profits to be gained through the continued maintenance of private mental health institutions may also serve as a source of subliminal resistance to these changes. In Campinas, the active participation of Cândido Ferreira Hospital as a site for the training of interns in social work, psychology, and occupational therapy ensures that the hospital's ethical and clinical values have the potential to be replicated in other facilities where these young professionals go to work later on. In Sobral, the active involvement of mental health care personnel in the Visconde de Sabóia Family Health School and the essential role this group plays in the development of broader public health priorities in the municipality has enabled it to wield a visible influence not only over current activities but the training of future generations of health care providers as well.

An additional question is whether, in this model, the various needs of sub-populations can be served, and what other alternate models might afford even greater responsiveness to this population. Certainly Campinas has raised the development of the specialized CAPS concept—whether those targeting addictions or children's mental health problems—to a level unsurpassed elsewhere in the country. But the ideological shift away from institutionalization may become a dogmatic stand against hospitalization in geographical settings where the physical capacity and/or degree of human resources training at CAPS facilities are insufficient or unsuited to serve the population's needs. There may likewise be clinical occasions when the severity or acuteness of a mental condition warrants its prompt treatment, even if this requires seeking services outside the community network. Sobral's strengths, on the other hand, are identifying populations at risk and prioritizing close collaboration between primary health care and psychiatry with a focus on outreach to peripheral communities and surrounding small towns.

Within the context of these observations, however, it is worth noting that the Brazilian Ministry of Health has identified one group as being insufficiently targeted by either of the two programs highlighted in this chapter. This sector includes those living in the midst of "social crisis, violence, and unemployment," and in this regard, perhaps Sobral's *terapia comunitária* approach comes closest to addressing the needs of this sub-population by providing an informal forum that facilitates the sharing of individual crises and the seeking of mutual validation and support (*9*).

In the midst of mental health care reform how can the continuity and responsiveness of services be guaranteed? As the experiences of the Cândido Ferreira Hospital have demonstrated, there is an argument to be made for the ability of philanthropic organizations to create treatment centers that can withstand—both financially and politically—the vicissitudes of changes of government which threaten the sustainability of nascent mental health reforms.

In the case of both Campinas and Sobral, to what degree do the services described in this chapter attempt to incorporate therapeutic options outside the scope of modern mainstream medical practice, including those in the informal mental health care sector where folk healers, Afro-Brazilian (*14*) and Kardecist (*15*) spiritualists (whose adherents are concentrated in the lower and middle classes, respectively)—and charismatic healers operate? Certainly, published anecdotal evidence supports the use of resources outside formal psychiatric institutions to treat disturbances categorized as psychiatric by the *International Classification of Diseases and Related Health Problems, Tenth Revision*, or following the *Diagnostic and Statistical Manual of Mental Disorders* nosology (*16–18*). While the incorporation of the *roda* at Cândido Ferreira Hospital provides a high-profile example of the institution's willingness to experiment with democratic processes as part of its therapeutic interventions, Sobral's mental health services might be judged to be more successful than those of Cândido in incorporating nontraditional psychiatric therapies and, consequently, in approximating authentic community-oriented or community-based psychiatry. The road to full social inclusion for patients would then include the application of nonstandard therapies. Regardless of their differences, however, both the Campinas and Sobral programs have adopted novel approaches in their response to the national government's call for the decentralization and deinstitutionalization of mental health services (*19*).

Clearly, both the absolute and relative limitation of resources for these programs at the national level poses a stumbling block beyond which few local jurisdictions, no matter how creative or determined, may proceed. However, Brazil's progress in overhauling mental health services has received international attention recently, despite perennial problems related to insufficient funding (*8*).

References

1.   Paulin LF, Turato ER. Antecedentes da reforma psiquiátrica no Brasil: as contradições dos anos 1970. Hist. cienc. saude-Manguinhos 2004;11(2):241–258.
2.   Alves DN, Valentini W. Mental health policy in Brazil: from dictatorship to democracy. In: Morrall P, Hazleton M, eds. Mental health: global policies and human rights. Hoboken: John Wiley & Sons; 2005.
3.   Amarante P. Psiquiatria social e reforma psiquiátrica. Rio de Janeiro: Fiocruz; 1994.
4.   Freire Costa J. História da psiquiatria no Brasil. 3rd edition. Rio de Janeiro: Editora Campus; 1981.
5.   Lougon M. Desinstitucionalização da assistência psiquiátrica: uma perspectiva crítica. Physis: Rev Saúde Col 1993;3(2):137–164.
6.   Vasconcelos E. Do hospício a comunidade. Belo Horizonte: Segrac; 1992.
7.   Vianna S, Piola S. Descentralização e gestão do gasto público com saúde no Brasil. In: Brasil: Radiografia da saúde. São Paulo: CEPAL/IPEA; 1999:105–140.
8.   Jacob KS, Sharan P, Mirza I, Garrido-Cumbrera M, Seedat S, Mari JJ, et al. Mental health systems in countries: where are we now? The Lancet 2007;370(9592):1061–1077.
9.   Brasil, Ministério da Saúde. Política de Saúde Mental. Available at: http://portal.saude.gov.br/saude/visualizar_texto.cfm?idtxt=16134. Accessed 8 October 2007.
10.   Campos FCB, Henriques CMP. Contra a maré à beira-mar: a experiência do SUS em Santos. 2nd ed. São Paulo: Editora Hucitec; 1997.
11.   Brasil, Ministério da Saúde. Saúde Mental no SUS: Os Centros de Atenção Psicossocial. Brasília; 2004.
12.   Campos GWS. Um método para a análise e co-gestão de coletivos: a constituição do sujeito, a produção de valor de uso e a democracia em instituições. São Paulo: Editora Hucitec; 2000.
13.   Bower P, Gilbody S. Managing common mental health disorders in primary care: conceptual models and evidence base. BMJ 2005;330(7495):839–842.
14.   Guedes SL. Umbanda e Loucura. In: Velho G, ed. Desvio e divergência: uma crítica da patologia social. Rio de Janeiro: Jorge Zahar; 1985.
15.   Greenfield SM. Spirits and spiritist therapy in southern Brazil: a case study of an innovative, syncretic healing group. Cult Med Psychiat 1992;16(1):23–51.
16.   Brody EB. The lost ones: social forces and mental illness in Rio de Janeiro. New York: International Universities Press; 1973.
17.   Duarte LFD. Da vida nervosa nas classes trabalhadoras urbanas. Rio de Janeiro: Zahar/CNPq; 1986.
18.   Noronha M. Medicinas paralelas: sua aceitação e eficácia. J Bras Psiquiatr 1991;40(2):89–93.
19.   Venâncio ATA. A construção social da pessoa e a psiquiatria: do alienismo à 'Nova Psiquiatria'. Physis: Rev Saúde Col 1993;3(2):117–135.

CHILE:
REFORMS IN NATIONAL MENTAL HEALTH POLICY
Carrie M. Farmer [1]

In the last decade, Chile developed and implemented a comprehensive national mental health plan (NMHP), which provides mental health benefits and services to the country's 15 million citizens. The scope of the plan is broad, addressing both medical and social aspects of mental illness, including the stigma and risk of marginalization that can come from a mental illness diagnosis. The national mental health plan promotes psychosocial interventions and recommends reforms to the delivery system for care; where possible, it uses an evidence-based approach. This chapter describes the national mental health plan's antecedents and its details; it also illustrates certain components of the plan "in action." The chapter also will highlight two national mental health programs in the country: the national depression program and a program for victims of the 17-year military dictatorship. The chapter will conclude by evaluating challenges posed by implementing the plan as it is written.

BACKGROUND

Mental Health in Chile
Several recent epidemiological studies have described the prevalence and incidence of mental health disorders in Chile (*1–4*). The prevalence of mental disorders is higher in Chile than in other countries in the Americas. For example, a 2003 study found that 31.5% of the Chilean population had had a psychiatric disorder over the course of their lifetime, and 22.2% had experienced one in the past 12 months (*4*). The lifetime prevalence of mental disorders is 26.4% in the United States and 17.8% in Colombia (*5*).The most common mental health problems in Chile include phobias, major depressive disorder, and alcohol dependence. Since epidemiological methodologies can differ from study to study, however, it is difficult to say definitively that the difference in prevalence rates is significant.

Depression
The lifetime prevalence of major depression in Chile is 9.0% (*3*, *4*), with a 6-month prevalence of 4.6% (*3*) and a 12-month prevalence of 5.7 percent (*4*). This is similar to rates of depression in other countries (*5*). According to a study completed by Chile's Ministry of Health, those at greatest risk for developing depression and who have the least access to care include women 20–45 years old, post-partum and menopausal women, those who suffer chronic illnesses, those who experience domestic violence, heads of household, and people living in crisis situations (*6*). For women, depression is the second leading cause of years of healthy life lost due to disability and premature death (years lived with disability, or YLD). Depression is at least twice more prevalent in women than in men. In fact, 92% of persons treated for depression in Chile are women (*6*).

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[1] Doctoral candidate, National Institutes of Mental Health Trainee, Department of Health Policy, Harvard University.

Substance Abuse

More than 14% of Chileans meet criteria for substance abuse or dependence during their lifetimes. These conditions are more than twice as prevalent in men as in women. Alcohol dependence, in particular, disproportionately affects men: lifetime prevalence for men is 11%, and only 2% for women (*3*). Of all men treated in primary care clinics, 40% meet criteria for alcohol abuse (*6*).

Health Insurance Coverage in Chile

Chile's health care system is best described as a public-private system with compulsory purchase of health insurance. Every formal sector worker or pensioner contributes 7% of his or her income to finance health insurance. Each contributor can choose whether to allocate the contribution to public insurance, via the national health fund (*Fondo Nacional de Salud*, FONASA), or to one of 22 private health insurers (*Instituciones de Salud Provisional*, ISAPREs). The contribution's recipient then provides insurance coverage for the worker and for his or her dependents. Unemployed or informal sector workers are automatically covered by public insurance. In 2003, 68% of the population was covered by FONASA; 22% had health insurance from one of the ISAPREs.

ISAPREs offer multiple policies with varying amounts of coverage, coinsurance, and copayments. Premiums for these policies vary not only on the basis of amount of coverage provided, but also on the age and gender of the person seeking coverage. Contributors to ISAPREs can opt to pay more than the required 7% of income in order to receive a more expensive (and arguably higher quality) policy. Depending on income level, almost everyone who chooses private insurance pays more than the required amount. In fact, data from the regulatory body within the Ministry of Health that oversees ISAPREs, indicate that persons whose insurance is provided through ISAPREs pay, on average, 9.1% of their incomes for premiums (*7*).

People use a variety of criteria to decide between ISAPRE and FONASA coverage, including the number of people in a family, which can affect the cost of the premium. Some ISAPREs are thought to offer better plans and have better physicians and clinics, which also can affect the choice. Since ISAPRE policies usually include a stop-loss component, limiting the company's financial risk, however, individuals who use a lot of health care (or are likely to) often opt for public insurance. Most ISAPREs provide minimal coverage for mental health services (*7, 8*). People with significant mental health care needs often choose public sector health insurance. Consequently, this chapter will focus on policies and services related to mental health in the public health system, FONASA.

A third health insurance option is available for a special group—victims of the Pinochet military dictatorship. These persons are entitled to receive free health care through the Program for Compensation and Comprehensive Health Care for Victims of Human Rights Violations (known as PRAIS, the acronym of its Spanish name, *Programa de Reparación y Atención Integral en Salud y Derechos Humanos*), an entitlement program run by the Ministry of Health and administered by the Mental Health Unit. Beneficiaries are not required to pay the 7% payroll contribution. Instead, they receive a special identification card that they present at primary and secondary care centers and at public hospitals when medical services are rendered. The PRAIS program will be described in more detail further on in the chapter.

THE NATIONAL MENTAL HEALTH PLAN

During the early 1990s, the Mental Health Unit was created within the Ministry of Health. Funding from sources such as the United States Agency for International Development (USAID),

the European Union, and the Government of Italy, helped to develop the Mental Health Unit (Alberto Minoletti, personal communication). In 1993, the Mental Health Unit drew up the first national mental health plan which focused on six priority areas: children's mental health, providing mental health care in primary care settings, development of a network of psychiatric and mental health services, treating alcohol and drug abuse problems, care and rehabilitation of mentally disabled people, and health effects of violence and human rights (*9*). The national mental health plan also endeavored to incorporate mental health care into primary care by having 'psychosocial reinforcement teams' work in community health centers throughout the country. Mental health care was to be delivered through a nationwide network of psychiatric and mental health services, with at least one staff person in charge of mental health in each health service area. Mental health teams in the health service areas were modeled after the 'team' at the central Mental Health Unit. With this model in place, each of the country's 28 health service areas would be able to independently manage its mental health budget, coordinate mental health services, plan for additional services, and evaluate the mental health care provided (*9*).

The 1993 National Mental Health Plan was implemented over the next decade and yielded many positive developments: group homes were established for newly deinstitutionalized populations, pilot programs placing mental health programs in day hospitals were well received, and efforts at intersectoral cooperation were successful. The plan did have some drawbacks, however: it was not implemented consistently across the country and government contracts for various aspects of the plan (day hospitals, for example) were only issued on a year-to-year basis, making continuity difficult to ensure (Alberto Minoletti, personal communication).

In 1997, as a first step towards national health reform, the Government of Chile conducted several studies to determine which health conditions should be considered priorities. Using disability adjusted life years (DALYs) to measure burden of disease, one study found that depression and other mental health problems conferred a significant disease burden on the country (*8*). Additional epidemiological studies confirmed this (*10*). As a result, there was renewed interest in the national mental health plan, and the Ministry of Health began to revise the national mental health plan in 1999.

During the development of the new plan, the Ministry of Health commissioned cost-effectiveness analyses to determine on which areas the limited mental health funds should be focused. The cost-effectiveness analyses led to a "priority list" based on several factors: the type and number of technicians or professionals needed to deliver services, the estimated annual demand, the average percentage of the population who would need the services, the average duration of each activity in hours per person attended, the estimated concentration or average number of treatments or services per year for a person in treatment, and the clinical evidence on the various treatments or services (*11*). The resulting priority list included the following seven components:

- Alzheimer's disease and other dementias,
- drug and alcohol abuse and dependence,
- hyperactivity disorders in children and adolescents,
- mental health promotion and risk prevention,
- mental disorders associated with violence (child abuse, domestic violence, and violence from the 1973–1990 dictatorship),
- depression, and
- schizophrenia.

When priorities are established, it can be difficult to determine the cut-off point. For example, if almost everything is important, where does the line get drawn between a "priority" and a "non-priority"? Or, if resources are limited, where should funds go? Though the intentions of this particular priority list are excellent, some may question whether these conditions could really be considered "priorities," given that the list covers almost all mental health conditions. One method, albeit imperfect, of determining which conditions are the real priorities in Chile is to examine the budget for the Mental Health Unit and its programs. In 2003, the mental health budget comprised 2.1% of the total health budget (8).[2] True priority areas, then, may be those that receive sizable portions of this relatively meager budget. From personal observations, these include the following:

- **Schizophrenia.** As in any mental health program, care for persons with schizophrenia is very expensive. First, many people with schizophrenia are treated as inpatients in psychiatric hospitals. Chile's four psychiatric hospitals, though in the process of deinstitutionalization, take up the bulk of the national mental health budget. Second, medications to treat schizophrenia are very expensive. Atypical anti-psychotics are extremely expensive in Chile; Clozapine, for example, is so expensive that the government imports it from China, where it is more than 10 times less expensive. Though the government provided atypical antipsychotic medications to more than 6,000 patients in 2004 (Alberto Minoletti, personal communication), the need is much greater than that. There is a priority system and a waiting list for patients who need these drugs. Some families must purchase them directly from pharmacies rather than wait for the government to provide them.

- **Mental Health Promotion and Risk Prevention.** This priority aims to modify various social determinants of health by improving material conditions (reduction of poverty) and encouraging health behaviors (diet, exercise). In including this area as a priority, the plan's architects drew on a substantial literature from social epidemiology and medical sociology regarding the power of social and societal determinants of health and disease (12). These determinants include social cohesion, equality in income distribution, and social capital. The national mental health plan argues that a deficiency in any of these areas can affect the neuroendocrine and immune systems, as well as general biological functioning (11). Furthermore, psychobiological changes induced by societal conditions affect the way people respond physiologically, behaviorally, and emotionally to stressors. Higher stress levels increase vulnerability to disease. An environment with poor social cohesion can result in (among other things) depression and compensatory lifestyles that include tobacco and alcohol abuse and excessive eating. To address these issues, the national mental health plan suggests that mental health teams should (1) coordinate activities with community groups and offices within other sectors, (2) develop social support networks and self-help groups within schools and the community, and (3) provide information to people at high risk and encourage their participation in psychosocial group activities. It is interesting to note that while there is evidence to claim that there is a direct relationship between social and environmental stressors and mental health (12–15), Chile's national mental health plan may be one of the first official documents to describe these issues as fact and to develop mechanisms to address them.

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[2] This is a significantly higher percentage of the total health budget than in other countries in the Americas (U.S. and Canada excluded). For example, Mexico dedicates 0.2% of the health budget to mental health, Colombia 0.08%, and Paraguay 0.05%. Source: WHO Atlas Project.

- **Depression.** The depression treatment program delineated in the plan will be discussed in more detail later in the chapter. Briefly, the program uses an evidence-based approach to treat depression in primary care. The focus is on the use of guidelines and treatment algorithms that standardize care across the country.

The 2001 National Mental Health Plan outlined a new way of organizing mental health services in the country. All mental health care is to be coordinated by an integrated network of services, which coalesces what had been a fragmented system. As the architects of the plan wrote: "This network should be a model of community care, in which a group of available resources, both public and private, will care for the existing mental health and psychiatric problems of a population within an established geographic area in a coordinated and integrated manner."

Various types of health establishments form the mental health network, ranging from rural outposts, rural health care clinics, urban general medical offices, emergency primary care centers, general hospitals, local primary care clinics, and emergency services. In each health service area, the network consists of a community primary care center; a mental health and psychiatric outpatient department at a health referral center; a therapeutic diagnostic center or a general hospital; a short-stay psychiatric clinic located in a general hospital; a day hospital associated with an outpatient primary care center; and medium-stay psychiatric care, usually located in a psychiatric hospital. In addition, each health service area has many group homes for mentally ill patients and maintains a solid relationship with organizations of mental health patients and their families. Finally, each service area usually has an active Program for Compensation and Comprehensive Health Care for Victims of Human Rights Violations (PRAIS) with teams of mental health professionals focused on outreach and treatment.

The national mental health plan emphasizes prevention and outpatient care. To wit, it requires that at least 30% of mental health activities should be devoted to promotion of mental health and prevention of mental health problems and psychiatric illnesses; that the number of spaces in day hospitals should be at least four times as great as the number of short-stay beds; and that the number of medium-stay beds should be fewer than the number of beds in psychiatric clinics.[3]

According to the plan, each health service area is supposed to have outpatient mental health teams in charge of an assigned population within a defined geographical region. Everyone in the beneficiary population should be assigned to one of these teams. In addition, each health service area develops its own strategic plan based on the following principles: (1) mental health activities within each health service area should be defined and prioritized by the epidemiological profile of the area; (2) plans and programs must encompass the whole spectrum from health to illness and should include primary, secondary, and tertiary prevention and care; (3) the family's and the community's participation must be enlisted; (4) there should be cost-effective use of resources; and (5) there should be coordination with other public and private sectors.

Mental health teams at the community or provincial levels are made up of a psychiatrist (ideally), a psychologist, a social worker, a nurse, an occupational therapist, a technical paramedic, and a health educator. These teams are responsible for a defined population within a defined geographic region. According to national standards, one team should be available for every 40,000

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[3] These and other technical guidelines were reached by consensus at the National Conference "Plan for Psychiatric Care for Chile,"held in May 1999, and at the World Mental Health Congress, held in September 1999. Attendees of both conferences included members of Chile's medical and psychiatric associations, community organizations, and health professionals.

beneficiaries. The teams can be located within community mental health centers or medium-sized healthcare facilities.

STRUCTURE OF MENTAL HEALTH SERVICES

The author visited a mental health unit in an health service area that covered 11 neighborhoods in the southern area of the capital, Santiago. The area included 29 primary care clinics, 4 community mental health centers, 6 hospitals, 2 outpatient psychiatric departments, and 7 emergency care centers.

Prior to the new national mental health plan, this health service area had had little organization or coordination of mental health services. Administrators of the mental health unit have had to work to coordinate services and develop a community-based mental health program according to the guidelines of the plan. A lack of sufficient resources has hindered this process. There is a waiting list for each of the services offered by the health service area, and access to medications is not guaranteed—there are months when there are more patients who need psychotropic medications than there are medications available.

Administrators at the mental health unit stated that the real problem lies not with resources, but rather with a need to change the "culture" of mental health care. They have had to train mental health providers and specialists at the different components of the network to work together as a team, which has not been easy. People who have worked in the mental health system for years have developed a way of doing things that has served them well throughout their careers, and they are resistant to the new priorities, standards, and organizational forms. Without addressing the resistance by ensuring that these ground-level workers buy into the new ways and, thus, initiating a form of cultural change, this author was told that additional financial resources would only reinforce doing things in the usual way.

Even with these challenges, the mental health unit has made remarkable progress. In the first two years after the national mental health plan came into being, it developed a clear mental health plan for the health service area and coordinated and streamlined many mental health services. Their health service area mental health plan is similar to the national mental health plan and serves to supplement it, focusing on community-based mental health care. The health service area plan also emphasizes the deinstitutionalization of El Peral, one of the country's four psychiatric hospitals, which is located in the area. The intent is to substitute the hospital's with community-oriented services such as group homes whenever possible. The health service area's mental health unit also emphasized the development and maintenance of the mental health network. To this end, the unit's administrators travel throughout the area on a daily basis, meeting with health care providers and administrators in the area's primary care clinics, day hospitals, group homes, and El Peral hospital.

The author visited many of the components of the mental health network in the area and had an overall good impression of the mental health services. All of the mental health workers seemed to have a passion for and dedication to their work, and were caring toward their patients. The following are personal observations of several of the mental health facilities within the HSA.

