Lessons learned in developing community mental health care in Latin American and Caribbean countries

Denise Razzouk[1], Guilherme Gregório[1], Renato Antunes[1], Jair de Jesus Mari[1,2]

[1]Department of Psychiatry, Universidade Federal de São Paulo, Rua Borges Lagoa 570, São Paulo, Brazil;
[2]Institute of Psychiatry, King's College, University of London, London, UK

This paper summarizes the findings for the Latin American and Caribbean countries of the WPA Task Force on Steps, Obstacles and Mistakes to Avoid in the Implementation of Community Mental Health Care. It presents an overview of the provision of mental health services in the region; describes key experiences in Argentina, Belize, Brazil, Chile, Cuba, Jamaica and Mexico; and discusses the lessons learned in developing community mental health care.

Key words: Community mental health care, Latin America, Carabbean countries, mental health policies, key experiences, lessons learned

(World Psychiatry 2012;11:191-195)

This paper is the sixth of a series describing the development of community mental health care in regions around the world (see 1-5), produced by a Task Force appointed by the WPA as part of the its Action Plan 2008-2011 (6,7). The WPA Guidance on Steps, Obstacles and Mistakes to Avoid in the Implementation of Community Mental Health Care, developed by this Task Force, has been previously published in the journal (8). In this article, we describe these issues in relation to Latin American and Caribbean countries.

The Latin America and Caribbean (LAC) region is comprised by 34 countries, with a population of approximately 600 million inhabitants, mostly living in urban areas, with a vast ethnic diversity mainly composed of Amerindians, Mestizos, Whites and Blacks. Although 44% are middle-income and 35% are upper-middle income countries, economic inequality is high, and near one-third of the population live below the poverty level (9). The one-year prevalence of mental disorders varies from 20 to 25%, with a predominance of alcohol dependence (5.7%), depression (4.9%) and generalized anxiety disorder (3.4%) (10). Over the past decade, most LAC countries have experienced economic and scientific growth (11,12), political shift from dictatorial to democratic regimes (13), civil rights movements, and implementation of national health policies leading to an increase in life expectancy and a reduction in infant mortality (8).

MENTAL HEALTH POLICIES AND KEY EXPERIENCES

In 2001, 70% of LAC countries had a mental health policy, and only 10% had a specific legislation for mental health (14,15). In addition, 50% had a rate of psychiatrists lower than 2,0 per 100,00 inhabitants, 70% had less than 20% of psychiatric beds in general hospitals, 30% did not provide essential psychotropics, and most of the countries allocated less than 2% of the health budget to mental health. Treatment coverage is limited, and the majority of countries still centralize mental health activities in psychiatric hospitals (15).

The Declaration of Caracas was the cornerstone to trigger psychiatric reform in LAC countries (16-18). The guiding principles of the Declaration were to protect human rights, to promote mental health care within the primary health system, to transfer inpatient psychiatric care from mental hospitals to general hospitals, and to build up a community network of options of care for people with mental disorders. These principles did stimulate the shift from hospital-based to community care (15,17), and since then, a new model of mental health care has been heterogeneously implemented according to local policies and financial resources (16,18). Some progress in integrating mental health to community care has been observed in countries like Argentina, Brazil, Belize, Chile, Cuba, El Salvador, Guatemala, Jamaica, Mexico, Nicaragua and Panama (19,20). We selected eleven key experiences, which are summarized as follows.

Argentina: the Rio Negro experience

Rio Negro, a state in the Patagonia region in the South of Argentina, with a population of 600,000 inhabitants, was the region where changes in mental health services advanced most in Argentina. This occurred especially after the approval of law 2440, in which treatment and rehabilitation were guaranteed for all people with mental disorders. The psychiatric hospital was closed and replaced by psychiatric beds in general hospitals and halfway houses. Mental health teams are now based in local general hospitals and provide supervision and care to patients referred from primary care (21). A course focusing on mental health services has been set up and a residency program in community mental health care aids the recruitment of mental health professionals.

Argentina: the Neuquén experience

The Neuquén Province is situated in Patagonia, with 350,000 inhabitants. Health reform was initiated in 1970, and this province led the development of community health

care systems in LAC countries. The province is divided into 6 zones, with different levels of health care complexity. In rural areas, the first contact is made either with traditional healers or general practitioners, who act under specialist supervision. The public system operates with 10 psychiatric beds in a general hospital and one detoxification unit. In 1995, a non-governmental organization (NGO) launched the AUSTRAL rehabilitation program, which offers one-month to one-year training for primary care physicians and mental health professionals.

Belize

Belize is a lower-middle income country, located in Central America with a population of 270,000 inhabitants (20,22). The health system is comprised of 37 primary health centres, 3 polyclinics, 2 outpatient mental health services, 4 psychiatric beds in a general hospital ward, and 8 general public hospitals (20). A program for training psychiatric nurses was launched with technical support provided by Pan American Health Organization (PAHO). The nurses are supervised by the two psychiatrists available in the country and they participate in the admission and discharge of patients, review side effects of medication, and perform psychotherapy. They communicate with schools, organize activities for the patients and provide home care in rural areas.

Brazil: the Sobral experience

Sobral is a city of Ceara, a State in the Northeast of Brazil, with 175,000 inhabitants. There are two specialized community mental health centres, one psychiatric emergency unit, one residential care facility (sheltered home) and primary health centres with health family programs. These programs are run by medical doctors and other health professionals. Patients with mental disorders are screened and treated by general practitioners, and the severe cases are referred to mental health teams. Moreover, specialists provide continuous supervision to general practitioners (23).

Brazil: the experience of Campinas

Campinas is a city located in the State of Sao Paulo, comprising approximately 1 million of inhabitants. In 1990, the mental hospital was remodelled, and new services were created: a crisis unit, a chemical dependency unit, outpatient unites and a social and cultural centre. The mental health system is now comprised of six 24-hr specialized mental health community centres, with 32 psychiatric beds (24). These services provide care for people with moderate and severe mental disorders. In addition, mental health teams provide support and technical supervision for health professionals in primary care (25). Thirty mental health residential facilities cover 150 long-stay patients discharged from the psychiatric hospital.

Brazil: the experience of Belo Horizonte

Belo Horizonte is a city in the State of Minas Gerais, with a population of 2,5 million inhabitants. There are 7 specialized community mental health centers including emergency care, and 8 primary health care centres (26,27). The community mental health centres were conceived to deal with severe cases that used to be referred to the psychiatric hospital.

Brazil: the experience of Santos

Santos is the biggest port of Latin America, situated in the State of Sao Paulo, with approximately 420,000 inhabitants. Psychiatric reform started 20 years ago. The main psychiatric hospital of the city was closed and community mental health services were implemented (28,29). In 2005, some important actions helped foster mental health systems: investments in developing community mental health units; an increase in the number of mental health workers; training in mental health for health professionals; and the implementation of the Return Home Program (benefits for psychiatric patients who leave hospitals). Currently, there are 5 community mental health centres and 6 outpatient mental health services. Twenty-five psychiatric beds are provided in community centres and in the general hospital. There are 13 mental health teams working in primary health centres. There are no residential facilities for patients post-discharge and psychiatric beds are insufficient to cover needs for acute cases, meaning that some psychiatric hospitalization takes place far away from the city.

Chile

The population of Chile is 16 million inhabitants. The Chilean reform was triggered in 1993, when group homes were established for newly deinstitutionalized populations, and mental health programs were developed in day hospitals. In 1997, a mental health plan was developed by the Ministry of Health, based on priorities set up by epidemiological studies (30). Afterwards, the impact of a trial showing that depression can be treated in a large low cost scale (31) led the government to set up a plan to treat depression on a national basis. As part of the Chilean Health Reform, depression was included in the Regime of Health Guarantees, providing financial cover and treatment for 56 priority diseases (32). The main component of the depression program was to incorporate mental health teams in primary care, performing standardized diagnosis, promoting education for patients and families, delivering psychosocial sessions mainly to moderate and mild cases, using antidepressants in the severe

cases, and monitoring and evaluating the feasibility and effectiveness of the program (33).