The General Hospital, Day Hospital, and Rehabilitation Program

One general hospital in this area contains a psychiatric unit, a day hospital, and a psychiatric rehabilitation program within its grounds. The hospital's psychiatric unit has 28 beds for short-stay visits (up to 60 days). Patients are classified as "less severe" and "more severe," though the

criteria for this classification are unclear. The more severe patients are restricted to a certain side of the ward, with a line on the floor and a change of wall color delineating the side. During the day, patients receive some psychosocial education and participate in rehabilitation activities in the ward's common area. Doors to the ward are kept locked, although staff stated that patients were free insofar that they could get a pass to leave the hospital if accompanied by a family member. The psychiatric unit's director has an extremely small office without a computer, which is extraordinary considering the challenges he faces in trying to implement the new network model of psychiatric care. He described the difficulties in making changes to the system of mental health care without adequate resources. For example, without an electronic database, he said it is difficult or impossible for him to track the number of patients seen in the psychiatric unit or the amount of medications each patient takes.

The day hospital treats about 20 patients at any one time; these patients generally have outpatient treatment lasting two to three months. The day program runs all day on Mondays, Wednesdays, and Fridays and half-days on Tuesdays and Thursdays. Each day follows a rigid schedule with activities such as psychosocial education, education about medications and treatment choices, workshops on drug abuse, and trips to the city to learn how to function in society. Patients also learn how to perform domestic chores such as preparing breakfast and setting the table. All patients participate in both group and individual therapy. The hospital atmosphere seemed positive; patients seemed content and well cared for and the staff seemed dedicated.

Unlike the day hospital, the rehabilitation program did not leave a good impression. Program activities took place in an unheated building that looked like a warehouse. The rehabilitation "task" I observed was shredding paper in order to recycle it. A few patients that attend the rehabilitation program have outside jobs, such as answering phones at the general hospital or selling chocolates, but the majority do not. It was not clear how these patients were being rehabilitated.

The Psychiatric Hospital

The national mental health plan specifies that no new psychiatric hospitals are to be built. Instead, the country's four psychiatric hospitals will form a part of the mental health network of their respective health service areas in an attempt to support deinstitutionalization. At El Peral, on the outskirts of Santiago, the tension surrounding deinstitutionalization was palpable. The hospital has reduced the long-stay beds from 600 to 200 since 1990. In 2002, Mauricio Gómez, El Peral's director, closed "section 7," which was historically the largest and most restrictive section of the hospital. Patients were moved to other hospital areas or to group homes, depending on the severity of their illnesses. This closure was viewed by the hospital community as a menace to the future of the hospital and to their own job stability.

Currently, El Peral cares for about 200 patients who are considered to be there for "extended stays;" it also has 76 short-stay beds. Some of the most severe traditionally "extended-stay" psychotic patients have been reclassified as "medium-stay." As structural evidence of this change, many of the extended-stay wards have been renovated to create private and semi-private rooms. According to the Ministry of Health, "medium stay" patients stay at the hospital for two months to a year. In reality, however, many of the medium-stay patients remain at the hospital for years. The goal of the medium stay program is to slowly but intensively rehabilitate patients by using an intensive live-work model: the patients have jobs within the hospital, such as taking care of the grounds, but still have a traditional clinical structure, almost like living in a group home within El

Peral. The idea is that medium-stay patients will one day be able to live in a group home outside the hospital. This model has resulted in a reduction of symptoms in a great number of the most severe patients, allowing them to leave the hospital.

Severe patients with pervasive developmental disorders live in a separate, locked area that includes a dining room and a play yard. Most of these patients, now adults, arrived many years ago as children and used to live in abominable conditions. Administrators at El Peral developed a program to improve their clinical condition and quality of life. A team now works one-on-one with each patient and every week reviews the patient's advances, goals, events of the past week, treatment options, new diagnoses, etc. Staff are genuinely concerned about the patients, and appear to be doing as much as they can with the limited resources that are available. According to the staff, working with this group of very severe patients is difficult, since the health system has all but ignored them. When or if these patients get better or more stable, there are few options. There are not enough group homes or community services for them. Even within the hospital, there is a definite lack of sufficient resources. Many patients need individual attention, and there are not enough staff.

Changing the norms and culture of the institution has been extremely difficult and presents a challenge to the implementation of the national mental health plan. For example, in the hospital's short-stay area, ten of the psychiatric beds recently were eliminated and taken up by a local general hospital. Ten workers from El Peral voluntarily agreed to work at the general hospital, in accordance with plans to increase the role of the general hospital and decrease the role of El Peral. Most of the staff were very upset about this, however. Any time there's a change, hospital workers fear losing their jobs and not having anywhere else to go. Many of the workers live on the outskirts of the hospital grounds. They share a community and culture among them; many of their parents also worked in the hospital and there is a way of doing things that is difficult to change.

In addition, Chile's Mental Health Society, a scientific organization for mental health professionals, opposed the closure and transfer of beds. Society members, I was told, tend to use traditional models of mental health treatment and are generally opposed to "newer" treatment models such as community psychiatry and defend the importance of psychiatric hospitals. The Society claimed that reducing the number of beds would lead to the abandonment of patients, leaving them to live on the streets as happened in the United States. Tensions increased to the point that Dr. Gómez, with support from the Mental Health Unit at the Ministry of Health, participated in a debate with the Health Commission of the National Congress. In the end, he won, and the beds were transferred.

The Group Home

Within El Peral's catchment area[4] are a long and/or medium-stay facility (inside El Peral), two short-stay services (one inside El Peral), two day hospitals, two psychiatric outpatient clinics and fourteen group homes. The author visited a group home housing nine patients recently discharged from El Peral. All the residents had been at El Peral for many years; one man had been there for 29 years. Staff in the home provide 24-hour coverage and help with meals, provide support, and give assistance with a variety of other needs of the residents. Most of the residents hold jobs, such as working on the grounds at El Peral or those of the local general hospital. One

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[4] El Peral's catchement area includes three health service areas; this section will describe the services available in one of them.

man was growing house plants in the back yard of the home to sell in the community. Once a week, residents attend a social club where they can interact with other former El Peral patients who now live in group homes. Residents will be able to live in this group home until the end of their lives; all living expenses and services are paid for by FONASA and the health service area.

TARGETED PROGRAMS

Two interesting and important components of the national mental health plan are the nationwide programs directed at special populations: those who were victims of the country's 17-year military dictatorship and those who suffer from depression. The following sections will describe these two programs in detail.

Program for The Compensation and Comprehensive Health Care for Victims of Human Rights Violations (PRAIS)

On September 11, 1973, General Augusto Pinochet and his army staged a coup d'état that ushered in a brutal and repressive military dictatorship that remained in power for 17 years. During the Pinochet regime, it is estimated that 10% of Chile's population (800,000 people) were executed, tortured, disappeared, imprisoned, sent to concentration camps, or exiled (*16*). Details about these atrocities came to light at the end of the dictatorship, when the newly elected democratic government created a National Truth and Reconciliation Commission. The Commission conducted an investigation and wrote the now famous "Rettig Report" (Informe Rettig), which reported on the events that had occurred during the regime. The "Rettig Report" led to the passage of the Law of Reparation and Reconciliation, which sets forth the rights of and benefits for those who were victims of the military regime. Among other things, beneficiaries under the law have the right to receive free health care though a special program that is authorized and controlled by the National Health System.

The Program for Compensation and Comprehensive Health Care for Victims of Human Rights Violations (PRAIS) is carried out by specialized teams in each health service area and is supervised by the Ministry of Health' Mental Health Unit. PRAIS provides integrated physical and mental health care for persons and families who have been officially designated as victims of the military dictatorship. As state-recognized victims, PRAIS beneficiaries are entitled to various physical and mental health treatments. Two key features of the PRAIS program include: the right to free health care in the public system; and the right to specific interventions that address the trauma experienced by each victim. Each qualified person receives a PRAIS identification card, which allows him or her to access health services free of charge (*16*).

When the program was began, 200,000 persons were expected to use its services. Enrollment got off to a slow start, however, and by 1999 only 46,000 Chileans were covered by PRAIS. In part this can be explained by victims' resistance to being publicly recognized. After the initial actions of the National Truth and Reconciliation Commission and the release of the "Rettig Report," a "national silence" took hold of the country. No one—not individuals, not groups, not the media—openly discussed the atrocities of the Pinochet regime. No one talked about the many human rights abuses or demanded to know the fates of the disappeared. Perhaps this was due to a lingering fear of reprisal for questioning the actions of the former government, or perhaps it was just Chile's way of dealing with the pain of those memories. Some have said that this is the Chilean way: to forgive and forget (*8*).

In 1998, Britain brought legal procedures against the aging Pinochet. This reopened the discussion of what had happened during the regime and led to a series of demands for Pinochet and other members of the Armed Forces to get at the "truth"—to disclose where bodies were buried, what happened to the disappeared, how many were tortured, and other details. The legal procedures effectively brought about an end to the silence. Chileans began to uncover the past and explore long repressed memories. It became more acceptable to be identified as a victim and, by extension, to take advantage of the associated benefits. As a result, the number of people enrolled in the PRAIS program tripled: in 2003, the number of beneficiaries had reached 180,000.[5]

Current Challenges

The national mental health plan requires that each health service area have a PRAIS team dedicated to outreach and treatment for each 5,000 to 10,000 beneficiaries in the area. In reality, however, some health service areas do not have a PRAIS team; in others, the program struggles with meager funds, often working with limited staff and resources. The PRAIS office in the health service area this author visited, for example, did not have a computer and occupied just two small rooms. There also was a lengthy waiting list for PRAIS services. A group of PRAIS beneficiaries recently scheduled marches on the capital and meetings with Ministry of Health officials, demanding more resources for the program. As Alberto Minoletti, the head of the Ministry of Health's Mental Health Unit said in a recent newsletter, "… it can't be [said] that these people are [undeserving] of the State's resources, when it was the State during the military dictatorship that tortured these people, that violated their human rights … because of this, the State has to repair the damages it caused" (*17*).

In addition, it has been difficult since the beginning of the program to define who is rightfully a "victim." For example, are cousins or uncles of the disappeared considered victims? How about those who witnessed torture? Information has been hard to come by, and no one in the country has a good idea of how many victims there had been (*8*). The Law of Reparation defined the PRAIS population as children, parents, spouses, and siblings of those tortured or disappeared. There are other groups, however, that are not covered by the law. It is difficult, for example, to decide who is a victim among multiple people living under the same roof when a person was disappeared, executed or tortured, since all were directly affected and all suffered. There has been some talk of relying on "directly affected" persons versus "indirectly affected" persons, rather than using strict definitions of son/daughter or parent, for example, as a possible way to define "victim." (Amnesty International claims that the Government has not acknowledged many torture victims.)

Partly due to lack of knowledge and understanding about PRAIS, health care providers have not always been willing to accept the PRAIS identification cards, which has made it difficult to ensure that victims receive free health care. This may be changing with the influx of new beneficiaries, as the program gets renewed attention.

One of the biggest challenges that PRAIS faces is the complex and disparate needs of some of its beneficiaries. In effect, the program must deal with both social and cultural aspects of victimization, which may require resources beyond the capacity of PRAIS teams. Several specific

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[5] In August 2004, Chile's Supreme Court lifted the immunity status Pinochet had enjoyed as a former president, opening the door for legal proceedings holding the former dictator responsible for the atrocities that occurred under his watch. What this means for PRAIS remains to be seen. One would expect the number of people who identify themselves as victims to rise and the issue of who "deserves" victim status to become part of the national dialogue again.

situations serve to illustrate this point. First, there have been problems with the "reincorporation" of children who were born in exile and have now returned to Chile—they are neither Chilean nor are they French, German, Swiss, or from wherever. What their parents may have told them about Chile is no longer the country's reality, given the great changes Chile has gone through in their absence. First, how can PRAIS address the distinct needs of this group of beneficiaries? Second, many PRAIS beneficiaries are poor and were repressed, which makes handling their situations extremely complex. Confronting both the damage from the dictatorship and the damage from living in poverty requires more from the system than it can often offer. Finally, some persons who were tortured have adverse responses to certain types of medical care, such as dental and gynecological visits, because it makes them relive their experiences of torture and rape. The health system needs to be sensitive to this and able to respond to it.

Gathering information about the use of health services by PRAIS beneficiaries is nearly impossible. According to FONASA records, all PRAIS beneficiaries are categorized along with the poorest members of society who receive free health services in the public sector. When collecting information, researchers can only find information about all persons in the free-care group; it is impossible to separate out those who belong in PRAIS, since there is no PRAIS-specific box to check on the health records. Some see the lack of such a check-box as an illustration of the ongoing silence about talking about the dictatorship.

Future Plans

In the late 1990s, PRAIS beneficiaries organized themselves to demand passage of a PRAIS legislation to designate specific funding resources for the program and formalize the guarantee of free access to health services (*8*). A Ministry of Health proposal that is aimed at addressing these concerns involves changing the system of credentialing of PRAIS beneficiaries. For example, all beneficiaries would receive a special FONASA card and health records would contain a check-box for PRAIS beneficiaries. A new credentialing system like this would enable PRAIS to collect useful data about its beneficiaries, such as the illnesses associated with victimization and specifics about beneficiaries' use of health services.

The future of the program as a whole depends on politics, however. In August 2003, one month before the 30-year anniversary of the coup, Chilean president Ricardo Lagos announced a new "human rights proposal" that included the conformation of a commission that will determine which torture victims should receive compensation from the government. The human rights proposal also ensures that PRAIS beneficiaries will continue to receive legal recognition and an extension of medical benefits.

Coping with Depression

Depression is a major cause of morbidity and mortality in Chile (*1*). Of persons with depression, 75% seek treatment in primary care settings. Many are misdiagnosed, however, and many patients receive the wrong treatments or are under-treated. A recent study estimated that fewer than 35% of persons suffering from depression receive effective treatment in primary care settings. Furthermore, fewer than 20% receive treatment for more than four weeks, even though the recommended treatment duration is more than six months (*18*). Physicians in primary care clinics generally have little or no training in treating depression and have few resources for treatment. Although some patients with severe depression are referred to specialists (psychiatrists), the waiting list can exceed two months. Without proper treatment, depression can become a chronic

and debilitating disease, leading to a higher incidence of suicide and prolonged suffering both for patients and for their families (*19*, *20*).

In 2000, as an attempt to address these issues, researchers from the University of Chile and from Great Britain and the United States conducted a randomized controlled trial to examine the effectiveness of a depression intervention program for primary care clinics in Chile (*21*). Araya and colleagues randomized low income women with a diagnosis of major depression either to the intervention or to usual care. Since the researchers were concerned with creating an intervention that could actually be implemented in low resource settings, they trained non-medical professionals such as social workers and nurses to have primary roles in the intervention. The intervention, a "stepped-care improvement program," included several components: weekly structured psychoeducational group sessions, systematic monitoring of clinical progress at three and six months, and structured pharmacotherapy for patients with severe depression. Results showed that the intervention had a positive effect: even after controlling for various factors, patients enrolled in the intervention had lower mean depression scores (measured by the Hamilton Depression Rating Scale [HDRS] and the Medical Outcomes Study Short-Form [SF-36]) at three and six months than patients receiving usual care.

Program for the Integrated Detection, Diagnosis, and Treatment of Depression within Primary Care

In response to the need for better primary care for patients with depression, the Ministry of Health has implemented a new program, modeled after the one outlined above (*21*) and others explored in recent studies. The program is currently being phased in nationwide. As of July 2003, it was working in parts of all the country's 28 health service areas; by 2004, it was to have reached 60% of the population; by 2006, it is meant to reach all the population.

Essential components of the program include the incorporation of psychologists into general health teams in primary care clinics; reliance on standardized diagnoses; and the provision of patient and family education, treatment with antidepressant medications (only in the context of a therapeutic relationship), group psychosocial sessions (six) for at least 50% of program enrollees, intensive and continual training for the mental health team, standardized registration of enrollees, and regular evaluation and monitoring of the program's effectiveness.

The key to this program is standardization through the use of treatment guidelines. Following an algorithm, a team of primary care health professionals evaluates, diagnoses, and develops a treatment plan for patients who present with symptoms of depression. Clinic health professionals, such as nurse midwives and social workers, undergo training to understand the symptoms of depression, including those associated with mood, thought, motor activity, and somatization. In addition, they learn how to conduct diagnostic evaluations according to ICD-10 standards, determine when a patient is at risk for suicide and needs an immediate referral to a specialist, make differential diagnoses, and recognize risk factors associated with depression.

Treatment proceeds according to a set flow. After the initial diagnosis, a physician or psychologist categorizes the patient as having mild, moderate, or severe depression. Those with mild or moderate depression receive psychosocial support and six sessions of a group psychosocial intervention. Those at greatest risk also receive a home visit and family education. In addition, those with moderate depression are treated with antidepressant medications. Those with severe depression are immediately referred to a specialist. Every two weeks, the team evaluates the clinical progression of patients in the depression program and revises the treatment plan if necessary.

International Experience with Treatment Guidelines

Treatment guidelines have been implemented in many places around the world. Evidence indicates that adherence to guidelines for a variety of diseases and conditions is fairly inconsistent (*22–26*), however. For example, one study looked at the use of depression practice guidelines in the United States Veteran's Administration (VA) primary care clinics (*27*). The VA health system provides health care to all veterans of the United States Armed Forces in various clinics and hospitals throughout the country. Because it is a government-run program, standardization of care is high on the list at the VA health system, and each clinic and hospital is expected to comply with national standards and guidelines. Despite this, Dobscha and colleagues (*27*) found that overall adherence to clinical practice guideline criteria only reached 51% in the study sample. A recent paper by Cabana and colleagues (*28*) suggested several barriers to guideline adherence: (1) lack of familiarity with the guideline's specific content or details, (2) lack of agreement with guidelines, (3) lack of ability to perform tasks or behaviors recommended by the guideline, (4) low outcome expectancy, (5) inertia of previous practice due to habit or custom, and (6) external barriers from patients, health care organizations, and influences (*28*).

Is Chile a One-of-a-Kind Case?

Chile's program has certain characteristics that may enable it to overcome some of the difficulties in implementing treatment guidelines. First, Chile's health system is controlled by a central authority, which allows for the standardization of services and programs across the country. The country has had a national health system since the 1950s, and public clinics and rural outposts are found in every area of the country. The health system's 28 regional health service areas report to the Ministry of Health. Although the directors of each health service area manage the health system's various functions at the regional level, they are required to conform to national standards.

Second, the program is part of a larger health reform and quality-of-care effort. The recently passed the System of Universal Access with Explicit Guarantees (known by the acronym AUGE, for the plan's name in Spanish, *Sistema de Acceso Universal con Garantías Explícitas*), which guarantees that all Chilean citizens have (1) access to care, (2) quality care, (3) opportunity, and (4) financial protection for 56 prioritized diseases or health conditions. Depression is one of them. Once the depression program has been fully implemented, it will be incorporated into AUGE's pilot phase, which means that the Ministry of Health will guarantee that all Chileans who suffer from depression will have access to the program. Under AUGE, depression will be covered as a group of services (like a diagnosis-related group in the United States Medicare system) rather than as fee-for-service.

Third, while the program initially focused on primary care, it has since expanded to include secondary and tertiary care, making it a truly "integrated" program in terms of all health care aspects in the country. Since 2003, depression treatment at the secondary and tertiary levels of care has improved greatly: a centralized system of purchasing and distributing newer anti-depressant medications has been established, psychosocial interventions have been introduced, and a pilot program geared to mental health specialists has been initiated (Alberto Minoletti, personal communication). By including the depression program in all levels of health care, Chile exponentially increases the odds that a person with depression will be adequately recognized and treated.

Finally, Chile's program has an extensive evaluation procedure in place to monitor the program and its effectiveness. Evaluation and monitoring of the program's implementation process and its results occurs twice a year in July and October. Results from 2001 and 2002 indicate that the program has more than met its goals each year. In 2001, for example, it set an enrollment goal of 14,000 persons, while in fact 18,224 persons enrolled (130% of the expected goal). Similarly, in 2002, a goal of 24,000 enrollees was set, while in fact there were 29,000 enrollees (121% of the expected goal) (*8*). Most of those enrolled in the program in 2001 and in 2002 were diagnosed with moderate depression (71% in 2001 and 69% in 2002). Indicators such as these are evaluated at each established time point to ensure that the program is moving in the intended direction and having the intended outcomes.

Every two years, the University of Chile also thoroughly evaluates the effectiveness of the program. In March 2002, the University team produced its first evaluation, which examined (1) the effectiveness of the program in terms of reduction of depression symptoms in female participants; (2) the actual functioning of the program, its relationship with secondary care and the associated costs of the program; and (3) changes in the well-being of the patient's family members. The team interviewed 169 women upon their enrollment into the program and then again after 10 weeks of treatment. They also interviewed 21 men who were the women's partners (spouse or other).

The University team found that most of the women enrolled in the program (79.5%) were suffering from moderate to severe depression. Many of these women also had co-morbidities: 40% suffered from anxiety and 63% had somatoform disorders. Most women interviewed (96%) were receiving pharmacological treatment with antidepressant medication. Seventy-two percent were enrolled in group therapy, although only 37% of them attended all sessions; 41% received individual psychotherapy, and 47% of them attended all sessions. In terms of the effectiveness of the program, the University team found that the women enrolled in the program experienced significant improvements in their depressive symptoms, with those that had more severe depression having a more marked improvement. In addition, the University team found that symptoms of co-morbid anxiety or somatoform disorders and general life satisfaction also improved. In terms of the program's functioning, the University team found that only a few (7%) of those that should have been referred to a higher level of care (secondary or tertiary) had actually been referred. They concluded that this was likely due to difficulties in accessing specialty care (*29*).

Remaining Challenges

Implementing this sort of a program within a traditional medical system does not happen without a certain amount of resistance. Program administrators have had to work with physicians and other professionals in primary care centers to persuade them of the benefits of the program compared to those of usual care. Having data to support the program has helped this endeavor; physicians understand that the majority of patients with depression are treated in primary care settings. In fact, this is one of the goals of AUGE—to have patients treated within primary care first, and then referred to specialty care. If this is to be successful, buy-in from physicians working in primary care settings is necessary.

Future Plans

The University of Chile evaluation revealed a distressing feature of the women they evaluated: more than half (51%) of those who were in marital or other partnerships were victims of domestic violence. In response, the Mental Health Unit has launched a pilot program in three neighborhoods to determine the best intervention for domestic violence as part of an effort to integrate treatment/care for domestic violence with the depression program (*30*).

CONCLUSION

The future of Chile's mental health program is promising. It is impressive to see how quickly the National Mental Health Plan has been implemented. Most of the services this author visited in 2003 had only been around for as little as a few months or as much as a few years. In addition, the rate of deinstitutionalization and development of community mental health services at El Peral is astounding, given the painfully slow changes that have occurred in most other countries. Data about the extent of the network and the number of people receiving services changes rapidly. There is likely to be an even higher use of services at this writing than when the visits were conducted in 2003.

Another promising feature of Chile's program is the fact that the Ministry of Health' Mental Health Unit has developed standards of care for most mental health services delivered as part of the National Mental Health Plan, such as group homes, community mental health and psychiatric care teams, and structure of day hospitals. These standards will help to ensure that mental health services delivered in the country meet a certain baseline level of quality. While the standards focus on specific aspects of the National Mental Health Plan, the Mental Health Unit also is interested in ensuring that there is sufficient coordination throughout the mental health network in each health service area. To this end, the Mental Health Unit is developing evaluation tools to help mental health teams within the health service areas determine the degree of coordination, cooperation, and quality existing in the mental health network. In addition, they plan to establish a peer review system, where mental health teams from one health service area evaluate the metal health network of another area, and vice versa.

Evaluations of the effectiveness of mental health services delivered in the country and the extent to which they meet the published standards are ongoing. Evaluations include site visits and follow-up interviews with patients. Other planned studies and evaluations include studies of mental health services for children, the process of depression care in primary care as compared to specialty care, and evaluations of the effectiveness of programs for substance abuse.

There remain significant challenges to a full realization of the National Mental Health Plan, however. Without data to back up the plan, buy-in from other government sectors is near impossible. An information system and database are being developed as a part of AUGE, which will aid in the conduct of these and other studies. Until recently, there was no way to know how many patients were using non-specialized mental health services or even to know anything more than the number of hospital days or the number of psychiatric visits per person. The new information system uses personal identification numbers (Rol Único Tributario, or RUT), which is similar to a person's Social Security Number in the United States, to track people through the health care system. By using the RUT, information in the health system's database can be connected to databases in other sectors. This will enable a more sophisticated understanding of the patterns of mental illness and use of mental health services in the country. For example, data on antidepressant use can be stratified by education level, income level, or some other sociodemographic factor.

While it is heartening to know that an information system is being developed, there is no guaranteed funding for the system. Some people with whom this author spoke were guarded about the long-term financial future of the system, suggesting that there was a great deal of politics involved in funding decisions. It is hard to imagine, given the lack of technology infrastructure in the health service areas, that such a system will be possible in the near future. The lack of computer resources means that local clinics cannot know how many mental health visits occur each month and mental health units cannot determine the prevalence of various mental disorders and the needs of the residents. While Chile's position with respect to computer technology is better than that of many other countries in the Americas, the fact that the National Mental Health Plan relies on an up-to-date information system to both justify its existence and evaluate its success means that a technologically sound national database is required. Without computers at the local level, mental health data will be scarce or seriously outdated.

Finally, change of this nature requires a shift in cultural norms on the part of the government, health professionals, and community members. The resistance to change mentioned in this chapter—the anger from the Chilean Mental Health Association against the regarding the proposed transfer of beds from El Peral to the general hospital and the resistance to the depression program within the HSAs, for example—are only a few of many instances. Change and progress will require education of and buy-in from the mental health professionals who will implement the various aspects of the National Mental Health Plan.

References

1. Minoletti A, López C. Las enfermedades mentales en Chile: magnitud y consecuencias. Santiago: Ministerio de Salud; 1999.
2. Araya R, Rojas G, et al. Common mental disorders in Santiago, Chile: prevalence and socio-demographic correlates. Br J Psychiatry 2001;178:228–33.
3. Vicente B, Rioseco P, et al. Estudio chileno de prevalencia de patología psiquiátrica. Rev Med Chil 2002;130:527-536.
4. Vicente B, Kohn R, et al. Lifetime and 12-month prevalence of DSM-III-R disorders in the Chile psychiatric prevalence study. Am J Psychiatry 2006;163(8):1362-70.
5. Demyttenaere K, Bruffaerts R, et al. Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. JAMA 2004;291(21):2581-90.
6. Chile, Ministerio de Salud, Departamento de Atención Primaria. Programa Nacional de Diagnóstico y Tratamiento de la Depresión en la Atención Primaria y Secundaria. (Presentation). Santiago, Chile; 2003.
7. Chile, Ministerio de Salud, Superintendencia de Instituciones de Salud Previsional (ISAPRE); 2003.
8. Chile, Ministerio de Salud, Unidad de Salud Mental; 2003.
9. Chile, Ministerio de Salud, División de Programas de Salud. Políticas y Plan Nacional de Salud Mental. Santiago: Ministerio de Salud; 1993.
10. Araya R, Wynn R, et al. Psychiatric morbidity in primary health care in Santiago, Chile: Preliminary findings. Br J Psychiatry 1994;165(4):530-533.
11. Chile, Ministerio de Salud, Unidad de Salud Mental. Plan Nacional de Salud Mental y Psiquiatría. Santiago: Ministerio de Salud; 2001.
12. Berkman LF, Kawachi I (eds). Social Epidemiology. New York: Oxford University Press; 2000.
13. Cohen S, Doyle WJ, et al. Social ties and susceptibility to the common cold. JAMA 1997;277(24):1940-1944.
14. Achat H, Kawachi I, et al. Social networks, stress and health-related quality of life. Qual Life Res 1998;7(8):735-50.
15. Kawachi I, Berkman LF. Social ties and mental health. J Urban Health 2001;78(3):458-67.
16. Chile, Ministerio de Salud, División de Rectoría y Regulación Sanitaria, Unidad de Salud Mental. Norma técnica para la atención de personas afectadas por la represión política ejercida por el Estado en el período 1973-1990. Santiago: MINSAL; 2002.
17. Minoletti A. Programa PRAIS: Busca elevar su rango a Ley de la República. Boletín Informativo No. 13. Santiago: Ministerio de Salud; 2003.
18. Chile, Ministerio de Salud. Guía clínica para la atención primaria. La depresión: detección, diagnóstico y tratamiento. Santiago: MINSAL; 2001.
19. Schulberg HC, Katon WJ, et al. Best clinical practice: guidelines for managing major depression in primary medical care. J Clin Psychiatry 1999;(60 Suppl 7):19-26; discussion 27-8.
20. Whooley MA, Simon GE. Managing depression in medical outpatients. N Engl J Med 2000;343(26):1942-50.
21. Araya R, Rojas G, et al. Treating depression in primary care in low-income women in Santiago, Chile: a randomised controlled trial. Lancet 2003;361(9362):995-1000.
22. Coon P, Zulkowski K. Adherence to American diabetes association standards of care by rural health care providers. Diabetes Care 2002;25(12):2224-9.

23. Atkinson LR, Escobar GJ, et al. Phototherapy use in jaundiced newborns in a large managed care organization: do clinicians adhere to the guideline? Pediatrics 2003;111(5 Pt 1):e555-61.

24. Dickey B, Normand SL, et al. Guideline recommendations for treatment of schizophrenia: the impact of managed care. Arch Gen Psychiatry 2003; 60(4):340-8.

25. Wei GS, Jackson JL, et al. Postmenopausal osteoporosis risk management in primary care: how well does it adhere to national practice guidelines? Journal of the Am Med Womens Assoc 2003;58(2):99-104.

26. Wulff M, Ekstrom EC. Iron supplementation during pregnancy in Sweden: to what extent is the national recommendation followed? Acta Obstet Gynecol Scand 2003;82(7):628-35.

27. Dobscha S, Gerrity M, et al. Measuring adherence to depression treatment guidelines in a VA primary care clinic. Gen Hosp Psychiatry 2003;25:230-237.

28. Cabana MD, Rushton JL, et al. Implementing practice guidelines for depression: applying a new framework to an old problem. Gen Hosp Psychiatry 2002;24(1):35-42.

29. Universidad de Chile, Escuela de Salud Pública, Facultad de Medicina. Evaluación de la efectividad del Programa de Detección, Diagnóstico y Tratamiento Integral de la Depresión en la Atención Primaria. Santiago, Chile; 2002.

30. Chile, Ministerio de Sallud y Servicio Nacional de la Mujer. Proyecto Piloto de Intervención en Violencia Intrafamiliar en la Atención Primaria (Draft). Santiago, Chile.

CUBA:
MENTAL HEALTH CARE AND COMMUNITY PARTICIPATION
Víctor Aparicio Basauri [1]

The Cuban mental health care experience is somewhat unique in the Latin American context. This chapter will describe and analyze a homogenous national mental health model with varying degrees of development at the provincial level within a public health care system of free and universal access. The country's current health system has its origins in the governmental policies developed following the 1959 Revolution and is characterized by a decentralized, community-based model whose central foundation is the primary health care strategy. Over the years, Cuba has also adapted and incorporated elements of community experiences from other parts of the world and has reoriented its mental health policies in accordance with the principles of the Caracas Declaration formulated by the Pan American Health Organization and signed by the countries of Latin America in 1990.

HISTORY
A Long Tradition of Institutionalization

The history of Cuban psychiatric care within the public health context dates back to the 19th century Colonial period. Cuba's political history is comprised of three clearly delineated eras: the Colonial period that ended with Cuba's independence from Spain in 1898, the republican period that ended with the Revolution of 1959, and the Revolutionary period that lasts until the current time. During each period, the provision of health care was structured in a different way. In the Colonial period, health services, to the extent that they existed, were offered by charitable groups and benevolent societies. During the republican period, a mutualist system of prepaid medical coverage prevailed, and in the Revolutionary period, the National Health System was established, incorporating elements of European social democracies, such as state regulation and the creation of state-sponsored programs to promote equality in access among all social classes to public services.

According to some accounts, the official response to the plight of the mentally ill occurred much earlier in Cuba than in other parts of Latin America (*1*). The first hospital for the treatment of mental disorders appeared during the Colonial period. The first public order addressing the issue was approved in 1804 (*2*), promoting the confinement of the mentally ill in various types of institutions, such as asylums, charity homes, and poorhouses. These measures were destined to remove this group from the streets, where most of them lived and where they were subject to ridicule and physical abuse by passersby.

The most aggressive women showing signs of mental illness were taken to the San Juan Nepomuceno internment facility, while the men were housed in the public jail (*3*). Sometimes men and women were also confined in the public bathhouse. In 1824, Bishop Espada from Havana promoted hospitalization of the mentally ill at the San Lázaro Hospital, indicating, however, that

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[1] Chief, Psychiatric Services, Jove Hospital Foundation, Gijón, Asturias, Spain.

an asylum would be built separated from the lepers of this hospital. In 1825, following an order from the Bishop, construction was begun on the San Dionisio Hospital (named after Captain-General Francisco Dionisio Vives) on the grounds of the San Lázaro Hospital near the Espada Cemetery (*4*). The asylum opened its doors on 1 September 1828 and began taking in Havana's mentally ill males. For their female counterparts, a special pavilion was constructed, but soon these patients found themselves "sharing with other people who had nothing in common with their sex or illness" (*3*). These experiences might be considered the first steps in a process of psychiatric institutionalization in Cuba. However, several more decades were to pass before the creation of the country's first public psychiatric institution, Mazorra Hospital.

On 26 October 1854, the government of the Marquis of Havana bought a tract of pastureland from a local citizen named José Mazorra and placed a military architect in charge of overseeing construction of a psychiatric hospital. The site, at considerable distance from the city, was actually cut in half by the Villanueva railroad, and was ruled out by the commission (1861) presided over by Dr. Nicolas José Gutiérrez (*4*) that had been appointed by the Colonial government to organize and supervise the hospital's services upon the building's completion. The government overrode the commission's recommendation and continued with the project. The hospital's first patients were received in 1864.

Dr. José Joaquín Muñoz was named Mazorra's first medical director. Educated in France, Muñoz had studied under neurologist and psychiatrist Jules Gabriel François Baillarger at La Salpêtrière Hospital. As the name suggests, this institution had originally been a gunpowder factory; it later was turned into a dumping ground for the poor of Paris before serving as a prison for prostitutes and a holding pen for the mentally disturbed, criminals, and epileptics. At the time of Muñoz's training there, La Salpêtrière was gaining world recognition as a psychiatric teaching center. In 1863, the same year as his appointment to Mazorra Hospital, Muñoz published a Spanish translation of Baillarger's studies on mental alienation. This work was considered the first full-length book to be published in Cuba on this topic. The only other previously known item—an article originally appearing in a Jamaican newspaper and subsequently translated into Spanish—dated back to 1791 (*3*).

Muñoz prepared and presented an organizational plan to the government proposing his supervision over key medical aspects of the hospital's functioning as well as its administration. This request, supported by his colleague and hospital commission head Dr. Gutiérrez, was denied. As a result, both Muñoz and Gutiérrez resigned from their respective government positions (*4*). The obstacles encountered by both doctors—remote and otherwise unsuitable physical sites, the imposition of administrative prerogatives over medical expediency, and insufficient financial and human resources—were similar to those experienced by their counterparts attempting to respond to the needs of the mentally ill in other parts of Latin America (*5*). The establishment of operational norms and standards would not come about until 1880, when a 3 July Royal Order was decreed, announcing "Regulations of the General Center for the Insane of the Isle of Cuba" (*1*).

As the events in the previous paragraphs show, the seeds for the development of the institutionalization of psychiatric care were sown during the 19th century, coinciding with the consolidation of the medical profession and the emergence of specializations and signalling the beginning of a new type of teaching at the University of Havana's Faculty of Medicine. The creation of the Academy of Sciences, in 1861, is also considered a hallmark in the history of medicine and public health development in Cuba (*4*). Despite these gains, however, there still remained no well-defined corps of alienists (a 19th century term used to refer to psychiatrists and others treating diseases of the mind), nor logically, of a consolidated body of psychiatric teachings

and knowledge. The handful of medical professionals trained in the treatment of mental health disorders all exhibited a decidedly French influence in their clinical experience, and upon their return to Cuba they found few practical opportunities for the application of their professional knowledge acquired overseas. Mazorra Hospital, as a repository for the mental ill, was not a model for those seeking to deepen their medical knowledge during the 19th century. Indeed, it was not until the republican era that followed that there was a surge in both knowledge and the creation of professional societies, although little progress was made in relieving the actual suffering of the patients themselves.

The Consolidation of a Medical Discipline

Beginning near the end of the 19th century and during the first half of the next century, the field of psychiatry gradually became consolidated as a medical specialty with its own corresponding academic training structure. Four papers on psychiatry were presented during the First Regional Medical Convention of Cuba held in 1890. In 1907, at the University of Havana's Faculty of Medicine, Dr. Valdés Anciano became the country's first professor of the clinical pathology of nervous and mental disorders, a post he would hold until 1923 (*2*). The other notable personality during this era was alienist Dr. Gustavo López, influenced by the French school of medicine, and the first president of the Cuban Society of Neurology and Psychiatry (1899), in addition to holding various appointments in the Academy of Medical Sciences (*1*).

The consolidation of the study and treatment of diseases and disorders of the mind as a separate and specialized field was not, however, a linear process and instead was characterized by both progress and stagnancy. J.A. Bustamante (*4*) considers that in the republican era, the period with the most contributions to psychiatry lasted from 1933 to 1958, with psychoanalysis and other forms of psychotherapy being introduced into Cuba only after 1933. The professional association movement was reactivated, following a period of dormancy, through the Cuban Society of Neurology and Psychiatry (1942) and the League of Mental Health (1948). In 1943, the first book on psychiatry in Cuba, written by Bustamante , was published, and in 1955, the first Psychiatric Congress of Cuba was held. These initiatives facilitated new opportunities for scientific production and debate.

Despite the creation of professional societies, a congress, and educational curricula, and the existence of an institution—Mazorra Hospital—where mental health specialists could observe, study, and treat mentally ill patients, this progress did not translate into concomitant improvements in health care, nor in increasing the population's access to the practical results of the new knowledge being generated. During the republican period, access to health services was based on a mutualist system and relied heavily on a strong private sector, which created significant imbalances in the geographic distribution of human resources, equipment, and supplies. Approximately 60% of the country's total number of hospital beds was located in Havana (*6*), and two-thirds of Cuba's 6,000 doctors worked in the private sector of that city (*7*). In 1959, obstacles related to the availability of psychiatric care in particular were not very different from those found throughout the health sector, with a significant concentration of beds (4,400 of 4,500) and of psychiatrists (60 out of 68) being Havana-based (*8*) and a scattering of services existing in Santiago de Cuba, Camagüey, Cienfuegos, and Santa Clara. Therefore, notable barriers to health services access—both geographical and economic—existed for a large proportion of the country's population.

CREATION OF THE POST-REVOLUTIONARY NATIONAL HEALTH SYSTEM

One of the most important outcomes of the 1959 Revolution was the creation of a universal, decentralized national public health system. In 1961, the Ministry of Public Health was charged with setting up a comprehensive system of health care to eliminate the enormous inequities in availability of medical services between urban and rural populations. Given that 65% of the country's physicians were based in Havana, while only 25% of the national population resided here (*9*), one of the initial thrusts was on prevention programs and increasing the numbers of health professionals. During the first five years following the Revolution, some 3,000 physicians left the country, forcing the Government to undertake an "accelerated plan" of educational training to ensure adequate numbers of health workers (*10*). One of the most innovative aspects of the overhaul of the national public health system was the selection of a community-based model rooted in the tenets of the primary health care strategy.

In 1960, Law #723 was approved creating the Rural Medical Social Service, in which newly-graduated medical students were required to respond to the medical needs of rural populations during a period of six months prior to their joining the State's regular health services system (*11*).

The operational expression of the structural changes being implemented was the opening in 1964 of a series of comprehensive polyclinics serving specific geographical areas. Each health division served a population of between 25,000 and 30,000 residents (*8*), while in rural areas, this number was considerably smaller and could be as few as 7,500 (*6*). The polyclinics' composition was diverse and included internists, pediatricians, gynecologists, psychologists, nurses, physiotherapists, ophthalmologists, and laboratory and dental technicians. After a decade of functioning, an evaluation was conducted of the polyclinics. It revealed the presence of some degree of fragmentation and weak coordination within the health teams, a predominance of curative (vs. preventive) interventions, excessive use of secondary-level services, and a bias in formal medical training toward a capital-intensive hospital environment, thus leaving medical graduates ill-equipped to deal within the primary care framework and the polyclinic setting. In response to these flaws, there was a shift toward the community medicine concept and the comprehensive polyclinics came to be called community polyclinics (*11*).

The final component incorporated into the primary health care structure was the family doctor system, initiated in 1984 and rooted in the specialty of family medicine. With the objective of having family doctors as geographically accessible to local populations as possible (*10*), the offices of these practitioners were established within the communities where they served and lived. Each family physician, together with a professional nurse, served approximately 500 inhabitants. Their work focused on the familial and community aspects of health protection and prevention and on close coordination with multidisciplinary health teams at the polyclinics (*12*).

The structural changes introduced in the national public health system following the 1959 Revolution and described in this section, supported by the implementation of other social and educational initiatives (such as the literacy campaign), produced significant improvements in the national population's health status over the next two decades (Table 1).

TABLE 1. Selected demographic indicators, Cuba, 1958–1981.

Life expectancy at birth	58 years (1958)	73 years (1981)
Birth rate (per 1,000 population)	28.7 (1959)	14 (1981)
Infant mortality rate (per 1,000 live births)	70 (1959)	18.5 (1981)
Age group 0–16 years old (% of total population)	40.5 (1970)	35 (1981)

Source: Aldereguía Valdés-Brito J, Aldereguía Henriquez J. The health status of the Cuban population. Int J Health Serv 1983;13(3):479–85.

Díaz-Briquets (*13*) points out that in the first decade after the Revolution, Cuba had the highest life expectancy in Latin America, and according to Warman (*10*), in 1994 life expectancy at birth stood at 75 years, compared to 68 for Latin America as a whole. As shown in Table 2, in more recent times, Cuba's life expectancy and infant mortality rates are similar to those found in developed countries, as well as the portion of gross domestic product (GDP) the country spends on health care (*12*). The achievement and sustainment of these rates must be considered within the context of the ongoing U.S. trade embargo dating back to 1961, making it the most enduring blockade in modern times, and the dissolution of the Soviet bloc in 1989, which had an immediate and devastating impact on the Cuban economy, causing a 60% drop in the GDP (*14*). These two factors have had negative repercussions on the quality of life of the Cuban population with a very clear effect on caloric intake. Between 1989 and 1993, importation of foodstuffs declined by 50%. Children, women, and the elderly—considered the most vulnerable to nutritional deficits—were targeted for protection through rationing, public health education, workplace and school-based feeding programs, and the promotion of urban gardening (*14*).

TABLE 2. Comparison of basic health indicators, Cuba, United Kingdom, and United States.[a]

Country	Under-5 mortality rate	Life expectancy	% GDP spent on health care
Cuba	8	76	7
United Kingdom	7	77.5	10
United States	9	77	13

[a]Based on data from Aitsiselmi A. An analysis of the Cuban system. Public Health 2004;118(8):599–601.

The economic crisis and the embargo also have had a negative effect on the supply of pharmaceuticals, resulting in the adoption of a strategy for the rational use of medicines. In 1991, a policy to ensure the availability of a group of essential medications was approved, and in 1996, a network of municipal drugstores was established (*15*), totalling 169, or one for each of the country's municipios. In 1998, this initiative was further bolstered by the formation of a network of pharmacoepidemiologists from 69 hospitals who together were responsible for carrying out continuing education programs to promote more rational drug use, improve the prescription process, and facilitate the flow of needed information to family medicine practitioners. A study conducted by Diogène and colleagues in 2003 (*16*) showed that the pharmaceuticals policy and work of the national pharmacoepidemiology network had resulted in an improved overall response to the population's health needs in this area.

However, above and beyond the strategies developed to address specific public health issues in post-Revolutionary Cuba, Greene (*17*) stresses the overarching importance played by health promotion and its corollary—community participation—within the primary health care framework. The country's free and universal educational system has also facilitated greater health protection awareness at the community level by increasing the population's receptivity to health education programs, at the same time that such grassroots organizations as the Committees for the Defense of the Revolution and the Federation of Cuban Women have provided opportunities for community participation in local health campaigns and related activities.

EVOLUTION OF THE PSYCHIATRIC CARE MODEL AFTER 1959

Reorganization and Decentralization

As we have seen, psychiatric care in Cuba prior to the Revolution was of a marked institutional nature, with little integration into the public health system, a strong concentration of trained health personnel in Havana, and a generalized scarcity of human resources and health supplies and equipment. The first changes introduced following the Revolution were based on four objectives: (1) to decentralize and extend the provision of psychiatric care throughout all of the country's provinces; (2) to integrate existing mental health services within the National Health System; (3) to modernize and humanize hospital care, particularly at the Havana Psychiatric Hospital (Mazorra Hospital); and (4) to diversify the types of mental health care facilities available and build a corps of suitably trained health workers.

Changes introduced into the mental health care structure followed a path similar to those being implemented throughout the rest of the public health care system. Groups of mental health professionals at the national and provincial levels were formed to provide specialized advice to public health authorities on this issue. At the same time, the Cuban Society of Neurology and Psychiatry was divided into two separate societies to reflect emerging awareness of the distinction between the two disciplines and facilitate the initiation of scientific and professional activities more specifically oriented to the interests of each entity.