Nowadays, the mental health system is based primarily in primary care and general hospitals, though including psychiatric specialized teams and psychiatric hospitals (32,33). Ambulatory mental health centres are often attached to general hospitals, and there are many group homes for deinstitutionalized and mentally ill across the country (33).

Cuba

The population of Cuba is 11 million inhabitants. The Caracas Declaration and the Havana Charter in 1995 both contributed to reorient the mental health system (34,35). Community centers were designed to coordinate, organize, and train human resources in mental health all over the country, which contributed to increased coverage of the population (about 1 centre to 30,000 people) (36). The system operates at three levels of care: the primary level, comprised of community mental health centers, mental health teams in polyclinics and family doctors; psychiatric services in general hospitals where there are crisis intervention teams; and psychiatric hospitals.

Jamaica

The population of Jamaica is around 2.7 million inhabitants. The health services are organized by regions. General hospital wards are used to treat acute cases, offering 24-hr emergency attendance. Outpatient clinics are run by psychiatrists and mental health officers (MHOs), who are specialized trained nurse practitioners, exposed to knowledge in community psychiatry, psychology, social work, psychopharmacology, and patient management. The MHOs provide crisis management, home treatment, and assertive outreach care, being authorized by an act of mental health law to perform detention whenever needed. MHOs see patients in primary care and outpatient clinics. Medication is initiated in collaboration with a primary care doctor, and severe and more complex cases are referred to psychiatrists (37,38).

Mexico: the Hidalgo experience

The Hidalgo experience relates to the shut down of the Ocaranza Asylum in the year 2000. This asylum was located in the Hidalgo State, a central region of Mexico with a population of 2.5 million inhabitants. Two NGOs, the Mental Disability Rights International, and the Mexican Foundation for the Rehabilitation of the Mentally Ill, and civilian activists had a crucial role in triggering the reform process, by denouncing the extreme situation and human rights violations in psychiatric institutions. The asylum was replaced by 10 villas which were built as residential alternatives, plus a 30 bed acute psychiatric ward with a 24-hr emergency department (39).

LESSONS LEARNED

As shown in the previous section, many innovative initiatives are taking place in the region (40). The number of psychiatric beds in custodial hospitals is declining; there has been a modest increase of psychiatric units in general hospitals; and mental health care is slowly becoming an integral component of primary health care. However, the overall picture is mixed: in most countries very few community-based services are available, particularly for the young and the elderly, and the capacity to monitor and evaluate services and programs remains insufficient.

The experience of Chile documents the power of well-conducted trials to influence policy. It was, in fact, the paper published in the Lancet by Araya et al (31) which led to the impressive nationwide expansion of treatment of depression in primary care.

The Rio Negro and Hidalgo state experiences show that a system which is successful in a given region may serve as a model for expanding community care to the entire country.

Several key experiences document the importance of involvement of psychiatric nurses in community mental health care. In Belize, the success of the inclusion of psychiatric nurses was mainly due to the high level of training in mental health offered to these professionals, the close supervision by psychiatrists, and they fact that they work using standardized protocols and guidelines. In Jamaica, well-trained nurses were the cornerstone of integrating mental health care in the health system. In Rio Negro, psychiatric nurses were effective in decreasing resistance from health professionals to treating people with mental disorders and in educating families and the community about mental health care.

Partnership with NGOs, private institutions and other international agencies were essential in triggering psychiatric reform in Mexico (Hidalgo experience), through advocating for the human rights of people with mental disorders. Denouncing human rights violations has also triggered the closure of psychiatric hospitals in Brazil (Santos and Sobral). As shown by the Mexican experience, it is crucial to have all the involved parties together to develop a plan of action.