The initial mental health care model took elements from the psychiatric services found at the General Calixto García University Hospital in Havana, where services of this type were first offered during the 1940s (18) and where Cuba's first mental health dispensary was also opened (4). The Havana Psychiatric Hospital became a tertiary-level reference facility devoted principally to extended hospitalization and rehabilitation.

The process of diversifying the types of care available included the development of psychiatric units in the general hospitals; the creation of outpatient units, with the first two being opened in 1962, one at Fajardo Hospital and the other at General Calixto García University Hospital (4); an increase in the number of mental health dispensaries; and the establishment of crisis intervention units, beginning with the first one opening at the "10 de octubre" University Hospital in 1976 (18). These units were located in general hospitals and directly linked to urgent care services with short-stay and 24-hour observation beds. This network of services operated within a clearly defined geographic area, was coordinated with the local polyclinics, and supported by community mental health programs carried out by psychologists and psycometricians.

The initial hospital-based model, complemented by a network of diversified services extending throughout the country, shared various similarities with the French care model then prevalent. However, during the first decades following the Revolution, the influence of the Soviet Union over psychiatric practice and services, particularly in the clinical and research areas, became very strong. Bustamante (4) states that, in 1972, after a meeting of members of national academies of sciences from various socialist countries, a psychiatric research group was created, and Cuba was assigned the topic of clinical and experimental research of neurosis. The coordination lasted from 1972 until 1983.

A Spanish psychiatrist (19), following a visit to Cuba in 1973, noted that the nature of psychiatry here was similar to that found in the rest of the socialist countries of that era, that the quality of care was high, and that the organization of services was based on principles of inclusion. Until the 1990s, the basis of the Cuban care model was largely biomedical, but during this period services were reoriented more toward the primary health care strategy and community medicine precepts, which were considered more in line with a bio-psycho-social vision (20).

These shifts in the nature of psychiatric care also influenced the development and diversification of the psychiatric specialty itself. One concern of national health authorities regarded care targeting children and youth, and in 1959 psychiatric services specifically for these age groups were introduced; beginning in 1964 a specialized three-year study program was required for health professionals wishing to practice in this field (*21*). The child and youth programs were integrated into the pediatric services and experienced a continuous growth. In 1970, these programs existed in only five provinces. However, by 1984, there were 66 health professionals working in this field (*8*). By 1999, there were 201 physicians throughout the country in this area; of these 169 were specialists (84%), and by 2003, this number had risen to 205, as shown in Table 4.

Community-based Care Versus Institutional and Medical Models

The initial care model underwent continual transformation over the next years, yet retained its essentially community-based, primary care focus. The grounding of Cuban psychiatrists in general medicine as part of their initial academic training has further nourished a culture of community-based work and of coordination with the family doctor network. Kates (*22*), following a 1983 visit to Cuba as part of a group of North American health workers, observed that the mental health system there was well integrated into the larger public health structure and demonstrated a clear emphasis on prevention and responding to local community needs. He stressed the important role played by the polyclinics as well as that the Committees for the Defense of the Revolution, a mass community organization created in 1961 whose volunteers have made a significant contribution to community health education and prevention activities.

On the other hand, Kates noted that issue of deinstitutionalization did not appear to be a top priority, stating that there were seven psychiatric hospitals in the country with between 200 and 600 beds each, with the exception of the Havana Psychiatric Hospital, which had 3,500 beds. He stressed the community nature of the polyclinics, where there were psychologists and psychometricians, contrasting this with the traditional medical model being used in the psychiatric hospitals. Even today, the drive to push ahead in this community-based orientation continues to be very intense and demanding, in the general health system (*23*) as well as in the specific field of mental health.

In 1987, a development plan for psychiatry up to the year 2000 was discussed and approved. In 1995, an important qualitative change was wrought with the Havana Charter (*24*) due to its focus on health promotion and prevention, which generated a reorientation in mental health towards the community care model, promotion of community mental health centers, and renewed emphasis on the role of the primary health care strategy in mental health interventions.

Current Situation

With regard to the process initiated in 1995 with the Havana Charter, Barrientos and colleagues (*8*) point out that the term used to refer to the changes being instituted was "reorientation" because it seemed to better reflect the Cuban reality than "restructuring," the term used in the 1990 Caracas Declaration, or "reform," which had been adopted by some European countries. The authors stress that the term "reorientation" most adequately captures the idea that in Cuba a mental health model had existed since 1959, that it is continuously evolving, and that it has undergone—and will continue to undergo— modifications in the ongoing quest for optimum results. By the same token, they assert that "restructuring" and "reform" posit the need to institute a profound overhaul of existing infrastructure. Despite these distinctions regarding the eventual language chosen, the philosophy of the statements of Barrientos et al. nonetheless coincides with

the basic concepts presented in the Caracas Declaration, in the sense of promoting the development of a strong community mental health model and the transformation of traditional psychiatric hospitals and other related facilities.

The motives behind the impetus in 1995 to reorient Cuba's mental health care system were of several types. One stemmed from the development of the family doctor system. The extension of this model throughout the country, its implications for community-level work, and its weight in comprehensive mental health care all pointed to the need to "reorient" toward the local level of care, where those among the population in need of this type of services actually resided. Another reason derived from the economic crisis of the 1990s, which required a re-adaptation by the public health system to even more austere circumstances. Within this context, it became even clearer that psychiatric hospitals were very costly to operate and not efficient in overcoming the population's mental health problems (8). Therefore, a gradual decrease in institutional beds and an increase in the number of community mental health centers came to be viewed as a viable alternative. At the same time, the ongoing economic crisis and the U.S. embargo have affected the availability of and access to essential medicines, thereby reinforcing the need for policies regarding the rational use of psychotropic drugs. The third reason relates to governmental decentralization and the subsequent granting of increased community voice through participation in the Peoples' Councils (created in 1992 and representing local jurisdictions of approximately 20,000–30,000 individuals each) as well as the development of a municipal health promotion movement that has been nourished in large part by increased community awareness of and participation in health issues.

The current organization of the public mental health system is based on three care levels that imply certain hierarchies of care for patients, but the linchpin of this system is the community mental health center. Mental health teams at these centers have a broad, yet diversified, composition, and include psychiatrists, psychologists, registered nurses, general practice physicians, defectologists (special education specialists), psycho-pedagogues, psychiatric social workers, occupational therapists, nursing assistants, and pyschometricans. The teams closely coordinate their work with the family doctor network and the community polyclinics, which in turn work with local community groups in a variety of health promotion and prevention activities. Dr. Guillermo Barrientos del Llano, a mental health expert at the Cuban Ministry of Public Health, defines the community mental health center as being "a guiding center providing care for all problems related to the mental health of the population and for the rehabilitation of the mentally ill, as well as for the prevention of problems related to the loss of well-being through the community-based promotion of healthy lifestyles" (personal communication).

The division of the three care levels may be summarized as follows: the primary level includes the community mental health centers, the work of the mental health teams in the community polyclinics, and the family doctor system. The secondary level consists of psychiatric services found in the country's general and pediatric hospitals. The tertiary level includes psychiatric institutions and hospitals. Tables 3 and 4 present data regarding the status of mental health facilities, services, and human resources available in Cuba.

TABLE 3. Available mental health resources, by category, Cuba, selected years.

Category	Number (by year)
Community mental health centers	199 (2003)
Psychiatric services (general hospitals)	28 (2003)
Psychiatric services targeted to children and youth	17 (2003)
Psychiatric hospitals	22 (2002)
Psychiatric beds	8,339 (2002)

Source: Ministry of Public Health of Cuba.

TABLE 4. Number of mental health personnel, by category, Cuba, 2003.

Category	Total number	Number in training
Psychiatrists	978	71
Psychiatrists specialized in treating children and youth	205	31
Occupational therapists	470	185
Psychometricians	794	185
Master's degree in social psychiatric	213	26

The 2003–2005 plan of action prepared by Cuba's Ministry of Public Health (Table 5) shows the community-based orientation of the national mental health program, as well as the priority accorded effective management and rational use of medicines to ensure the health system's sustainability, particularly in view of the ongoing U.S. embargo and scarcity of economic resources.

SITE VISITS

In March 2004, at the request of the Pan American Health Organization, I spent a week in Cuba conducting *in situ* visits to various mental health establishments and analyzing different examples of the community mental health model. Dr. Guillermo Barrientos del Llano, head of the National Psychiatric Group, provided me with background on Cuba's mental health program at the national level and the characteristics of the health care model. During that week I visited different projects and programs carried out in the "10 de octubre" and Boyeros municipalities located in the City of Havana province. The sites I visited and the experiences shared with me by health personnel may be considered paradigmatic of the community vision that guides the mental health care system and of the system's coordination with other appropriate entities within the primary health care framework.

The "10 de Octubre" Municipality

One of 15 municipalities in the City of Havana province, "10 de octubre" is eminently urban, with a population of approximately 250,000 inhabitants. It has eight polyclinics, one of which is the Lawton Polyclinic, where the Lawton Community Mental Health Center was located at the time of the site visit, pending its relocation to a new building being constructed specifically to house the polyclinic's mental health services. During my visit to this polyclinic, I observed various activities being carried out there, including several group activities, and I additionally was afforded the opportunity to learn more about the variety of mental health programs being carried out by the polyclinic in the community at large. I also gained first-hand knowledge of the municipality's program to address alcohol-related health issues being carried out in another part of the "10 de octubre" mental health network. Services visited at the secondary care level include the psychiatric services, crisis intervention unit, short-stay ward, and psychiatric liaison program, all located at the "10 de octubre" University Hospital and also described in the following sections.

TABLE 5. Priority areas and actions, mental health plan, Cuba, 2003–2005.

Priority areas	Scenario 1 (Mid-level)	Scenario 2 (High level)
Ensure the integration of psychiatric care in primary health care services		-Improve the efficacy of management of mental health disorders at the primary care level -Improve remission mechanisms
Ensure the availability of psychotropic medications	-Ensure the availability of all essential psychotropic medications for treatment of all mental disorders	-Maximize the rational use of available psychotropic substances
Strengthen community-based approach in the provision of psychiatric care	-Link and coordinate psychiatric hospital care with other community interventions	-Provide 100% coverage of community health services -Provide individualized care to community members with serious mental disorders -Stratify community-level psychiatric services
Educate the general public regarding mental health and addiction issues	-Promote the prevention, identification, and treatment of mental disorders and addictions through the mass media	-Maximize confidentiality in patient care in all provinces
Establish national-level policies and programs	-Enhance strategies at the national level for drug and alcohol addiction and suicide prevention and control	-Stratify prevention and control activities in the areas of drug and alcohol addiction and suicide
Develop human resources	-Enhance national programs for the training of psychiatrists, occupational therapists, nurses, psychologists, and social psychiatric workers	-Enhance curricula and number of graduates in social psychiatry master's programs, as well as in diploma programs in community mental health and addictions -Provide advanced training for specialized treatment forms
Establish linkages between health and other public sectors	-Enhance intersectoral coordination between the Ministry of Public Health, Ministry of Education, Ministry of Higher Education, Ministry of the Interior, and the Councils of People's Power	-Establish coordination of mental health interventions for households identified as vulnerable to problems related to addictions -Initiate evidence-based prevention and health promotion programs in collaboration with other appropriate public sectors
Monitor mental health situation at the community level	-Establish mechanisms for monitoring specific mental disorders in the community	-Achieve epidemiological stratification of prevention and control services in the areas of addictions, psychosocial rehabilitation, suicidal behavior, and depression
Support new research	-Undertake efficacy and cost-effectiveness studies on the management of mental disorders in primary health care services	-Carry out research on services provision -Study available research regarding the prevention of mental disorders -Enhance community-level mental health diagnostic capacity

Source: Ministry of Public Health of Cuba.

Lawton Community Mental Health Center

The Lawton mental health team serves both the Lawton Polyclinic's geographical area and that of the 30 de Noviembre Polyclinic as well, for a total population of approximately 46,000, of whom 17% are over age 65 and 25% are under age 18. The mental health team is led by Dr. Mario León González, a psychiatrist holding a master's degree in social psychiatry. The other members include three additional psychiatrists, one of whom is specialized in treating children and youth; a part-time psychologist, a registered nurse, two occupational therapists, a psychiatric social worker, and a nursing assistant.

The organization of the team's workweek consists of individual consultations on the polyclinic's premises as well as a broad variety of group activities in the community, including interventions based on preventive, psychotherapeutic, and natural and traditional medicine strategies. The team's different members lead participation in these activities and employ such diverse techniques as hatha yoga, tai chi, shiatsu massages, digital pressure therapy, auricular acupuncture, other forms of acupuncture, relaxation therapy, Lama rejuvenation rites, aromatherapy, and energy treatments. The psychotherapy groups are principally targeted to individuals with organic, affective, and neurotic disorders. There are also groups for students and adolescents, a stress clinic, and family groups. During my visit I participated in some of these activities, and I was impressed with the team's enthusiasm, the pride taken in their work, and, above all, the creativity and imagination incorporated in the community-level activities to help offset obstacles wrought by the long-term U.S. embargo and economic crisis. Just as these difficulties have led to the implementation of the rational use of psychotropic drugs policy, they have hindered the ability to update the physical structure of mental health facilities and have raised community awareness of the need to promote and protect health as a valuable asset and a collective endeavor. Thus, the Lawton multidisciplinary mental health team's work within the community is not limited merely to the provision of care services, but also focuses on the active participation by all residents in prevention and health promotion activities. In addition, the team visits an average of four or five family doctor offices per week. During my visit to the "10 de octubre" municipality, I was able to meet with one of these physicians. He showed a very good knowledge of mental health programs and a deep understanding of the importance of coordinating his work with that of the local mental health team. His office was located in his private residence, a pattern that is gradually being spread throughout the country and helps strengthen the integration of these health professionals in their respective communities.

Other mental health resources in the municipality include stress reduction programs in the workplace and preventive interventions in schools. During a visit to a high school, we observed a relaxation session under way and were shown the particulars of the Government-sponsored school nutrition program. We also attended a session of a gymnastic program targeted to older adults. During all of our site visits, the gamut of individuals with whom we spoke, from urban dwellers to public health workers, amply demonstrated their understanding of the public health system's functioning and commitment to a prevention and health promotion culture.

An indelible aspect of the Cuban reality is the high-profile support by locally based organizations, such as the Committees for the Defense of the Revolution, Federation of Cuban Women, and Councils of People's Power, of community health promotion campaigns, projects, and programs focusing on a variety of health issues ranging from community health education to disease prevention and control. The contribution of these organizations strengthens the social network through their creation of opportunities for community participation in health enterprises, such as those of a rehabilitative nature developed to facilitate the effective reintegration of patients back into the community. We learned of one such example involving a group of patients

participating in an urban beautification project. The close collaboration between these organizations, mental health teams, family doctors system, and polyclinics has reinforced the effectiveness of each group's work. An evaluation of the Lawton mental health team's activities revealed that an increase in community-level activities had resulted in a decrease in hospital admissions, emergency visits, and the number of homeless patients. The evaluation also found that the change to a community-based model produced a more favorable cost-benefit ratio than the previous hospital-based model.

The SARCA Program

Within Cuba's mental health strategies for the 2003–2005 period, there are a series of programs focusing on specific mental health issues, such as suicide, depression, addictions, and psychosis, and their rehabilitation. Among these is a pioneer program based in the "10 de octubre" municipality and designed to prevent and control alcohol-related health problems. Known by its Spanish acronym, SARCA, for *Servicio de Atención y Rehabilitación Comunitaria al Alcoholismo y Otras Adicciones*), the initiative was launched in March 1966 in the health district of Luyanó with the participation of three clinics and later extended its coverage throughout the entire "10 de octubre" municipality.

The program has three levels of activities: prevention, control, and rehabilitation. Its methodology highlights community participation and inclusion of the family in the treatment strategy. Two psychiatrists and a psychiatric social worker staff the program. Referrals to the program's services may be made through the various components of the health care network, such as the family doctor system, polyclinics or community mental health centers and their respective mental health teams, or a hospital unit, as well as through social institutions such as homes for the elderly, the workplace, or schools. The program may also be accessed directly by the potential user.

At the prevention and control levels, the program's information and promotion campaigns and interventions stress the creation and maintenance of healthy behaviors and lifestyles. At the control and rehabilitation levels, a broad, standard clinic history is conducted of each patient that includes psychopathological, somatic, and social aspects, as well as individual consumption habits and preferences (beer and rum are the most commonly consumed beverages), followed by an evaluation of family support capacity and rehabilitation options. In the treatment phase, priority is given to psychotherapeutic interventions, particularly mutual self-help groups. During my visit to SARCA, I had the opportunity to meet with a group of users and their family members, who expressed their satisfaction with the services they were receiving. Data regarding group therapy activities indicate a high degree of acceptance by users and the community at large. In one year, more than 450 individuals received treatment, with an overwhelming majority of these being males (male-female ratio = 10:1).

The "10 de Octubre" University Hospital's Mental Health Services

This hospital, whose chief of psychiatric services is Dr. Guillermo Barrientos del Llano, is considered a pioneer mental health care facility in Cuba for its development of a crisis intervention unit (CIU) in 1976, when it conducted 5,188 consultations and processed 355 admissions (*25*). It responds to crisis and emergency cases referred to the hospital from other components of the heath care network. Users may also access these services directly without a referral. The CIU team is made up of three psychiatrists, one psychologist, one social worker, and one nurse. It has six short-stay beds at the hospital. Its primary objective is crisis care and resolution including sending patients them to beds in the CIU, to the short-stay ward, or referring

them to other entities in the health care network, such as the community mental health care center or family doctor. Each morning, the CIU team evaluates new patient cases presented by the on-duty medical team, as well as those of CIU inpatients. Among the intervention strategies used to relieve the patients' symptoms are psychopharmacological treatment, the expression of feelings, multimodal crisis therapy, and cognitive and behavioral adaptation. During the last three months of 2003, the CIU treated 217 patients, 54 of whom were under observation during a period of 24 to 48 hours. There were 24 admissions during the months of October and November. The most frequent diagnoses of these patients were alcoholism and substance abuse disorders (45%), followed by affective disorders (16%), attempted suicide through poisoning (12%), and adaptive disorders (12%). The average inpatient stay was 14.7 days.

The hospital's psychiatric services also include a ward for acute episodes of mental disorders, with 10 beds and an average patient stay of 20.6 days. In December 2003, there were 15 admissions, five (30%) of which were from outside the "10 de octubre" municipality. In this ward, the types of admissions varied from those of the CIU in that 30% were due to affective disorders, 26% were psychosis-related, and 26% were due to personality disorders. A study of a similar, although more recent, experience in the province of Cienfuegos (*26*) shows the relationship between these two types of treatment units although the average stay was shorter at the Cienfuegos facility, being 3.5 days for ICU patients and 15 days for the ward for the seriously ill. In both cases, however, we were able to observe that concomitant with the development of community programs, the demand for hospitalization decreased.

There is a home care program, which is set in motion through a request from the patient's family doctor to the community mental health team. The team evaluates the particular characteristics of the case and conducts a daily follow-up of the patient's condition. At the time of the site visit, the Lawton Community Mental Health Center was overseeing an annual average of 25 to 30 cases of this type.

Another of the hospital's psychiatric services is its partial hospitalization program, which offers hospital-setting treatment without requiring an overnight stay to two separate user groups: those with acute conditions and those with chronic disorders. Each service is equipped to respond to the needs of approximately 30 patients. The first service type is staffed by a team of two psychiatrists, one psychologist, two ergotherapist, and one nurse. Services to the second group are provided by the same two psychiatrists from the first group, two additional psychiatrists from the local community mental health center, two ergotherapists, one nurse, and one secretary.

An additional psychiatric service offered by the "10 de octubre" University Hospital is its psychiatric liaison program with the rest of the hospital. Over the past five years, the program has provided psychiatric consultation and liaison services to approximately patient cases, principally interacting with the hospital's rheumatology, dermatology, internal medicine, and geriatrics units.

During our visit to the hospital, we observed a close collaboration between the community mental health team and the hospital's regular staff. The facility's physical structure was basic, and the need for modernization (particularly in the wards themselves), to increase staffing, and for better access to psychotropic medicines was apparent, another reminder of the difficulties produced by the embargo and economic crisis the country continues to experience.

The Boyeros Municipality

This semi–urban municipality near the city of Havana has a population of 125,000 inhabitants. It is divided into seven health areas. Currently, there is one community mental health center serving three health areas covering a total of 73,000 inhabitants. The only exception to this services gap is

the drug program, which is carried out for the entire municipality. Projections and plans are under way to provide the municipality with a total of four community mental health centers.

The Boyeros center is headed by a general medicine specialist overseeing a team consisting of three psychiatrics, three psychologists, two psychometricians, two general medicine specialists (each holding a master's degree in social psychiatry), two registered nurses, two social workers, two occupational therapists, one defectologist, and one biostatistician. The center's physical structure is adequate, but basic and unadorned. It receives support for its community outreach activities from the Councils of People's Power, the Committees for the Defense of the Revolution, and the Federation of Cuban Women.

The center's primary focus is the provision of comprehensive care to the community through prevention and risk-avoidance interventions. Services users are grouped into four categories: healthy, at-risk of experiencing poor health, currently experiencing one or more health issues, and those dealing with health condition sequelae. During our visit, we observed the center's "mental health school" initiative underway in a local school. Following instruction regarding ways to protect mental health and avoid mental health problems, in our conversations with them, the students revealed the knowledge they had assimilated from the exercise. In addition to its outreach to area schools, the center provides support to a day care center.

The center also leads a stress reduction and prevention clinic consisting of three-week sessions from 8:30 a.m. to 11:30 a.m. on Mondays through Thursdays in groups of from five to 15 participants. A group of women was completing the program the day of our visit, and they invited us to a lunch of food dishes prepared by them in their homes. As we ate, they expressed their satisfaction for having taken part in the clinic.

As in the case of the Lawton Community Mental Health Center visit, here, too, we were able to meet with a local family doctor and discuss the particulars of his coordination with the activities of the Boyeros center.

The work of this center is firmly rooted in the principles of prevention and health promotion and propelled by a palpable spirit of community participation.

CONCLUSIONS

The evolution of mental health services in Cuba must be viewed within the context of the National Health System and its provisions for universal health care that is decentralized and geographically accessible. This structure has allowed a sustained growth of mental health facilities since 1959. Its community focus is most visible at the primary care level with the development of the polyclinic and family doctor networks. However, psychiatric hospitals at the tertiary level still hold important institutional significance. Currently, the need to reorient and transform the role of these facilities and under discussion, given the high costs associated with their maintenance and the growing evidence base indicating their ineffectiveness in addressing and resolving mental health problems.

The U.S. embargo and economic crisis are obstacles for a more normalized functioning of the public health sector, especially due to the difficulties in acquiring medical supplies for patient care and equipment for improvements in physical infrastructure.

Two common threads interwoven throughout public health activities in the Cuban experience are health promotion and community participation. The social network is well organized and cohesive, with mass organizations such as the Committees for the Defense of the Revolution, Federation of Cuban Women, and Councils of People's Power supporting and strengthening community participation through a variety of activities promoting the importance of maintaining good health, on the one hand, and, on the other, offering creative opportunities for

the rehabilitation and reincorporation of those with mental health challenges back into society and their communities.

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Acknowledgments

References

1. Huertas R. Sobre los orígenes de la psiquiatría cubana: la obra de Gustavo López (1860–1912). Asclepio 1991;43(2):69–87.

2. Ordaz Ducunge EB, Cuesta Dávila L, Alonso Rodríguez A. Psiquiatría forense: antecedentes, situación actual y perspectiva de desarrollo. Rev Hosp Psiquiat 1988; 29(3):341–9.

3. López Espinosa JA. Primeras publicaciones cubanas sobre psiquiatría. ACIMED 2001;91(2):229–33.

4. Bustamante JA. Desarrollo de la psiquiatría en Cuba. In: Mariátegui J, ed. La psiquiatría en América Latina. Buenos Aires: Editorial Losada; 1989:89–101.

5. Aparicio Basauri V, Sánchez Gutiérrez AE. Norma y ley en la psiquiatría española: 1822–1986. In: Aparicio Basauri V. Orígenes de la psiquiatría en España. Madrid: ELA; 1997:21–53.

6. Ubell RN. High-tech medicine in the Caribbean: 25 years of Cuban health care. N Engl J Med 1983;309(23):1468–72.

7. Bell B, Keyman B, Kingham M. Images of the Cuban health care system. Nursing Standard 1990;4(30):36–8.

8. Barrientos del Llano G, Martínez Gómez C, Rodríguez Sánchez J, Valdés Mier M. La reorientación de la atención psiquiátrica en Cuba. In: Enfoques para un debate en salud mental. Havana: Ediciones Conexiones; 2002:87–108.

9. Campos-Outcalt D, Janoff E. Health care in modern Cuba. West J Med 1980;132(3):265–271.

10. Warman A. Living the revolution: Cuban health workers. J Clin Nurs 2001;10:311–19.

11. Rojas Ochoa F. Orígenes del movimiento de atención primaria de salud en Cuba. Rev Cubana Med Gen Integr 2003;19(1):56–61.

12. Aitsiselmi A. An analysis of the Cuban system. Public Health 2004;118(8):599–601.

13. Díaz-Briquets S. The health revolution in Cuba. Austin: University of Texas Press; 1983.

14. Garfield R, Santana S. The impact of the economic crisis and the US embargo on health in Cuba. Am J Public Health 1997;87(1):15–20.

15. Laporte JR, Dotres C, Diogéne E, Pérez Peña J, Reggi V, Márquez M. Cuba: improving use of medicines. Lancet 1997;349(Suppl 3):S4.

16. Diogène E, Pérez-Peña J, Figueras A, Furones JA, Debesa F, Laporte JR. The Cuban experience in focusing pharmaceuticals policy to health population needs: initial results of the National Pharmacoepidemiology Network (1996–2001). Pharmacoepidemiol and Drug Safety 2003;12:405–07.

17. Greene R. Effective community health participation strategies: a Cuban example. Int J Health Plann Manage 2003;18:105–16.

18. Barrientos del Llano G, Rodríguez J, Alonso O, Guzmán G. Comunidad, atención primaria y reestructuración de la atención psiquiátrica: experiencias en Cuba. In: Organización Panamericana de la Salud. Programas de atención psiquiátrica en la comunidad: experiencias latinoamericanas. Washington, DC: OPS; 1994:Cuaderno 1, 22–36.

19. Solé Sagarra J. La psiquiatría en Cuba y otros países socialistas (impresiones de un viaje). Arch Neurobiol 1974;37(6):579–88.

20. León González M. La atención comunitaria en salud mental. Rev Cubana Med Gen Integr 2002;18(5):340–2.

21. Gutiérrez Baró E, Frank M. Desarrollo de la psiquiatría infanto-juvenil en Cuba. La clínica del adolescente. Rev Hosp Psiq Hab 2000;41(1):62–8.

22. Kates N. Mental health services in Cuba. Hosp Community Psychiatry 1987;38(7): 755–8.

23. Sansó Soberats FJ. El sistema de salud cubano camino a la comunidad. Rev Cub Med Gen Integral 2002;18(3).

24. Cervantes Tablada HR, Oliva Ruiz X. Demanda de atención institucional y psiquiatría comunitaria. MEDISAN 2002;6(4):11–17.

25. Murias Regalado FJ. Unidades de tratamiento psiquiátrico intensivo: su desarrollo en Cuba. Bol Oficina Sanit Panam 1986;101(6):660–77.

26. Jiménez Hernández B, Árias Cabezas A, Fernández López O, de Armas Águila Y. La reorientación de la salud mental hacia la atencion primaria en la provincia de Cienfuegos. In: Enfoques para un debate en salud mental. Havana: Ediciones Conexiones; 2002:109–37.

JAMAICA:
COMMUNITY MENTAL HEALTH SERVICES
Kwame McKenzie, MD [1]

Mental health services in Jamaica are in transition. Jamaica's Ministry of Health is trying to develop a better and more comprehensive community mental health system by building on the success of pioneer community services while scaling down Bellevue, the country's biggest and best known psychiatric hospital. Mental health officers (MHOs) are at the heart of the transformation; increasing the number of specialist nurses also is considered crucial for sustaining the delivery of quality services. These changes are occurring within the context of an ailing economy with tight fiscal controls.

This chapter describes the work of MHOs, as a way to showcase a model of mental health care delivery that can be replicated in other low- and middle-income countries. The material is based on a review of the literature on psychiatric services in Jamaica, as well as on 2003 field work during which Jamaica's MHOs and other mental health service providers were interviewed. The author would like to thank the Government of Jamaica's Ministry of Health, the Pan American Health Organization's country office, and last, but certainly not least, all the clinicians who were interviewed.

THE JAMAICAN CONTEXT

Jamaica, a former colony of the United Kingdom, lies in the Caribbean Sea just south of Cuba (*1*). Jamaica became independent from the United Kingdom in 1962, although it remains as a member of the British Commonwealth off Nations; Queen Elizabeth II is the country's Executive Chief of State, represented by the Governor General. The Prime Minister and members of the House of Representatives are democratically elected, but members of the Senate are appointed. The party that wins the general election automatically gets a senate majority. Administratively the country is divided into 14 parishes—Clarendon, Hanover, Kingston, Manchester, Portland, Saint Andrew, Saint Ann, Saint Catherine, Saint Elizabeth, Saint James, Saint Mary, Saint Thomas, Trelawny, Westmoreland (*2*).

Of the total territory, 25% is used for farming. The country suffers from extensive deforestation; its coastal waters are polluted by industrial waste, sewage, and oil spills; and coral reefs have been damaged. Kingston, the capital, has serious vehicle-emission air pollution (*1*).

Jamaica has a population of 2.5 million, most of which lives in coastland areas; Kingston and its surrounding areas being are the most densely populated. Of the population, 91% is of African descent, originally brought to the island as slaves; the next largest group (7%) is of mixed race. The country's age structure is much like that of other low- or middle-income countries—30 % under 14 years of age and 7% over 65 years of age. There is a net negative migration of seven persons per 1,000 per year. Official figures report a relatively long life expectancy, more than 73 years of age (*3*).

One in seven people over the age of 15 have never attended school. School non-attendance is more common among men than women.

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[1] Senior Lecturer in Transcultural Psychiatry, Royal Free and University College Medical School, London, UK.

The economy depends heavily on tourism and bauxite mining. The annual per capita GDP in international dollars is $3,776 (*1*). Deteriorating economic conditions during the 1970s led to recurrent violence and a drop in tourism. The democratic socialists were voted out of office in elections in 1980. Political violence marred elections in 1992, when the current Prime Minister, Percival James Patterson came to office. Through 1995–2000, the economy stagnated, but grew by 0.8% in 2000 and by 1.1% in 2001. Since autumn 2001, the global economic slowdown has stunted economic recovery. As of this writing, serious economic problems persist—high interest rates, increased foreign competition, changes in the exchange rates, a widening merchandise trade deficit, and a growing internal debt. Thirty four percent of Jamaicans live below the poverty line. Not surprisingly, the depressed economic conditions have led to increased crime (*1*).

Jamaica's economic situation also is marked by wide disparities. Inequality in the distribution of family income in a society can be measured using the Gini coefficient. A perfectly equal society would have a Gini coefficient of 0; a totally unequal country would have a Gini coefficient of 100. Gini coefficient values in Scandinavian countries tend to fall somewhere in the 20s, those in some sub-Saharan countries, in the 50s. Jamaica's Gini coefficient is 37.9, similar to the United Kingdom's (36.8), indicating that family income is more equally distributed than in the United States (45) (*4*).

The total health expenditure as a percentage of GDP as of the year 2000 was 5.5%, a figure in line with that of other Caribbean islands, but far behind that of the United States (13%) and somewhat less than that of its nearest neighbour, Cuba (6.8%) (*3*). The country' total per capita expenditure on health per year is approximately 200 international dollars—53% of this is private expenditure, either out-of-pocket payments by individuals, insurers, and third party payers other than social security or activities of non-governmental health care providers. This figure is high for the Region. It is in line with that of the United States (55.7%), but not that of similar Caribbean islands, which runs in the range of 30%-40% (*3*).

Income inequality, economic downturn, crime, and violence are all associated with higher rates of mental illness (*5*). Coupled with the fact that only a relatively low percentage of health expenditures come from government sources, these factors pose serious challenges for restructuring the country's mental health services.

MENTAL HEALTH SERVICES IN JAMAICA

The overall delivery of mental health services is under the control of Jamaica's Ministry of Health. A mental health unit in the Ministry's Programme, Planning, and Integration Division sets policy, regulates, monitors, conducts research, and undertakes program development. There is significant decentralisation, however. Both mental and physical health services are organized by regions, as follows: South East (including Kingston and St. Andrew), North East, Southern, and Western. Mental health teams for each region are led by a psychiatrist, and the configuration of each team and its working practices differ from region to region.

Inpatient Units

Bellevue Hospital in Kingston is Jamaica's largest hospital, with more than 1,000 beds. Of the hospital's patients, 40% are older than 65 years, 60% off them are regarded as chronically ill, and 300 of them have lived in the hospital for most of their adult lives. Most admissions come from Kingston and St. Andrew, but any patient requiring psychiatric intensive care may be transferred there. University Hospital West Indies (UHWI), also located in Kingston, has a 20-bed psychiatric unit. It is an acute unit with an average length of stay of 15 days. Jamaica's rural and western

regions are served partly by Cornwall Regional Hospital. This 60-bed unit offers a full range of services, but only 30 beds are used because of staff shortages.

Beds in general hospital wards also are used to treat people with acute mental illness. The level of care given to those treated in these non-specialist beds depends on the availability of mental health officers or of a psychiatrist in the area to take over care or support physicians and surgeons in managing patients. It also may depend on the proximity of a mental health unit: the nearer a general hospital is to a mental health unit, the less pressure it may feel to admit patients with psychiatric illnesses. In general hospitals, patients with mental health problems are nursed on open wards. In the North East and Southern regions, where there are no specialist psychiatric hospitals, patients with mental health problems are mainly treated on general wards.

Emergency Psychiatric Hospital Services

General hospitals offer island-wide emergency services 24 hours a day seven days a week. In addition, psychiatric units at Bellevue, Cornwall and UHWI also offer 24-hour services.

Emergency calls are directed to mental health officers (MHOs), specialist psychiatric community-based nurses, who may make home visits with a team including psychiatric aides. There are two mobile crisis teams in operation and others are under development.

Outpatient Care

Adult outpatients are seen at Bellevue Hospital, UHWI, and the regional and general hospitals. Clinics also are conducted in primary care. Outpatient clinics are conducted by psychiatrists and MHOs. Most clinics in primary care are conducted by MHOs.

Medication

Medications for treating mental health problems are limited and their availability varies district by district. Older antipsychotic drugs are usually available, but there is only limited availability of the newer, more expensive anti-psychotics. In the North East, some patients are treated with clozapine by special arrangement by the district psychiatrist. Moreover, because it sees so many patients and has control over its own budget, Bellevue Hospital can take advantage of economies of scale and, thus, keep a more varied medicine armamentarium than is typical in the public sector. A wider selection of drugs is available in the private sector where cost is less of a concern.

There is about a US$ 2 charge for prescribed medications. Depot injections are free, but anti-cholinergic medication to counter side effects is not. There is government assistance for low-income patients. However, the frontline staff interviewed for this chapter said that, in practice, few people ask for it. This impression was supported by this author's findings in one clinic, where none of those who were prescribed medication (at least 35) had asked for assistance, despite the fact that none of them were working. It is customary for families to pay for their relatives' medication. Caregivers considered a lack of money and the need to pay for prescriptions as a deterrent for coming to the clinic. Government assistance did not seem to counter this, because of the stigma attached to being considered eligible for assistance. In fact, some of this stigma seemed to have shaped the way in which the system was enacted. For instance, in one district the decision about whether the patient should be asked to pay for medication or not was made by the pharmacist. The pharmacists had to decide whether or not to ask for proof that a patient requesting assistance was in genuine need, but pharmacists do not like asking such questions. With no guidelines in force, the pharmacist often relies on cues such as how the patient is dressed to make a decision. Because being considered scruffy is considered insulting, patients with mental health problems dress up when they come to the clinic, hence they are not asked whether they

need assistance and are sent directly to the clerk to pay. They could, of course tell the clerk that they need assistance, but this is considered embarrassing because the setting lacks privacy. As a result, some patients do not come to the clinic unless they have enough money to pay for their medication.

Community Mental Health Services

Community mental health services are fragmented in Jamaica. The range of services and access to them is limited. The mental health officers are the backbone of the service; their responsibilities will be detailed below. This section will outline currently available services.

By crude estimates, there are 500,000 persons in Jamaica who have mental health problems (*2*). The number of patients on the books of the community services has increased from 7,779 in 1995 to 10,907 in 2000 (*6*). Community services treat patients with serious mental illness. There is little or no service for people with more common mental disorders such as anxiety disorders and mild depression .

To date, Jamaica has not had a strategic development of rehabilitation services. This is partly due to a lack of funds. In addition, there are only a handful of occupational therapists on the island and there are no specific training programs in rehabilitation nursing. Rehabilitation services are primarily located in Bellevue and UHWI.

There are three halfway houses for mentally ill persons that are operated by private, nonprofit organizations in the community. All three facilities are in St. Andrew, and they offer assisted living and independent living; one facility is for clients with dual diagnosis. Each house has places for between 10 and 20 persons. Referrals can be from relatives, carers, or mental health practitioners. However, families have to pay for these services. Data on length of stay is not available.

Four Church organizations offer counselling, with two of them providing a mixture of counselling, rehabilitation, and night shelter.

Old Age, Child, and Forensic Services

Old age, child and adolescent and forensic adolescent services are important for the proper management of the mentally ill in the community. On the one hand, child and adolescent services have expanded in the country. However, although they are staffed by a dedicated group of professionals working in difficult circumstances, they do not meet the population's needs. On the other hand, there is presently no funded national strategy for developing old age or forensic services. There have been discussions about the need for and possible models of forensic services, and there are psychiatrists who offer their services to prisons and diversion schemes, but these efforts are not centrally coordinated and coverage is patchy.

Among the mentally ill population of Jamaica, 2% is homeless, and this group accounts for 60% of the homeless in the country. Homeless shelters are not provided by the government. Six hundred and twenty people are housed in charity, NGO or church hostels. The models of care and rehabilitation are variable.

Training

The University of the West Indies offers training in general nursing, psychiatric nursing, psychology, social work, and medicine; it also offers a residency program in psychiatry. At the time of this writing, two doctors were going through this program, but there was no assurance that there would be enough work to absorb them once they were qualified. The strategic mental

health plan suggests that all doctors doing their post graduate residency should undertake some time in psychiatry, but this has not as yet been enacted.

The Ministry of Health offers courses in general nursing and training to become a mental health officer or psychiatric aid (a nursing assistant who undergoes a four month course in psychiatry).

Mental Health Law

Jamaica's mental health law has recently undergone changes. The Mental Health Act of 1873 was amended in 1974, a change that authorized Mental Health Officers to enter the home of any mentally ill person and take that person to a clinic or hospital for evaluation and treatment by medical practitioners. This authorization fell under the common law system which governs the treatment of physically ill persons who are incapacitated. Those living with the person deemed mentally ill were required by law to assist the MHO. This law used the same powers of detention for those with mental health problems as for those with physical health problems.

A new Mental Health Act was passed in 1997. The new legislation detailed many of the powers covered by the 1974 amendment, but added clauses covering compulsory detention and appeals. It made detention different from that for physical illness and limited detention to 14 days (7).

The overall impact of the new legislation on psychiatric practice is still to be assessed. In a recent test case in the courts, an MHO was charged with battery and false imprisonment and the plaintiff (patient) was awarded damages. The decision led to a discussion over whether there is a need for a code of conduct to be drawn up, for protocols and regulations for MHOs field work, a formal program of education on the Mental Health Act for practitioners, and another review of the law.

THE DEVELOPMENT OF COMMUNITY CARE IN JAMAICA

Psychiatry in Jamaica has been dominated by Bellevue Hospital. This huge Victorian institution was built by the British Colonial Government in 1862, and was originally called the Lunatic Asylum. It was designed to meet the needs of an extended-stay population when there was no effective treatment or management of severe, enduring mental health problems. By the time Jamaica gained its independence a century later, the hospital had 3,000 inpatients and little psychiatric care was provided anywhere else on the island. However, plans were already afoot to diversify psychiatric treatment. Reports published by PAHO in 1958 and 1963 paved the way for change (2).

By the 1960s, modern approaches to treatment, the recognition that large psychiatric institutions could lead to patients becoming "institutionalized," and the advent of pharmaceutical treatment and contemporary rehabilitative methods were accepted worldwide. Jamaica's move away from custodial care followed this trend. A new mental health inpatient unit was built on the island's west; given that there were only a handful of psychiatrists employed by the Government at the time, physicians and other medical ward staff were trained and supported in treating acute psychosis on their wards. These wards aimed to discharge clients in 10–14 days (2). In addition, the role of primary care was expanded. By 1992, there were 335 local clinics and 1,200 general practitioners. Primary care physicians treat moderately severe mental illness and work with

MHOs to assess and treat persons suffering from severe mental illness that are stable. More complex cases and the more severely ill are referred to mental health clinics (*8*).

PAHO was instrumental in developing countrywide community care in Jamaica (*9*). In 1962, PAHO consultants recommended that Jamaica redraft its mental health legislation and develop a community mental health service, an intensive training program for mental health providers and rehabilitation, and a systematic deinstitutionalization program for Bellevue (*2*).

An analysis of Jamaica's mental health statistics demonstrates that the admission rate and resident population off the main psychiatric hospital, Bellevue, decreased between 1960 and 1990. Although the country's population increased by 50% in these three decades, the resident population of Bellevue Hospital decreased by 58% (from 3,094 to 1,296) and the admission numbers decreased by 67% (from 1,097 to 557 patients a year). In 1975, the community psychiatric services referred 139 patients to Bellevue and 606 to parish hospitals. By 1990, they were referring only 29 patients to Bellevue and 551 to parish hospitals. Total referrals dropped by 22%, but this does not take into account the length of stay or the fact that the number of patients seen by the services had increased by 10% over this period. At the same time, home visits to patients increased by more than 300%.

Taking into account increases in the population, the admission rate per 100,000 decreased by 50% between 1971 and 1988 (*2*).

When asked why admissions to Bellevue Hospital had decreased, Dr Earl Wright, the current head of psychiatry in the Department of Health of Jamaica, cited three reasons:

1) The way that health services were regionally restructured, with local acute hospitals being expected to take psychiatric admissions, made it more difficult to admit patients.
2) The opening of Cornwall Hospital.
3) MHOs were developed which increased the capacity in the community. He also said that all services were encouraged to use outpatient treatments, which was facilitated by the existence of the MHOs.

Professor Fredrick Hickling, Head of the Department of Psychiatry at the University of the West Indies, added that Bellevue was not working and a decision had been made to shut it down. Therefore, MHOs were developed and trained to take over the care of people who either came out of or were not admitted to Bellevue.

There is broad agreement that mental health care has shifted from hospital to community-based care. Some of the Bellevue figures reflect the use of general hospital beds for the treatment of acute psychosis, but it is generally agreed that there has been a decrease in all hospitalizations, and that this has been due to an increase in community care. Because there is little in the way of rehabilitation services or true community-based psychiatrists, community care has had to rely on MHOs.

Several other factors have encouraged the use of MHOs. First, as primary care expanded, it allowed for some medical support for community care. Second, the decrease in the number of psychiatric beds made admission to hospital more difficult. Third, because of a lack of psychiatrists, there was a need for a group that could offer support to medical wards, which now were expected to offer care to acutely ill patients with mental health illness. Thus, MHOs have become the backbone of community services, and their deployment is considered vital for the success of Jamaica's community care.

Deinstitutionalization may well be the end point of several initiatives, but the unique role of the Mental Health Officer is what is remarkable. Despite a far from comprehensive strategy to

promote community care, the multifaceted nature of the work of MHOs has been the glue that has held together the country's mental health system. It is unclear how regionalization of mental health services, decreasing beds and expanding primary care could have worked without MHOs. Moreover, given the fact that so few were originally employed, it could be argued that it is a testimony to the hard work of these professionals that community care in Jamaica has even survived.

MENTAL HEALTH OFFICERS

A Brief History

A pilot project in three of the country's eastern parishes employed the first two mental health officers in the early 1960s. By 1969, there were five MHOs employed; by 1972, there were 19 and every parish had least one (*2*). As discussed previously, a 1974 amendment to the 1873 Mental Health Act authorized MHOs to enter the home of any mentally ill person and take that person to a clinic or hospital for evaluation and treatment by a medical practitioner.