CONCLUSIONS

Reform means to protect the human rights of patients, to provide the best available treatments, to treat severe cases in the community, and to use the least restrictive possible modalities of care. However, it is noteworthy that no mental health system can function with insufficient beds for acute admissions. Where less acute beds than needed were available, as in the Santos case, it was necessary to transfer acute cases to other cities, causing unnecessary suffering to pa-

tients and their families. A crucial problem is represented by the scarcity of human resources, particularly psychiatrists and specialized nurses, which leads to an overload of work for mental health professionals, representing in some countries a powerful factor leading to brain drain. The example of Chile, where mental health programs were based on scientific data, should be taken into account especially by countries with more financial resources, like Brazil, Argentina and Mexico.

Acknowledgements

The authors would like to thank Drs. R. Alvarado and R. Araya, who provided important input on Chile; Dr. J. Rodriguez, who solicited reports from various countries; Dr. V.A. Basauri, who supplied materials from Panama; and Dr. C. Hanlon, who helped in revising the paper.

References

1. Hanlon C, Wondimagegn D, Alem A. Lessons learned in developing community mental health care in Africa. World Psychiatry 2010;9: 185-9.
2. Semrau M, Barley E, Law A et al. Lessons learned in developing community mental health care in Europe. World Psychiatry 2011;10:217-25.
3. Drake RE, Latimer E. Lessons learned in developing community mental health care in North America. World Psychiatry 2012;11:47-51.
4. McGeorge P. Lessons learned in developing community mental health care in Australasia and the South Pacific. World Psychiatry 2012;11:129-32.
5. Ito M, Setoya Y, Suzuki Y. Lessons learned in developing community mental health care in East and South East Asia. World Psychiatry 2012;11:186-90.
6. Maj M. Mistakes to avoid in the implementation of community mental health care. World Psychiatry 2010;9:65-6.
7. Maj M. Report on the implementation of the WPA Action Plan 2008-2011. World Psychiatry 2011;10:161-4.
8. Thornicroft G, Alem A, Dos Santos RA et al. WPA guidance on steps, obstacles and mistakes to avoid in the implementation of community mental health care. World Psychiatry 2010;9:67-77.
9. Alarcon RD. Mental health and mental health care in Latin America. World Psychiatry 2003;2:54-6.
10. Kohn R, Levav I, Caldas-Almeida JM et al. Los trastornos mentales en América Latina y el Caribe: asunto prioritario para la salud publica. Rev Panam Salud Publica 2005;18:229-40.
11. Razzouk D, Zorzetto R, Dubugras MT et al. Leading countries in mental health research in Latin America and the Caribbean. Rev Bras Psiquiatria 2007;29:118-22.
12. Razzouk D, Gallo C, Olifson S et al. Challenges to reduce the "10/90 gap": mental health research in Latin American and Caribbean countries. Acta Psychiatr Scand 2008;118:490-8.
13. Larrobla C, Botega NJ. Restructuring mental health: a South American survey. Soc Psychiatry Psychiatr Epidemiol 2001;36:256-9.
14. World Health Organization. Mental health atlas. Geneva: World Health Organization, 2005.
15. Caldas de Almeida JM. Estrategias de cooperación técnica de la Organización Panamericana de la Salud en la nueva fase de la reforma de los servicios de salud mental en América Latina y el Caribe. Rev Panam Salud Publica 2005;18:314-26.
16. Levav I, Restrepo H, Guerra de Macedo C. The restructuring of psychiatric care in Latin America: a new policy for mental health services. J Public Health Policy 1994;15:71-85.
17. Bolis M. The impact of the Caracas Declaration on the modernization of mental health legislation in Latin America and the English-speaking Caribbean. Presented at the 27th International Congress on Law and Mental Health, Amsterdam, July 2002.
18. Mari J de J, Saraceno B, Rodriguez J et al. Mental health systems in Latin America and Caribbean countries: a change in the making. Psychol Med 2007;37:1514-6.