As of this writing, there are 41 MHOs in the country (*6*), which includes five regional supervisors and one national coordinator. Nationwide, the total active caseload is more than 14,000 patients. The average caseload of an MHO is 500 patients, but some of these may not be active. They see more than 200 patients a month. Care is, however, shared with regional psychiatrists, district medical officers and, more often than not, the patient's family. Indeed, it is hard to envisage community care in Jamaica working without robust family support networks. The family acts to support, to offer home treatment, to ensure compliance and to monitor patient's mental state and risk. With minimal financial aid and rehabilitation, the family is vital for sustained recovery.

Who They Are

A Mental Health Officer is a specially trained nurse practitioner, a cross between a community psychiatric nurse such as seen in many other services around the world, and junior doctors working in community psychiatry. The MHO training, which is undertaken by Jamaica's Ministry of Health, includes courses in general medicine, psychiatry, psychology, social work, psychopharmacology, and patient management. Training is geared to allow MHOs to deal with most psychiatric referrals, offer initial assessments, advise primary-care and hospital physicians on how to treat people with mental health problems, and offer crisis, home treatment, assertive outreach and case management.

MHOs are not expected to initiate treatment themselves nor to change the type of treatment a patient is already receiving. (For that, patients are expected to see a doctor—a primary care physician, a physician in hospital, or a psychiatrist.) MHOs can reinstitute treatment in the event of a patient's noncompliance or when a patient has previously been treated.

There are significant differences between a MHO and a community psychiatric nurse. The breadth and depth of the job are much greater for MHOs. Not only can they reinstate drug therapy, they also are designated by law as the group which can initiate detention under the mental health act. Rather than being part of a multidisciplinary team, MHOs are professionals who are largely autonomous but are supported by others when they request it.

The major differences between MHOs and a junior psychiatrist in training are that the former do not have a medical qualification and the scope of their training is limited. In theory, this should make MHOs quicker and less expensive to train. In practice, however, there is stiff

competition to become an MHO, and most of them have many years of nursing experience before they are accepted to the MHO course.

It is important for those who are considering adopting this model to know that it is not clear whether it is the job's specifications, the training, or the high standard of applicants that are mainly responsible for the reputedly first rate care that MHOs are said to provide. Indeed, Dr. Earl Wright, Director of Mental Health and Substance Abuse in Jamaica's Ministry of Health, stated that the main barrier to increasing the number of MHOs to the desired figure of 101 was finding the right applicants. This may, in part, reflect the high calibre of nurses required to fill the role, but may also have to do with the attractive financial packages currently offered to applicants if they leave Jamaica and take jobs in high-income countries, where salaries are much higher and the quality of life is thought to be much better. Dr. Wright did not offer figures, but stated that the flight of nurses from Jamaica to the United States of America was a major problem.

Continuing Professional Development and MHOs

Local MHOs meet regularly (at least once a week) to discuss patients and support each other. There also are weekly national educational meetings for MHOs where they can discuss clinical issues and other service-related issues. Some of the meetings may include presentations from outside speakers. Attendance at these formal, chaired meetings tops 90%. MHOs also can take courses to maintain skills or develop new ones. These are often off island and so can be costly; there is a limited budget available to facilitate this.

Another qualification, that of psychiatric nurse practitioner, is available on other Caribbean islands, although not on Jamaica. MHOs attendance to this course depends on Ministry of Health funding. It happens rarely (only 4 of the 41 MHOs have taken that course) and there are no set criteria for a successful application for funding. Only 4 of 41 of the MHOs have taken this course.

Mental Health Officers In Action

It is perhaps easier to understand how MHOs work by considering the pathway to assessment and care of a person with an acute mental health problem.

Referral can be from any source—social worker, probation officer, or family member. Routine referrals also come from prenatal clinics, well-baby clinics, primary care practitioners at all levels, nurses in various hospital clinics, the police, the courts, and self referrals. These referral systems are informal and have been established mostly by contact between different services. They vary from area to area, depending on the closeness of the relationship between different MHO teams and other parts of the service.

Referrals are made directly to the MHO or to a psychiatrist. There are differences in balance between areas but, in general, the majority of people are initially seen by a MHO, a crisis response team, or at an accident and emergency department. The MHO is the point of access for the crisis response team. They are telephoned by a hospital unit.

Crisis calls are usually made directly to a hospital unit. After 5 p.m., the hospital forwards the call to the MHO on duty, who then discusses the case with the carer or with the relatives. At this stage, there are two possible outcomes: advice alone or a visit by the on-call team, which consists of an MHO and two to four psychiatric aids, depending on the district. (Doctors are not part of on-call teams.) Mobile response units with the same composition have also been developed. Initially, two teams were set up, one in the South East and one in the West. Jamaica's Strategic Plan calls for a psychiatric emergency team in each parish by 2006. mobile teams will eventually act as proactive outreach and home treatment teams.

The teams also visit and assess patients. Three possible outcomes can come out of these visits: the patient is taken to the nearest treatment point, the patient is given treatment at home, or no treatment is given but support and counselling is offered to the responsible carer.

For those treated at home, medication is initiated in liaison with a primary care physician. However, since MHOs' training in psychopharmacology varies and there is no mandatory psychiatric rotation as part of their training, complex cases are referred to a psychiatrist for assessment. Treatment in hospital is usually recommended either because patients are experiencing high levels of arousal or because a lack of family support makes home treatment impossible. But, because ambulances are not always available out of hours, in some regions the move to a hospital is facilitated by the police. The police are sometimes are reluctant to do this, however. If the police decline to convey people to hospital, family members may be called on to help. Training the police and setting up specific police response teams has proved feasible, and it has increased the capability of the police force to respond to the needs of crisis assessment teams. Patients who arrive at accident and emergency departments are assessed there by an attending doctor who may or may not be a psychiatrist. The assessment is done in association with an MHO. That said, most people are treated in the community and admission to hospital is rare. Those who are considered suitable for community treatment are discharged to the care of an MHO. If people are admitted to hospital, the MHO sees them regularly and liaises with the inpatient team and local psychiatrist. The average stay is two weeks.

Acutely psychotic patients are treated with intramuscular injections or oral antipsychotics until they become less aroused. Once they are more settled (not necessarily less psychotic) they are discharged to the care of an MHO in the community. The patient's family is counselled on how to continue treatment and a clinic appointment is made for two or three days after when they will see an MHO. Family support is vital for success in community-based treatment because without it patient non-attendance at follow-up appointments and non-compliance with the medication is much more likely.

Follow-up by home visit rather than out-patient clinics is more likely if the patient lives far from the hospital or if there is no family support.

As previously stated, treatment for psychiatric problems is started by either a primary care physician or a psychiatrist. Continuing care for those who have seen a psychiatrist is provided by the MHO. Referral back to a psychiatrist by an MHO is only made if further assessment or a change in medication is required. MHOs defer to doctors and refer back to doctors if a case is complex or treatment needs change. In practice, this may not be as much of a safeguard as it might first seem, because some doctors have much less experience than MHOs and are unsupervised.

Some MHOs said they often gave relatives their mobile telephone number and sometimes gave depressed or suicidal patients their telephone number as well. They said that they were known in the community anyway, so people could always find them if they really wanted to. All MHOs live in the regions that they service. They thought this open access worked well.

In addition to direct patient care, MHOs in some regions also take part in health promotion. They offer health promotion for community groups and seminars on conflict resolution, stress management, anxiety management, child disorders, and substance abuse. MHOs said that, at one time, they did more work in schools, but that much of this work is now being done through the new child guidance clinics.

Problems Cited by MHOs and Other Service Providers

MHOs noted several problems concerning funding for education and other activities. In addition, they cited that not everyone acknowledged their expertise, including some doctors in hospital who preferred to deal with other doctors and did not like referring their patients to nurses. The problem also held true in court—an MHO stated that the judges preferred a doctor's opinion.

There were other practical problems that had to do with the context in which MHOs work. For instance, working in Kingston is challenging, as the high level of violence hinders the care that can be offered. In fact, some clinics, such as the one in Olympic Gardens, have closed because of violence. Population density and traffic congestion also cause problems for responding to emergency calls; in some instances, police units have been asked to clear the way. Kingston MHOs said that policemen were becoming increasingly necessary, because patients sometimes carried dangerous weapons. These health workers stated that police presence calmed down 95% of patients who were armed and aggressive, allowing an assessment to be made or admission to occur. Although MHOs only go on such assessments with supervision and support from police, the potential for violence prevents assessments in about 5% of the cases.

MHOs also said that there were practical issues concerning the need to have more social workers in the community. They felt that there was insufficient expertise and assistance for patients with regards to housing, financial, and childcare issues, a fact that impeded recovery and rehabilitation. Additionally, given the need for appropriate accommodation and community-based rehabilitation for patients, coupled with the central government's tight fiscal control, led MHOs to conclude that there was an urgent need to engage nongovernmental organization to cover these needs.

Future Plans for MHOs

Dr. Earl Wright stated that there was a plan to increase the number of MHOs to 101 in the next five years. He said the Government would try to train 12 MHOs each year, but that the real limiting factor would be finding the right persons. As already stated, there is a flight of highly qualified nurses leaving Jamaica to work in the United States, where salaries and quality of life are considered to be better.

MHOs have indicated that it is important to incorporate psychologists into teams. They believed that psychologists would increase the therapeutic options available, and that this would improve patient care.

Discussion

Mental health services in Jamaica have been shifting toward to a community-based system since the early 1960s. A balanced assessment of the research would conclude that MHOs have played a major role in keeping admission rates down and treating people in the community. Given the lack of other community resources, it would seem that the services offered by MHOs are among the most important factors for the decrease in admission rates. Without question, the direct care given by MHOs is important, but the liaison work with primary care physicians and other clinicians and hospital clinical teams also must be considered.

Though many referrals go through MHOs, it is unclear whether it is their role as gatekeepers, educators, or facilitators of appropriate treatment by other professionals that is the most important. It is likely to be a bit of all three, but I would hazard a guess that the general reluctance of physicians to admit or prolong inpatient treatment for people with mental health problems, coupled with the MHOs focus on community-based care, are the reasons for low admission rates. Clearly, the work of the MHOs, or indeed any complex job, is more than the sum

of its parts, and so there may be limited merit in trying to disentangle and assess separately the different aspects of their work. They work in a context, and the different parts of their job are interrelated. Moreover, the multifaceted nature of the job may, in part, be what attracts high calibre applicants.

The independence to practice much as they wish once medication has been initiated is likely to be important in keeping patients in the community, but also in keeping MHOs in their jobs. Most professionals would prefer to treat people in their own domain if it is safe to do so. Moreover, the fact that they have power to change the level of treatment and re-initiate treatment offers immediate care that supplements the close relationships they build with their clients.

MHOs are the backbone of the service. They are a well-motivated and dedicated group. They are experienced and well-educated. They are cohesive; their group activities and meetings are well attended. In addition, they are enthusiastic and willing to accept continuing professional development, although this seems to have been limited by economic imperatives. Perhaps most importantly, MHOs have a good reputation and standing in the community.

Mental health officers are potentially quicker to train and significantly less expensive to employ than doctors. Moreover, they may be more flexible. They offer a truly community-based service, which is unlikely to be offered by psychiatrists. Moreover, psychiatrists are in short supply in Jamaica, as they are in most low-income countries. It is difficult to envisage the Government being able to afford a huge expansion of medical staffing. Even if it did, it is not clear that psychiatrists would be willing to offer community-based or home-based treatment. It also is unclear that such a system would attract doctors to psychiatry.

Given that relatively autonomous, community-based work is considered attractive to highly skilled nurses, and that the goal is to move psychiatry into the community, it would seem logical to expand services with less well-paid, tried-and-trusted MHOs, rather than opt for approaches such as have been developed in the United Kingdom where psychiatrists have moved into the community along with community nurses.

It should be noted, however, that there has been no systematic evaluation of the quality of MHOs' work. There has also been no evaluation at all from a patient's perspective. Of course, given the dearth of other community care initiatives it will be difficult to properly evaluate the potential impact of MHOs, per se, as any addition to community-based mental health resources is likely to be welcomed and to improve service delivery.

MHOs currently have no specific governing body or union, so their work terms and conditions seem to be fluid. Moreover, there is no body that inspects or evaluates the quality of individual MHO's work.

Currently there are plans to more than double the number of MHOs. The aim is to offer a more comprehensive community service and more rehabilitation, and to decrease the prominence of Bellevue as a provider. Part of the plans includes some offering some sub-specialization of MHOs' roles. While is seems reasonable to assume that MHOs represent a cost-effective strategy to meet community care needs, and one could argue that more MHOs would lead to more need being met, this may not, in fact, be the case. Context is very important in this regard. MHOs are a relatively small group of dedicated people. They were set up at a time when there was little or no community care. It is very likely that the initial returns of such a situation will be great. But times have changed. The first MHOs have set the bar high and do a huge amount of work. They have improved the level of community care. There is much less improvement available for newer mental health officers to make. The individual returns start to could diminish.

One of the appealing facets of the job, and possibly a reason why MHOs seem to offer much more than they are paid for, is that many still view themselves as pioneers. As several of

them stated, there is an obvious need for the work they do, and they can see the positive results. It is unclear whether the need will continue to be as clear when there are more MHOs. It also is unclear whether specialization in rehabilitation, or crisis, or continuing care will diminish the "all-things-to-everybody" role of the MHO, a role that makes their job exciting and confers status on them. Finally, newer recruits who are overly specialized may be less happy to work as a doctor while being paid as a nurse.

And there would be added complications as MHO numbers increase. For example, it is not surprising that an MHOs interviewed for this review spoke of the need to have a building that they could call their own. MHOs felt that they were an important group of professionals who understood how community mental health services worked in Jamaica, and that this should be reflected in their status. The building would confer some status: it would form the basis for a professional organization, for the development of a greater hierarchy, and for the establishment of protocols, professional standards, and career pathways. As MHOs numbers increase, there also would be differences in the level of experience between MHOs. There also would be generational differences, and even differences in the specifications of the job that they are asked to do. Some MHOs may be involved in assertive outreach while others continue a more general role; some may take a teaching role. It would be difficult to continue running the professional group as a cohort of like-minded individuals with little or no internal structure, however. Given that it is unclear who would decide on such a structure, there could be disagreement. The current set up of regional supervisors is a hierarchy that functions for clinical purposes, but it may not work for policy making. As can be seen, this could prove to be fertile ground for divisive politics and could diffuse energy away from direct patient care. As groups try to define not only what they currently do, but how their jobs should be structured in the future, there may be different views on the way forward. This would need to be carefully negotiated, as would the balance of power among the MHOs, the Ministry of Health, and psychiatrists.

In short, increasing the number of MHOs may change the context in which they work and the efficiency of services. It is unclear whether these changes will be gradual or whether a threshold will be reached after which it will be difficult to keep the model working. Even if there are no problems associated with increasing the numbers of mental health officers, it seems that in addition to the pioneer aspect of the job, the working of mental health officers is dependent on close bonds between individuals and groups of individuals and a strong group identity. Group loyalty and identity may be important for promoting quality of work in the absence of proper external scrutiny. Such bonding and increased social capital can produce effective teams, but it may be size dependent. Sub-specialization, an increase in team size, and external scrutiny are all possible threats to the cohesion which may be important for the efficacy of the model. Adding numbers of MHOs may bring new challenges to the model which will need to be dealt with.

Expanding community care reflects the need for better quality services, as well as a desire to shut down Bellevue Hospital. Most of the remaining patients in Bellevue are extended stay or elderly patients, however, so they would not be the sort of patients with whom MHOs would traditionally work. Moreover, there would be a need to acquire significant extra community resources in support of MHOs in order to make community-based work with patients remaining in Bellevue possible and rewarding. The historical link between MHOs and the decreased admission rates should not lead to the mistaken belief that the number of remaining patients could be further decreased by training and employing more MHOs. Moreover a significant change in the work that MHOs perform or a perceived change in the efficacy of the work because they are taking on patients for whom the model is unproved, could undermine the status of MHOs in the community and their job satisfaction.

Could Others Learn and Adopt the MHO Model?

The MHO model seems to offer a cost-effective model for community care and home treatment in areas where there are few doctors. It also could be argued that in developed countries where there are doctor shortages, such as the United Kingdom, MHOs could offer an alternative care strategy. The fact that many MHOs live and work in the same area, and so were considered to be part of the community, would be attractive to developed countries where the remoteness of mental health professionals is considered a problem.

Clearly, local circumstances will dictate how the MHOs role should be modified, but it does seem that the core principles of experienced nurses working autonomously in the community and when patients are admitted to hospital, who are able to prescribe, and who are a link between primary and secondary care would need to remain in place—as would the status, support networks, and continued reflection and training.

It also would be useful to recognize the possibility that team size should not increase too much and that the regional structure might be necessary to maintain group and ensure the model's success.

It should be stressed that any country that wishes to adopt this model must have a strong department of health willing to persuade primary care physicians to treat psychosis and to listen to the advice of nurses. MHOs also rely significantly on the support of families so this would have to be taken into account when designing services.

In areas where capital funding is difficult, it would make sense to invest in people-led services rather than in infrastructure. The caveat for MHOs is that there needs to be sufficient infrastructure to facilitate the work and sufficient peer support and cohesion to retain highly trained and motivated staff in the services.

CONCLUSION

Delivering community care with tight resources is difficult. With a dearth of doctors and no real likelihood that there will be a significant expansion in numbers to meet the population needs, MHOs have been an answer for Jamaica. They offer a service that is different from traditional community psychiatric nurses or junior doctors working in community teams. They are well regarded and considered effective. Whether they are the answer to the need to increase available community care and to improve its quality remains to be seen.

References

1. Central Intelligence Agency World Factbook, accessed 6/2003
   (www.cia.gov/cia/publications/factbook/geos/jm.html)
2. Hickling F. Situational Needs Analysis of the Mental Health Services in Jamaica. Mona, Jamaica: University of the West Indies; 1999.
3. World Health Organization. WHO statistics by country or region. Geneva: WHO; 2003 (Accessed 7/2003).
   (www3.who.int/whosis/country/indicators.cfm?country=JAM&language=english)
4. World Bank. World development indicators, 1998. Washington DC:World Bank; 1998, (also available at: worldbank.org/data/pdfs/tab2_8.pdf)
5. Warner R. Recovery from schizophrenia: psychiatry and political economy. 3rd ed. New York:Routledge; 2004.
6. Ministry of Health of Jamaica. Strategic Mental Health Plan 2001–2006. Kingston; Ministry of Health; 2001.
7. Government of Jamaica 1997. Mental Health Act 1997 Government Printing Services, Jamaica.
8. Hickling F. Community psychiatry and deinstitutionalization in Jamaica. Hosp Comm Psych 1994;45 (11) 1122–1126.
9. Collins R, Green P. 1976: Community psychiatry and the Pan American Health Organization: the Jamaican experience. PAHO Bull 1976;10: 233–240.

MEXICO:
THE HIDALGO EXPERIENCE
A NEW APPROACH TO MENTAL HEALTH CARE

Miguel Xavier, MD, PHD [1]

INTRODUCTION

The Historical Evolution of Assistance to Mentally Ill Persons in Mexico

Up to the middle of the 19th century, care for persons with mental disorders in Mexico was mainly provided by religious institutions. This was the practice followed in Europe, particularly in the Iberian Peninsula, and it was adopted throughout much of Latin America. The approach's priority was to shelter patients, isolating them from their family and community. San Hipólito Hospital, the first institution in the Americas devoted to caring for persons with mental disorders, was founded by Fray Bernardino Alvarez in Mexico City in 1566. Subsequently, the Divino Salvador Hospital was established in 1698 in Mexico City, followed by the Belén Hospital in Guadalajara in 1794. All three hospitals were operated by the Catholic Church.

In the mid 19th century, liberal currents ushered in a period of economic, political, and social change in Mexico; as part of the changes, the country's health services were increasingly transferred to the government. In 1861, President Benito Juarez formalized this shift, issuing a decree that legally transferred the operation and coordination of health institutions from religious authorities to the public administration (i.e., the governments of the federal states). With the advent of this secular, and presumably more scientific, approach to care, several government hospitals were created, such as the Civil Hospital (Monterrey, 1860), the Insane Asylum of the State of Orizaba (Veracruz, 1898), and the Leandro León Ayala Psychiatric Hospital (Merida, 1906). Government control of hospitals also led to a centralization of care of persons with mental disorders. In 1910, the La Castaneda General Insane Asylum opened its doors in Mexico City, and began to receive patients who in the past had been committed to the centuries-old San Hipólito Hospital (for men) and Divino Salvador Hospital (for women). La Castaneda's original plans were formulated in 1870, as part of a project that also included the General Hospital of Mexico. The latter hospital was given priority, and the construction of La Castaneda was repeatedly delayed. When it finally opened some 32 years behind schedule, the original plans for a 200-bed capacity had been revised to some 1,000–1,200 beds.

The delays notwithstanding, the opening of La Castaneda represented a milestone in the history of Mexican psychiatry. Without doubt, the plans for this hospital included care-giving and functional innovations not seen in any Mexican mental health institutions up to that point. For example, the design incorporated the use of separate pavilions for housing patients with different clinical and behavioral typologies, geographically separate administrative and patient areas, and areas specifically intended for recreational activities. Nonetheless, a scarcity of resources and a lack of effective treatment, as well as the prevailing belief that mental illness inexorably leads to deterioration, rendered the institutional approach the norm even in this "modern"

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[1] Clínica Universitária de Psiquiatria e Saúde Mental, Faculdade de Ciências Médicas de Lisboa, Calçada da Tapada, Lisbon

hospital—patients became virtual recluses within the asylum, isolated from the community and without the benefit of any rehabilitation programs.

These conditions also were made possible by a view that held that health care was mainly a charitable activity, a widespread idea in early 20th century Mexico. In fact, despite attempts to modernize medical institutions, an effort that began at the end of the 19th century, it was only in the 1930s that the provision of sociomedical care began to be considered as a proper and necessary governmental function. This conceptual shift was reinforced in practical terms by the creation between 1937 and 1943 of several regulatory bodies to oversee health-related activities, for example, the Department of Social Assistance for Children (*Departamento de Asistencia Social Infantil*), the Secretariat for Public Assistance (*Secretaría de la Asistencia Pública*), and the Secretariat for Public Health and Assistance (*Secretaría de Salubridad y Asistencia-SSA*).

Fueled by the political and economic impetus triggered by the creation of these government agencies, in the 1940s psychiatric care began to be expanded to general hospitals—such as the Hospital Español and the Ministry of Health's Children's Hospital of Mexico, both in Mexico City—and to some health centers. In response, the Secretariat for Public Health and Assistance's Department of Neuropsychiatry and Mental Hygiene developed the first structured program specifically designed for planning psychiatric services, including organizational areas (creation of services, coordination and monitoring of delivery of care), the training of various professional groups, and the promotion of mental health.

Perhaps more importantly, in the 1940s many elements of Mexico's psychiatry sector were reacting strongly against La Castaneda's institutional model and began searching for alternative care-delivery options, with *granjas* (farms) emerging as a salient example. *Granjas* were medical institutions based on an agricultural enterprise model (a model that had been used in some European countries), whereby the work undertaken by patients was considered to be occupational therapy. This type of institution was one of the pillars of Mexico's mental health policy for about 20 years, until the end of the 1960s. In hindsight it seems paradoxical that a model that purported to be an alternative to the asylum approach actually ended up isolating patients from the community because of its location and the patients' lack of contact with the outside world. And so, the *granja* model unintentionally recreated the conditions that lead to the "institutionalization" of patients, similar to what had occurred in psychiatric asylums.

No other significant developments emerged in Mexico's mental health policy until 1964, when the newly established Mental Health Directorate (part of Secretariat for Public Health and Assistance) began to shut down the La Castaneda asylum, which at the time housed more than 3,000 patients in deplorable conditions. In an attempt to improve the quality of care and residential conditions of patients, the old asylum was finally closed in 1967; it was replaced by six smaller medical units, including the Fray Bernardino Alvarez Hospital for adults and the Juan N. Navarro Hospital for children. This improved the quality of care, but it also fostered the preservation of the hospital-centered model that had been at the core of Mexico's mental health policy.

There were two organizations of great importance for Mexico's mental health created in the 1970s: The first, the National Institute of Mental Health (Instituto Nacional de Salud Mental), was from its inception primarily oriented toward providing care in child psychiatry, and became the predecessor of the current Comprehensive Center for Mental Health, known for its Spanish acronym, CISAME. The second, the Mexican Institute of Psychiatry (forerunner of the current Ramón de la Fuente National Institute of Psychiatry), rapidly took on a central role in formulating mental health care programs, training professionals, and implementing research activities, roles that it retains.

The departments that coordinate mental health policy continued to be reorganized throughout the 1980s, first with the creation of the National Council against Addiction (Consejo Nacional contra las Adicciones, CONADIC) and subsequently with the integration of psychiatric units within state health authorities; the development of guidelines was the only element that remained centralized. The practical result of these structural modifications was only felt in terms of the renovation or the creation of hospital units, while there was not a concurrent development of community-based facilities.

The first departure from the traditional way of organizing mental health services came in 1995, with the issuance of standard-setting document NOM-025-SSA2-1994 (NOM-025), which was developed in through a partnership that included CONADIC, the General Directorate of Mental Health, and the Directorate of Mental Health Standards. At least at a conceptual level, the document called for psychiatric-care standards in Mexico that were clearly based within a community context in which holistic views of mental disorders, continuity of care, protection of patients' rights, and preventative mental health efforts were priorities. In 1997, coordination of the various programs came under the responsibility of a new organization, the Mental Health Coordinating Body (Coordinación de Salud Mental , COORSAME). A later restructuring exercise turned this responsibility over to the General Directorate of Mental Health Services (Dirección General de los Servicios de Salud Mental).

Mental Health in Today's Mexico
Organization of Services

The organization of mental health services in Mexico is relatively complex, partly due to its many agents and structures, partly due to its frequent policy shifts. Adding to this complexity is the organization and regulation of services which, in accordance with the government's federalist structure, establishes two levels of responsibility for decision-making regarding the provision of services—the federal states, which have and coordinate their own mental health policies, structures, and resources; and the federal government, which, through the Ministry of Health, centralizes general planning activity, standard setting, and monitoring of various state programs. The fact that different states have different policies, along with economic and sociogeographic conditions, are the determining factors that create disparities in the types and the quality of care across Mexico.

In addition to the federal Ministry of Health and the state governments, there are other agents involved in mental health care: the Mexican Social Security Institute (IMSS), the Institute of Social Security and Services for Government Workers (ISSSTE), and the National System for the Comprehensive Development of the Family (DIF). The first two offer outpatient and hospital care, and the third develops preventive initiatives and implements programs for the early detection of mental disorders.

Despite recent initiatives designed to shift mental health care to a community-based model, in Mexico the hospital-centered model prevails, with mental health care continued to be provided mainly by the 35 psychiatric hospitals (approximately 5,500 beds) located throughout the states. This appears to be related the country's history of psychiatric care based on the institutional asylum model. In fact, the country's government authorities continued to publicly defend psychiatric hospitals as indispensable, as can be seen in the 2001–2006 official mental health program, edited by the Ministry of Health:

Unlike what was thought some decades ago, nowadays there is no doubt that the existence of psychiatric hospitals is necessary, since they have been shown to be both necessary and effective in the handling of chronic and severe patients; it should also be noted that they are not the only option in the treatment of mental illness, and what we now seek to create is a community-hospital continuity.

—Action Program in Mental Health, SSA (2001)

There also are 11 private psychiatric hospitals and 4 hospitals operated by the Mexican Social Security Institute. Mexico has a total capacity of between 30,000 and 35,000 hospital beds, of which some 6,000 are specifically devoted to mental health. Beyond psychiatric hospitals, the public network of mental health services includes other varied types of facilities scattered throughout the country Mexico, such as general health centers, mental health centers, psychiatric units integrated in general hospitals, shelters.

Regarding the degree of specialization of the services, the Ministry of Health establishes three hierarchical differentiation levels, each with distinct, though complementary, objectives and scope of action. The primary level, developed within the scope of primary health care, is oriented toward early detection and treatment of the most frequently occurring cases in the health centers. The secondary level corresponds to hospital care, and encompasses both the psychiatric units in general hospitals and institutions specifically oriented towards mental health (for example, psychiatric hospitals or units within institutes). The tertiary level corresponds to the highly specialized psychiatric hospitals—such as Dr. Juan N. Navarro and Fray Bernardino Alvarez hospitals—which are considered the most qualified institutions of the entire public mental health construct in Mexico.

Interestingly, this organization of mental health services reflects, yet again, the hospital-centered perspective that has been prevalent in Mexico. Rather than placing the comprehensive, community-based models of care currently under development at the top of the hierarchy, it is the two psychiatric hospitals that are considered to be the most qualified institutions in all of Mexico's public mental health.

In terms of legislation, the provision of mental health care in Mexico is framed in two levels, each with corresponding legal ordinances with different scopes. The more generalized legal context is given by the country's Constitution and by the General Health Law, both of which encompass a vast group of basic principles and civil rights. More specifically, the legal document that regulates the provision of mental health care is NOM-025, in which concepts such as reincorporation into society, rehabilitation, prevention, continuity of care, programs outside the hospital setting, and users' rights are given ample coverage. Nonetheless, a detailed analysis of NOM-025 confirms that not all the general principles previously spelled out were later validated in the document, which seems to be fundamentally oriented towards setting up hospital units, which are always the first to be mentioned.

Epidemiology

Representative studies done in the Federal District's urban region showed a total prevalence of psychiatric disorders between 15%–18% (*1*), with affective disorders constituting the most frequent conditions in both females (9.7%) and males (4.9%). Another study conducted on a representative population (*2*), found a relatively high prevalence of alcohol abuse and addiction, both in urban populations (9.3% in males, 0.7% in females) and in rural ones (10.5% and 0.4%, respectively).

More recent epidemiological data from a representative sample of the Mexican population was obtained through a survey undertaken in relation to a 2000 World Health Organization (WHO) initiative, which brought together several countries under the aegis of the World Mental Health Survey Consortium (*3*). Using a uniform methodology and the Spanish-language, computerized version of WHO's World Mental Health Survey Initiative version of the Composite International Diagnostic Interview (WMH-CIDI), the survey collected data on the prevalence of psychiatric disorders (ICD-10), sociodemographic correlatives, and the use of services by Mexico's population aged 18–65 years old (5,862 interviews completed). Results showed a prevalence for at least one ICD-10 diagnosis of 28.6% in a lifetime, 13.7% in the 12 months prior to the survey, and 5.8% (in the last month prior to the survey). By category, anxiety disorders had the highest prevalence in the lifetime category (14.3%), followed by substance abuse (9.2%) and affective disorders (9.1%); in the "last month prior to the survey" the order was reversed, with anxiety and affective disorders predominating.

Equally important were sociodemographic correlatives such as being female, unemployed, and separated or divorced, all of which were associated with higher prevalence of affective and anxiety disorders.

In terms of the pattern of use of health services (specialized or otherwise), the survey revealed that the proportion of people who received care was 1 in 10 among those with a single diagnosis, 1 in 5 among those with two diagnoses, and 1 in 10 among those with three or more diagnosis. Finally, the survey showed that only 1 in 15 patients with three or more diagnosis received care in specialized services (*4*).

These data clearly highlight a serious problem in the accessibility of patients to services, especially to more specialized services, and point to the probable existence of a high number of unmet needs in the Mexican population that suffers from psychiatric disorders.

A Debate on Mexico's Present Mental Health Situation—the Human Rights Issue

Mexico's mental health policy has been the subject of intense ideological and political debate in the last few years, with various factors playing a part. For example, at the macropolitical level, although the prevalence of psychiatric disorders in the general population hovers around 15%, the federal authorities allotted only 0.85% of their total budget to mental health (*5*). This chronic underfinancing has resulted in an extraordinary degradation of many mental health institutions, particularly those psychiatric hospitals built according to the *granjas* model. The lack of financial resources also has affected the available mental health professionals, whose numbers are insufficient to meet the country's needs. For example, there are only about 3,000 psychiatrists in Mexico, covering the country's more than 100 million population. Furthermore, most psychiatrists work in the great urban centers, which means that rural populations have scant access to specialized services (*5*). Much the same is true for other mental health professionals, such as nurses, psychologists, and social workers, many of whom have not received adequate training.

Given this situation, and considering that the psychiatric hospital has been the foundation of the mental health care system, aspects as important as prevention of illness, mental health promotion, early detection of psychiatric disorders, continuity in care-giving, and rehabilitation can hardly be expected to be considered as crucial tenets in the reform of mental health care. The conjunction of all these factors brought on a significant reaction from organizations such as the Mexican Foundation for the Rehabilitation of the Mentally Ill (FMREM), which supported changes in the country's mental health policy. First they began by pointing out to the Ministry of Health

the deplorable conditions in the asylum hospitals, as well as the absence of a national prevention and reincorporation into society system that could respond patient needs.

This pressure notwithstanding, the government did not yield, and the conflict progressively intensified, contributing to a polarization between the two main players—CONACID, which despite some modernization in their discourse, maintained that the mental health policy should remain unaltered, and FMREM, which proposed deep reforms to the model of care, advocating for the replacement of asylums with a comprehensive system of care in the community.

With the two parties facing off in polar positions, an outside organization, Mental Disability Rights International (MDRI), stepped in to try an overcome the stalemate (*6*). In an effort to assess the degree to which human rights were being respected in Mexican psychiatric institutions, an MDRI team undertook three missions (1996, 1998, and 1999), in the course of which various facilities were visited, including asylum-like structures (Ramirez Moreno, Nieto, Sayazo, Ocaranza, and Jalico), short term internment hospitals (Fray Bernardino), social protection institutions (coordinated by the federal government), and several programs directed by NGOs (FMREM, Dignity Foundation).

Despite declarations by Ministry of Health officials regarding the government's commitment to the community-based orientation of Mexico's mental health policy (NOM–025), MDRI found that reality belied official statements, both in terms of the quality of care and of respect for patients' human rights. Given the dire results of experiments in deinstitutionalization in Europe and North America, MDRI considered that Mexico's low-budget allocation for mental health and the scarcity of community-based facilities as alternatives to asylums were potentially dangerous for users. In addition, living conditions in asylums visited by MDRI investigators were generally characterized by isolation or segregation, inactivity, absence of privacy, poor hygiene, insufficient diet, no rehabilitation activities, frequent and inappropriate use of physical restraint, and insufficient dental and general medical care.

Most patients did not present a specific need for institutional care, yet many remained institutionalized because they did not have family members willing to care for them at home. These patients were referred to as "the abandoned ones." Many patients suffered from epilepsy or mental retardation, and probably would have been far better off if given the opportunity to live in the community. In some cases the situations encountered by MDRI were shocking, particularly in cases that involved children as inpatients, such as rooms with excrement on the floor, patients tied to beds or wheelchairs for prolonged periods of time, sexual self-stimulation and other sexual practices in the common rooms, frequent infectious respiratory diseases, and secondary complications (fractures, muscular atrophy, pressure-induced ulcers) arising from lack of mobility.

Given these circumstances, MDRI considered that the human rights of mental patients, as defined by various international organizations, were probably being violated. MDRI's visits also uncovered legal problems. For example, informed consent was rarely used. In fact, even though this practice is universally considered to be one of the fundamental pillars of humane medicine and health care, it was viewed as unnecessary by the medical staff. In addition, disparities between Mexican law (NOM-025) and norms established by international law were observed in involuntary commitment procedures. In Mexico, services and units were required to file a legal notification—a referral of the committed patients to the courts—but periodic independent review of clinical cases was not mandatory. Thus, the decision to admit the patient, as well as continuing or stopping to commit an inpatient was exclusively in the hands of the very same institutions (i.e.,

of its employees and officials), resulting clearly in a diminution of the due process guarantees of the patient.

Just as critical was the naming of a guardian (such as the Director of the Institution) without any judicial procedure, which clearly goes against the basic tenets of international law. For example, the director of the Ocaranza asylum told MDRI investigators that he was the guardian (personal representative) of about 300 patients, without having been nominated by any court.

The facts uncovered by the researchers were subsequently compiled in a report (*6*) that received the enthusiastic support of NGOs, including FMREM. First, health authorities tried to dismiss the report, pointing out what they considered to be errors, such as generalizing to the entire country a reality encountered in only a few places, the minimization of the work of the health authorities, and the use of sources who were not objective. The authorities called for the report to be revamped, using a more scientific and rigorous methodology. And yet, the report came to have a deep impact at the national and international levels and forced the Mexican government to introduce immediate changes in the traditional model of mental health care, giving particular attention to the community-based perspective and to patients' human rights. The report's publicity also forced the Mexican government to increase the resources to and improve conditions in the institutions named in the report.

Although the additional investments helped in a few cases, they did not lead to significant changes, given that, in practice, political directives continued to favor the perpetuation of the hospital-centered model. Things remained virtually unchanged until 2003, although some sectors protested over time, accusing the authorities (in this case, CONADIC) of maintaining the status quo in the provision of mental health care and of not implementing the reforms necessary to transform the organization of mental health services in the country, despite the federal government's previous commitments. By the end of 2003, with the resignation of CONADIC's director, mental health policy in Mexico entered a new era, as health authorities removed several functions from CONADIC's responsibility (e.g., reform of the services, drafting legislation, training, and research), giving them instead to a new autonomous body, the National Council of Mental Health, which had the same status as CONADIC. The Council was given a set of important functions dealing with the reform of Mexico's mental health model: 1) to ensure the full and effective enforcement of NOM-025; 2) to disseminate the "Hidalgo experience;" and 3) to promote respect for human rights and fight against the stigma and discrimination that affect people with mental disorders.

THE HIDALGO MENTAL HEALTH REFORM
The Development Phase
Synopsis

The Hidalgo experience began in the late 1990s, and followed the concepts of social psychiatry and the practices of community-based psychiatry. Its main objective was to bring about a radical change in the psychiatric care in the state of Hidalgo, Mexico. This transformation change would be brought about by establishing a decentralized system of community programs and facilities, including integrated prevention activities, hospitalization, and psychosocial rehabilitation in the context of respect for patients' human rights patients and in close collaboration with the state of Hidalgo's health authorities. In appreciation of the value of the Hidalgo experience, the Ministry of Health created a new federal department (the General Directorate of Psychosocial Rehabilitation, Civic Participation, and Human Rights), which had direct responsibility for the

development, implementation, evaluation, and expansion of the Hidalgo experience throughout the country.

Agents of Change

The Hidalgo mental health reform was based on two key elements: a critical analysis of psychiatric reform in Europe, with particular attention to successful experiments in Italy (Trieste) and Spain (Leganes Hospital in Madrid), and the expertise of Mexican Foundation for the Rehabilitation of the Mentally Ill (FMREM), an NGO with a long history of civic action in favor of mental patients, namely in the area of human rights and in creating support networks within the community. FMREM, which was founded in 1980, has provided psychosocial and rehabilitation programs in a number of Mexican psychiatric hospitals, as well as community residential support programs for patients recently discharged from psychiatric institutions. In the 1990s, FMREM launched a campaign to expose human rights violations in Mexican asylums, including actions in such media hot spots as the World Federation for Mental Health Congress (1991) and the United Nations Human Rights Commission (1994). It also exerted pressure on the Mexican Human Rights Commission through the presentation of successive complaints, and promoted the emergence of citizens' committees to advocate for the respect of human rights in psychiatric hospitals. The first committee was formed in Ramirez Moreno Hospital in Mexico's Federal District.

Because FMREM's activities were held in such high regard, the NGO was asked to participate in the drafting of NOM-025, particularly the section on human rights and how to officially recognize the citizens' committees. As a result the official recognition of citizens' committees contemplated in NOM-25, committees began to be formed in more psychiatric hospitals, which increased their influence through advocacy and media exposure. In 1999, the Ministry of Health invited FMREM to participate in the development of the psychiatric reform program that was to be called the Miguel Hidalgo Model of Mental Health.

Beyond the importance of FMREM's work, which was the result of the collective effort of professionals and mental health service users, the role played by human rights activist Virgina González Torres deserves special mention. Torres first became aware of the plight of mentally ill people after her sister was committed for bipolar disorder in the early 1980s. Soon afterwards, Torres established a training program in rehabilitation for volunteers at Jose Sagayo Psychiatric hospital in Mexico's Federal District. Later in the decade, she created the first community residential program for patients recently-discharged from psychiatric institutions. The program, which she financed with her own money, was specifically intended for former patients who did not have any effective social support network.

In the 1990s, Torres began a campaign to denounce violations of the human rights of mental patients. A campaign strategy was to shoot unauthorized film of psychiatric hospital conditions and the release the film to the media. As a result of these actions, the administrative authorities of a number of Mexican psychiatric hospitals were dismissed, and Torres became not only a public figure, but also someone who was feared within the most traditional circles of psychiatry in Mexico. This notoriety had some dire consequences. In 1997, for example, while seeking to enter Jose Sagayo Hospital for a meeting with the director as part of her activities with the Citizens' Committee, she was restrained and violently beaten by hospital workers, suffering head trauma that included a brain hemorrhage. The incident was widely covered locally and internationally and spawned a support movement that involved organizations such as the World Association for Psychiatric Rehabilitation, MDRI, and the World Federation for Mental Health. The publicity reinforced Torres' stature as one of the major advocates for the rights of individuals with mental disorders in Mexico.

Goals and Attaining Them

Given its ideological orientation, it is not surprising that the general objectives of the Hidalgo experience were similar to the basic principles of community-based psychiatry, especially in the following areas:

- To prevent the risk of psychiatric marginalization and/or institutionalization.
- To assist users, helping them develop their personal resources.
- To foster the recovery or the acquiring of personal and social skills necessary for functioning within the community in ameliorated conditions of autonomy, normalization, integration, and quality of life.
- To encourage the integration of users into society and professionally and to stimulate the fulfillment of social roles.
- To provide support and information to families.
- To sensitize the community about mental illness through the promotion of mental health.
- To prevent the development of mental illness through adequate care, initiated at the moment when symptoms first arise.
- To establish collaborations with NGOs to implement community-based programs that facilitate the reintegration of the users into society.
- To support citizens' committees, so as to improve their performance.

The objectives of the Hidalgo experience also addressed quality-assurance aspects of Mexico's mental health system, such as:

- To encourage the integration of users into psychosocial rehabilitation activities.
- To establish direct support mechanisms for the user in the environment where he or she has integrated.
- To achieve the closure of psychiatric hospitals with asylum-like characteristics throughout the country in a progressive but definitive fashion.
- To seek that those states that implement the Hidalgo experience continue to communicate with the Ministry of Health's General Directorate of Psychosocial Rehabilitation, Citizen Participation and, Human Rights.
- To seek that those states that implement the Hidalgo experience periodically publish documents on their process of development of the program.
- To ensure that all structures that constitute the network of the Hidalgo experience function with excellence, quality, and are free of charge.
- To ensure that mental health professionals within the network receive special recognition and incentives.
- To ensure that in all the facilities of the network there are pleasant and efficient environments that ensure the respect for users' human rights.

On the basis of this set of general and specific objectives, the architects (leading members of FMREM) of the Hidalgo experience drew up an organizational plan for the health facility network that would respond to the following issues:

1) Prevention would be achieved through public education and early detection and/or treatment efforts targeting the greatest possible number of mental disorders, especially of

less severe cases (for example, adaptation disorders, depressive syndromes, and anxiety disorders). To ensure the greatest possible effectiveness, it was proposed that this work would take place in health centers, health centers that have a mental health team, mental health community centers, and comprehensive mental health centers (these last two facilities also deal with more serious conditions).

2) Hospitalization for relatively longer periods should take place in general hospitals, short-term psychiatric hospitals, or the new facilities called *villas* (residences), until the patient can be transferred to a facility in the community. Particular stress was put on the compulsory observation of NOM-025, as well as on the role of the citizens' committees in the operation of the hospital units.

3) A patient's reincorporation into society was to be achieved through the use of community-based facilities—preferably developed and overseen by NGOs—such as halfway houses, community-based residences, independent apartments, residences for seniors, protected workshops, cooperatives, and social clubs.

Once the reform plan was finalized and the federal and state authorities committed themselves to support the effort politically and financially, it was possible to immediately proceed to the implementation phase of the reform in the state of Hidalgo, a process that is described in greater detail below.

Implementation on the Ground
Historical and Sociogeographic Context

The State of Hidalgo, which covers 20,905 km² and has a population of 2.5 million persons, is located in Mexico's central region, between the eastern Sierra Madre and the coastal plains of the Gulf of Mexico. The terrain is quite mountainous, which contributes to a marked variations in the population density in different districts across the state.

The state's economy, which is helped by access to a good railway network, mainly centers on agriculture and cattle ranching—together these sectors employ about 60% of the working population. Gold, silver, copper, and magnesium mining; industries such as cement, machinery, chemicals, electronics manufacture; and services (health, banking, administrative) also constitute important sectors of Hidalgo's economy. Increasingly, the labor market has shifted to the service sector, and this change has led to an uneven development in the state's various regions, as well as to a rise in migration of rural populations to urban centers, particularly to Pachuca, the state capital (230,000 population), Tulancingo, Tula de Allende, Tepeji de Ocampo, and Actopan. As a result of these factors, the state of Hidalgo is characterized by wide differences between city and countryside and between region and region: there is an uneven distribution of basic services and facilities, and a significant percentage of the population—especially the indigenous population—finds itself socially marginalized or experiencing true social exclusion.