19. Caldas de Almeida JM, Cohen A (eds). Innovative mental health programs in Latin America & the Caribbean. Washington: Pan American Health Organization, 2008.
20. World Health Organization and World Organization of Family Doctors. Integrating mental health into primary care: a global perspective. Geneva: World Health Organization and World Organization of Family Doctors, 2008.
21. Collins PY. Argentina: waving the mental health revolution banner – psychiatric reform and community mental health in the province of Rio Negro. In: Caldas de Almeida JM, Cohen A (eds). Innovative mental health programs in Latin America & the Caribbean. Washington: Pan American Health Organization, 2008:1-32.
22. Killion C, Cayetano C. Making mental health a priority in Belize. Arch Psychiatr Nurs 2009;23:157-65.
23. Henry C. Brazil: two experiences with psychiatric deinstitutionalization, Campinas and Sobral. In: Caldas de Almeida JM, Cohen A (eds). Innovative mental health programs in Latin America & the Caribbean. Washington: Pan American Health Organization, 2008: 33-43.
24. Campos RTO, Furtado JP, Passos E et al. Avaliação da rede de centros de atenção psicossocial: entre a saúde coletiva e a saúde mental. Rev Saúde Pública 2009;43:16-22.
25. Figueiredo MD, Campos RO. Saúde mental na atenção básica à saúde de Campinas, SP: uma rede ou um emaranhado? Ciência & Saúde Coletiva 2009;14:129-38.
26. Silveira MR, Alves M. O enfermeiro na equipe de saúde mental – o caso dos CERSAMs de Belo Horizonte. Rev Latino-americana Enfermagem 2003;11:645-51.
27. Oliveira GL, Caiaffa WT, Cherchiglia ML. Mental health and continuity of care in health care centers in a city of southeastern Brazil. Rev Saúde Pública 2008;42:707-16.
28. Andreoli SB, Ronchetti SSB, Miranda ALP et al. Utilização dos centros de atenção psicossocial (CAPS) na cidade de Santos, São Paulo, Brasil. Cadernos de Saúde Pública 2004;20:836-44.
29. Calipo PCB. Estudo descritivo do sistema de saúde mental do município de Santos no contexto da reforma da assistência psiquiátrica do sistema único de saúde do Brasil. Santos: Universidade Católica de Santos, 2008.
30. Ministerio de Salud, Unidad de Salud Mental, Chile. Plan Nacional de Salud Mental y Psiquiatría. Santiago: Ministerio de Salud, 2001.
31. Araya R, Rojas G, Fritsch R et al. Treating depression in primary care in low-income women in Santiago, Chile: a randomised controlled trial. Lancet 2003;361:995-1000.
32. Araya R, Alvarado R, Minoletti A. Chile: an ongoing mental health revolution. Lancet 2009;374:597-8.
33. Frammer CM. Chile: reforms in national mental health policy. In: Caldas de Almeida JM, Cohen A (eds). Innovative mental health programs in Latin America & the Caribbean. Washington: Pan American Health Organization, 2008:44-60.
34. Tablada HRC, Oliva RX. Demanda de atención institucional y psiquiatría comunitaria. Medisan 2002;6:11-17.
35. Tablada HRC, Oliva RX. Estratégias de proyección comunitaria del hospital psiquiátrico su impacto en los indicadores hospitalarios. Rev Hosp Psiquiátrico Habana 2006:3.
36. Hernandez BJ, Cabeza AA, Lopez OF. La reorientación de la salud mental hacia la atención primaria en la provincia de Cienfuegos. Departamento de Salud Mental de la Provincia de Cienfuegos. In:

Enfoques para um debate en salud mental. Havana: Ediciones Conexiones, 2002:109-37.
37. Collins T, Green P. Community psychiatry and the Pan American Health Organization: the Jamaican experience. PAHO Bull 1976;10: 233-40.
38. McKenzie K. Jamaica: community mental health services. In: Caldas de Almeida JM, Cohen A (eds). Innovative mental health programs in Latin America & the Caribbean. Washington: Pan American Health Organization, 2008:79-92.
39. Xavier M. Mexico: the Hidalgo experience. A new approach to mental health care. In: Caldas de Almeida JM, Cohen A (eds). Innovative mental health programs in Latin America & the Caribbean. Washington: Pan American Health Organization, 2008:97-111.
40. Alarcon RD, Aguillar-Gaxiola SA. Mental health policy developments in Latin America. Bull World Health Organ 2000;78:483-90.