Organization of Health Services in the State of Hidalgo

The organizational structure and operations of Hidalgo's have undergone significant modernization in the last few years. The Governor of Hidalgo, Manuel Ángel Núñez, has spearheaded this effort. He has played a notable role in improving the health system overall, and he has been very influential in transforming the state's psychiatric care services.

Care delivery in the public health system is done along two complementary levels that vary depending on the setting and the degree of technical development. The units at the first level respond to most of the population's needs for curative, preventive (vaccination, early oncological detection, family planning), and health education areas. In more complex situations, patients are

referred to one of the 11 state hospitals (second-level units) that are found throughout the state. It is within this second level that Villa Ocaranza fits in. Villa Ocaranza, which is at the heart of Hidalgo's experience, is an institution that provides care exclusively in psychiatry and mental health; it replaced the old Ocaranza asylum.

From the Asylum to Villa Ocaranza—the Reform Process

Until 1999, psychiatric care in Hidalgo centered around the Raúl Fernando Ocaranza Hospital, an asylum-like institution built in the 1960s based on the *granjas* model. As discussed earlier, when the MDRI members conducted their site visits, the logistical and care delivery conditions at the hospital were extremely deficient, in terms of hygiene, nutrition, and health care, despite efforts of the hospital's citizens committee to bring about improvements. The men and women were housed in separate but overcrowded pavilions, where they remained most of the day without any therapeutic or leisure activities; alternatively, patients were left to wander in small enclosed and unsanitary areas that lacked any comfort. Some patients urinated on the floor of common areas where other patients walked barefoot. Patients were not given basic hygiene (hand washing) before meals, even though many patients, especially those who suffered from mental retardation, ate with their hands. The same glass of water was used to administer medications to all the patients. When asked about these practices, the hospital's director explained to the MDRI team that he barely had enough funds to feed and medicate the patients, and had nothing left over to purchase clothing, footwear, glasses, and toilet paper, among other basic necessities.

The exposure of the terrible conditions in Ocaranza (and in other asylums) in the television and printed media led the Minister of Health, Secretary González Fernández, to propose and promote a program to immediately reform the hospital, which was to be technically assisted by Robert Okin (chief of psychiatry at San Francisco General Hospital) and Virginia Gonzalez Torres (from FMREM). This reform effort was undertaken with the understanding that it would later expand to cover the entire system of psychiatric care in the country. Federal and state authorities invested Mex\$ 12 billion for the reform's initial phase (May 2000). This phase involved the systematic evaluation of the hospitals inpatients by a group of North-American experts to gauge patients' capability to be reincorporated into the community immediately.

After verifying that renovating the hospital would be much more costly than building a new structure from scratch, Mexican authorities opted for shutting down the hospital and building residential alternatives called villas. By June 2000, two community-based residences (with a total capacity of about 30 people) had been built in the state's capital, Pachuca, and construction of several other residences was under way in land adjacent to Ocaranza Hospital.

The next step involved redistributing patients according to the clinical and functional evaluation method discussed earlier. Of the 287 long-term patients, 117 were sent to other psychiatric hospitals because of physical needs and/or neurological deterioration, and 34 individuals with greater independence were placed in two halfway houses. The remaining patients, including long-term ones along with some acute patients, were placed in the 10 villas built so far.

On 21 November 2000, Villa Ocaranza and the community-based residences of Pachuca were officially inaugurated under the aegis of the Health Ministry, the Mexican Foundation for the Rehabilitation of People with Mental Illness, IAP, and the government of the state of Hidalgo.

Current Situation
Structure

Primary health care level. Due Given technical and scientific issues, as well as the impossibility for specialized services to respond to every persons with a mental disorder, one of the most important aspects of the Hidalgo experience has been maintaining a close connection and communication between specialized psychiatric services and primary health care. An outstanding example of this approach is found in the Huejutla region, where a team made up of a general practitioner, a nurse, a social worker, and a psychologist put together a program that offers a wide range of activities and that refers only the most clinically difficult cases to specialized care. The integrated functioning of health centers (first level) and specialized services (second level) allowed, in about three years, to decrease the number of patients who were confined, whose only care alternative until 2000 was limited to the Ocaranza asylum.

Hospitalization level. The decision to close down the Ocaranza asylum created immediate challenges for the officials responsible for Hidalgo's reform process: on the one hand, they had to ensure inpatient treatment for persons suffering from acute conditions; on the other, they needed to provide housing for long-term patients who had lived at the hospital permanently, some of them for many years.

In regard to the first, the objective was to provide care in wards within general hospitals according to principles of community psychiatry; patients were planned to be housed at the Pachuca, Tula, Tulancigo, Ixmiquilpan, and Actopan hospitals. This proved to be a slow process, however, so it became necessary to construct Azaleas, a 30-bed ward located relatively close to the old Hospital. This unit was designed for patients in acute states, and stays were limited to 30 days. To allow for initial stabilization of patients, an emergency service also is available that allows for stays up to 48 hours. Although this ward has only 30 beds, it receives patients from all over Hidalgo, since it is the only psychiatric inpatient unit in the public system.

To solve the housing problem of long-term patients who were capable of more independent living, 10 small, attractive houses (villas) were built on a plot near the old asylum. The Azaleas inpatient unit, the rehabilitation workshops, the outpatient clinics, the pharmacy, and the administrative units, constitute the Villa Ocaranza complex. In a harmonious, well-designed setting that includes large gardens, each villa has four rooms (for three persons each) connected to a common area that has a living room, a kitchen, a dining room, a nurse station, and an observation room. The nurse station and the observation room are so well integrated that their function is not easily identifiable. The villas are decorated in a simple, functional style, and are built on a human scale, which stands in stark contrast with the wards in asylum-type psychiatric hospitals.

As their capabilities and skills allow, residents help in the upkeep, namely cooking and cleaning rooms. They are free to go to rehabilitation activities, since none of the complex's facilities are locked. Psychosocial rehabilitation programs take place in several buildings located on the campus and involve resident patients and acute patients, whenever their clinical condition permits it. There also are external consultation units on campus, where outpatients are assessed in psychiatry, neurology (with EEG laboratory), and psychology. Villa Ocaranza has a pharmacy that provides drugs in all pharmacological groups, including atypical anti-psychotics. The complex also includes buildings housing management, administration, and professional training programs (undergraduate and postgraduate).

From an organizational standpoint, the institution is divided into departments on a professional basis—psychiatry, psychology, and social work—directed by psychiatrist Alejandro Islas Perez. As of 2003, 321 professionals were employed in the institution, including 7 psychiatrists, 9 general practitioners, 1 internist, one neurologist, 1 dentist, 9 psychologists, 9 social workers, and 110 nurses (other staff includes office clerks, secretaries, cleaning crew, cooks, and drivers).

Besides management, the operation care delivery at Villa Ocaranza is ensured by a group of technical committees, each one with a set of responsibilities:

- medical care quality committee,
- epidemiological surveillance committee,
- hospital mortality committee,
- safety and disaster-response committee,
- cost/budgeting committee,
- education, research, and ethics committee, and
- continuous quality improvement committee.

Social reintegration level. As mentioned earlier, Hidalgo's reforms call for the creation of a set of residential/rehabilitation facilities within the community, such as halfway houses, community-based residences, independent apartments, senior residences, secure workshops, cooperatives, and social clubs. Although these structures are clearly important for the reintegration of persons with serious mental disorders into society, experiments in other countries in the past three decades have demonstrated that the on-the-ground development of mental health facilities outside hospitals is one of the most difficult and arduous processes in psychiatric reform. The reasons for this are 1) funds for psychiatric hospitals are not reallocated to new community facilities; 2) municipal authorities resist the change; 3) community members resist the change because of the stigmatization of mental health patients; 4) many mental health professionals are opposed to working according to a new model; and 5) a lack of legislation to bring together health, labor, and social security authorities.

At the beginning of Hidalgo's reform process, however, these obstacles were not present, and the close collaboration between federal and state authorities and the participating NGO made it possible to establish two halfway houses in Pachuca in a very short time. The houses, financed by the state health authorities, opened in 2000; they are indistinguishable from regular residences in the area. Each house has space for 17 persons and is supervised by an FMREM member. The houses, which do not have any medical staff, are designed to receive mentally ill individuals, especially those without any social or family support, upon their discharge from the hospital. Here, patients continue their rehabilitation process. They are able to have jobs in Pachuca or in Benedetto Cooperative, a social cooperative directed by FMREM that also is located in the city. In the cooperative the patients work producing food, pottery, and handicrafts which are sold in the community, creating a revenue source outside the health and social security services.

Process and Results
What happened to Ocaranza's long-term patients? When Ocaranza asylum was closed, approximately 123 patients were transferred to the new villas, distributed by sex (females, 58%), age (mean, 43 years old), degree of independence, social behavior, and psychiatric diagnosis (there was a predominance of mental retardation and schizophrenia). Simultaneously, an intensive rehabilitation program was established, which initially centered on helping patients

acquire, in a non-restrictive setting, the necessary skills for daily life. At the end of six months, the process was extensively evaluated. A comparison of data obtained when patients were still housed at the hospital and data collected after the reforms and the hospital's reorganization, revealed that patients had significantly improved in all areas studied (Table 1).

TABLE 1. Comparison of success (%) in performing daily life activities between the psychiatric hospital and Villa Ocaranza rehabilitation program, November 2000 and July 2001.

Daily life activities	Psychiatric hospital (%) (n: 287)	Villa Ocaranza (%) (n: 123)
Leisure activities	35	95
Skills training	9	41
Reading/writing	4	34
Sowing	6	15
Sphincter control	53	84
Bathing (without assistance	0	80
Dental hygiene	25	84
Self-image care	10	90
Making the bed	0	93
Cleaning the bedroom	0	90
Laundry	0	78
Using cutlery	52 (spoon only)	74 (total)
Food preparation	0	20 (prepare); 66 assist

New cases: pathways to care and interventions. Since ensuring accessibility to services is one of the tenets of the Hidalgo experience, the process of referral and continuity of care has received special attention. To this end, effective communication and integration among all the care delivery levels has been promoted. Training general practitioners to recognize and manage mental disorders has been an important component of the effort, because a significant proportion of new mental illness cases are first seen in primary health centers. When a case is severe enough to warrant care beyond the general practitioner, the patient is referred to health centers that have mental health teams or to Villa Ocaranza's outpatient unit. In the former, the patient in observed by teams that include at least one psychiatrist. In the latter, the patient may be referred to a day care unit, to undergo structured psychotherapy (individual, group, or couple, mostly using the cognitive-behavioral model), or be kept on the external consultation outpatient clinic for follow-up.

If a patient's clinical condition requires it, he or she may be admitted to the Azaleas unit, until his or her acute condition stabilizes. In the acute phase interventions follow a biopsychosocial approach, highly influenced by the 'crisis' model—there are written protocols for treating depression and psychoses. Electroconvulsive therapy is not used.

If the clinical situation is resolved in under one month, the patient is then referred to external outpatient services and, if indicated, may undertake rehabilitation. If the situation lasts for longer, the patient is transferred to a villa, where he or she is integrated into a rehabilitation

process appropriate to his or her needs. The rehabilitation model followed has six stages: the first four are conducted while patients are in the villas; the last two take place outside of the hospital setting.

In the first stage (observation) special emphasis is placed on daily life activities, and the interests of the patient are identified on the basis of his or her behavior at occupational therapy sessions. On the basis of these general indications, the second stage (evaluation) is initiated, in which a comprehensive, individualized rehabilitation program is established for each patient. The program is based on six approaches: training in daily life activities, physical therapy, ergotherapy, educational therapy, artistic expression, and sport/recreational/cultural activities. The program is consolidated in the third stage (stimulus), during which improvements in the patient's psychosocial competence are sought, and (fourth stage) in which the patient begins to be prepared for his or her discharge and return to the community (transition). The final part of this process takes place at one of the halfway houses run by FMREM (fifth stage) and, ultimately, at the patient's home, if he or she has support at this level (sixth stage). In these last two phases, efforts are focused on professional and interpersonal relationship issues, aiming to help the person achieve the highest possible degree of autonomy.

It should be noted that throughout this process the Villa Ocaranza Citizens' Committee played an active role in organizing paid work and cultural activities, and in seeking to promote the active participation of the users in the institution's general assemblies, where various aspects of its functioning and management are regularly discussed.

Changes in care and their costs. Available data on the changes in care at Villa Ocaranza in 2001 and 2002 show a significant increase in the number of clinical actions, although there was no increase in human resources. In 2001, 10,133 psychiatric observations were carried out, of which 3,415 (33.7%) were done in the outpatient unit, 3,438 (33.9%) in the villas, and the remaining 3,280 (32.4%) in the acute inpatient Azaleas unit. In the same year, 3,543 observations were carried out by psychologists, with those done in the Azaleas unit predominating by a small margin (38.3%).

In 2002, the number of psychiatric observations rose to 11,797, mainly due to a significant increase in observations in the outpatient clinic (713 first contacts), and in the acute unit. Increases also occurred in the psychology area, with 3,679 contacts. During that year 419 patients were admitted as inpatients (245 males and 174 females, of which 212 were first-episode cases. Hospital stays averaged 17.6 days and the maximum bed capacity was never reached (mean occupation rate was 83%). In terms of diagnoses, the most common disorders were schizophrenia, bipolar disorders, personality disorders, and mental retardation.

Regarding costs, Mex$ 12 million were invested in the initial infrastructure (villas, outpatient and administrative units, protected workshops), which corresponded to a 100% reallocation of the funds initially set aside for the improvement of conditions at Ocaranza Hospital. The daily cost of a bed in 2001 was Mex$ 446 at the villas and Mex$ 421 at the Azaleas unit, including all expenditures on human resources, medications, nutrition, and maintenance materials.

Other activities. Along with their care delivery responsibilities, Villa Ocaranza clinical staff also are charged conducting a training program for professionals who work in primary health care in the state of Hidalgo. The training's objective is to promote collaboration between health professionals and specialized mental health teams in detecting, diagnosing, conducting assertive treatment, and escorting users and their families. Several issues have already been raised, such as patient assessment, clinical description of major psychiatric disorders, use of drugs, and interventions with families. To supplement the training, a manual was developed to help health

professionals with decisions about therapeutic interventions (e.g., anxiety and depressive disorders, alcohol abuse, agitation).

Besides these contributions, the Villa Ocaranza professionals have been involved in several academic and technical competence-training initiatives at undergraduate and postgraduate levels. In the undergraduate area, they collaborate with the Public Health Department of the School of Medicine of the Independent University of the State of Hidalgo; in the postgraduate area they are responsible for the Psychosocial Rehabilitation Course, which takes place at Villa Ocaranza.

WHAT DOES THE FUTURE HOLD FOR THE HIDALGO EXPERIENCE?

Despite difficulties encountered in the last few years, especially in terms of a lack of defined mental health policies in Mexico, there is general agreement that the Hidalgo experience constitutes one of the most important psychiatric reform example ever undertaken in Mexico. Implemented in the aftermath of human rights denunciations, the Hidalgo experience took advantage of the lengthy reflection process at the core of FMREM since the early 1980s, as well as the successful examples of deinstitutionalization experiments carried out in Europe. This explains why, in 2000, federal authorities designated the implementation of the Hidalgo experience in all the states as the central objective of the psychiatric reform in Mexico. To achieve this the government placed the General Directorate for Psychosocial Rehabilitation, Civic Participation, and Human Rights in charge of promoting and supervising the effort. After a troubled period, which culminated with the resignation of the director of CONACID, these objectives were confirmed by the Minister of Health, Dr. Julio Frenk Mora, both in the official visit he made to Hidalgo in November 2003, and in statements he made to the media. In an interview with the *New York Times*, Frenk stated, "in 2006, the government hopes to establish similar mental health systems in every state and close its 18 government hospitals."

When the facts are analyzed, it is easy to identify the factors that contributed to Hidalgo's experience playing a role as a compass for the psychiatric reform in Mexico. First, the experience demonstrated that it is feasible to change the focus of care from the hospital to the community, and that this change is invariably accompanied by significant increases in the satisfaction of both users and professionals. Second, Hidalgo's experience reinforced the idea that a reform process, although complex, does not have to take a long time (which could lead to discouragement). In fact, the time between the decision to embark on the reform and the inauguration of Villa Ocaranza (together with the resulting closing down of the asylum) was not even two years!

The close connection to primary health care, based on a referral-counter-referral system and on the training and supervision of general practitioners, once more demonstrated that a significant proportion of psychiatric disorders can be dealt with in health centers by professionals who are not psychiatrists and still maintain high stands of quality without resorting to hospitalization. The emphasis on patient rights was another essential element of the experience, both from an ideological (e.g., ethical values) and from a practical point of view. This is amply illustrated by the catalyzing role played by NGOs in sparking the reform process, through the denunciation of extreme situations that violated the human rights of mentally ill persons. Furthermore, the impact of using the media in information and denunciation campaigns was clearly proven, especially when led by charismatic leaders (in this case, Virginia Gonzalez Torres); the campaigns can be especially effective as a means of pressuring recalcitrant authorities. Finally, a facet of the Hidalgo experience that deserves particular emphasis is the immersion of the care-delivery aspects within a much wider and complex philosophy, that of positive mental health,

where promotion and prevention are closely linked to sociocultural, historical, and humanistic factors.

Villa Ocaranza is useful as an example for its innovative and positive aspects, as well as for its less successful aspects, which are an important source for learning and reflection and provide an understanding of the obstacles and difficulties that might impede the successful expansion of the Hidalgo experience to other places. For example, although a considerable amount of patient transfers from institution to institution occurred (117 of the initial 287 long-term patients were sent to other psychiatric hospitals), 40% of patients did not benefit from the reform. Moreover, a reform of this type always demands a developed network of structures outside hospitals, which implies the need for a significant financial commitment from the government. In the case of Villa Ocaranza, the initial investment amounted to Mex\$ 12 million, and FMREM estimates that the costs of implementation of the experience in each state would amount to Mex\$ 30 million. In light of this, it is understandable that only with solid political and financial support, as was the case with the state of Hidalgo authorities, will it be possible to realize a project of this size and scope.

Another lesson concerns the difficulties of integrating mental health at the hospital level even more than at the primary health care level: the botched attempt of creating psychiatric wards in several general hospitals in the state of Hidalgo, despite the enthusiastic support from the state health authorities, is a typical example of the long way still to travel in transforming set ways of thinking, beginning with the public health system professionals themselves. The same can be said of the community, which must be prepared to accept the structures and facilities that support the social reintegration programs. Although residential conditions at Villa Ocaranza are incomparably superior, from all points of view, than those in the old asylum, the distance to the city of Pachuca means that residents in the villas are not being truly integrated in the community. This concern does not apply, however, to the more centrally located halfway houses.

Thus, it seems that the process of deinstitutionalization has not been fully accomplished in Hidalgo. Proceeding with the development of residential structures within the community is, therefore, a crucial challenge for the success of the implementation of the Hidalgo experience, since as it stands now, there are not enough structures to satisfy the identified needs.

FINAL REMARKS

In the past few decades, health authorities and WHO have undertaken a sustained effort in medicine overall, and in psychiatry in particular, to ensure that health care is provided in the community and that hospitalization is avoided whenever possible. As a result of deinstitutionalization movements and the spread of the concepts of social psychiatry, an important set of community-based alternatives to the inpatient confinement of patients in psychiatric hospitals has been developed, assisted by different therapeutic models and programs, whose effectiveness has been validated by methodologically rigorous studies (*7–9*). The Hidalgo experience is a part of this current of transformation of care-delivery principles and practices. As such, it is an example of a radical transformation of a restrictive mental illness paradigm into a open and liberal one, in which respect for human rights assumes an organizing role of primary importance.

As happened in the United Kingdom with the TAPS project (*8*), the psychiatric reform process that took place in the state of Hidalgo demonstrated, in a short period of time, that: when service networks are implemented in an integrated way, there is no clinical or functional deterioration of the patients, nor is there in an increase in the number of suicides or criminal acts, predictions of which are frequently and unjustifiably made by the opponents of reform processes

already undertaken in other countries (*10–12*). Verifying these facts is enormously important, because it points to aspects that can be independent from socio-economic contexts and, therefore, can be reproduced in different realities and terrains. The next few years will show how far the Hidalgo experience can expand beyond Villa Ocaranza.

References

1. Caraveo A, Colmenares B, Saldivar H: Morbilidad psiquiátrica en la ciudad de México. Prevalência y comorbilidad durante la vida. Salud Mental. 1999;22 (special number):62–67.

2. Secretaría de Salud, Instituto Nacional de Psiquiatría Ramón de La Fuente Muñiz, Direccion General de Epidemiología, Consejo Nacional contra las Adicciones. Encuesta Nacional de Adicciones: Tabaco, Alcohol y otras Drogas. Reporte Ejecutivo. México DF: Secretaría de Salud; 2002.

3. World Mental Health Survey Consortium. Prevalence, severity, and unmet needs for treatment of mental disorders in the World Health Organization World Mental Health Surveys. JAMA. 2004;June 2, Vol 291 (21): 2581–2590.

4. Medina-Mora ME, Borges G, Muñoz CL et al. Prevalencia de trastornos mentales y uso de servicios: Resultados de la encuesta nacional de epidemiologia psiquiátrica en México. Salud Mental. 2003;Vol. 26 (4), Agosto.

5. Secretaria de Salud (ed.). Programa de Acción en Salud Mental. México DF: Secretaría de Salud; 2001.

6. Mental Disability Rights International (ed.). Human Rights and Mental Health: Mexico. Washington, DC: MDRI; 2000.

7. Craig T, Pathare S.. Assertive community treatment for the several mentally ill in West Lambeth. Advances in Psychiatric Treatment. 1997;3: 111–118.

8. Leff J. The outcome for long-stay non-demented patients. In: Leff J., eds. Care in the community: illusion or reality. Chichester: John Wiley and Sons; 1997, pp. 69–92.

9. Mueser K., Bond G., Drake R. Models of community care for severe mental ilness: a review of research on case management. Schizophrenia Bul. 1998;24(1): 37–74.

10. Tansella M. The Italian experience and its implications. Psychol Med, 1987;17: 283–289.

11. Crepet P. A transition period in psychiatric care in Italy tem years after the reform. Br J Psychiatry. 1990; 156: 27–36.

12. Mignolli G, Faccincani C, Platt S. Psychopathology and social performance in a cohort of patients with schizophrenic psychoses. Psychological Medicine. 1991;Suppl. 19:17–26.