Artículos de revisión

Mental Healthcare in Rural Latin America

Jody Epstein

DOI: https://doi.org/10.23936/pfr.v2i1.59

PRÁCTICA FAMILIAR RURAL | Vol.2 | No.1 | Marzo 2017 | Recibido: 07/12/2016 | Aprobado: 20/02/2017

Como citar este artículo

Epstein J. Atención a la salud mental en América Latina rural. PFR [Internet]. 29 de marzo de 2017; 2(1). Disponible en: https://www.practicafamiliarrural.org/index.php/pfr/article/view/59 .

Abstract

The goal of this article is to provide an overview of epidemiology of mental health disorders in Latin America, discuss unique issues in mental health faced by rural Latin American communities, summarize the history of Latin American healthcare systems, and describe current strategies to improve and innovate mental health service delivery in Latin America.

Keywords

Mental Healthcare in Rural Latin America

Atención a la salud mental en América Latina rural

Resumen

El objetivo de este artículo es proporcionar una descripción general de la epidemiología de los trastornos de salud mental en América Latina, discutir problemas únicos de salud mental que enfrentan las comunidades rurales de América Latina, resumir la historia de los sistemas de salud de América Latina y describir las estrategias actuales para mejorar e innovar. Prestación de servicios de salud mental en América Latina.

Palabras clave

Atención a la salud mental en América Latina rural

Introduction

The goal of this article is to provide an overview of epidemiology of mental health disorders in Latin America, discuss unique issues in mental health faced by rural Latin American communities, summarize the history of Latin American healthcare systems, and describe current strategies to improve and innovate mental health service delivery in Latin America.

Epidemiology

The International Consortium in Psychiatric Epidemiology (ICPE) reports lifetime prevalence of any mental disorder at between one quarter and one third of the population in Latin America, based on an urban sample (1). This report also found that mental disorders were positively correlated with socioeconomic measures of disadvantage and there are significant gaps in care for people with mental disorders. Depression is most common mental disorder and affects women more often than men. From 20% to 40% of women in developing countries suffer from depression during pregnancy or the postpartum period (2).

One systematic review on the prevalence of mental disorders in indigenous populations in the Americas found "no differences between Indigenous and similar non-Indigenous groups in the 12-month prevalence of depressive, generalised anxiety and panic disorders. However, Indigenous people were at greater risk of PTSD. For lifetime prevalence, rates of generalised anxiety, panic and all the depressive disorders were significantly lower in Indigenous."(3)

These data must be considered with some skepticism. First, the data is limited, with less than 50% of Latin American countries collecting and reporting information on mental health (4). Further, many of these providers are concentrated in urban centers and reporting from urban areas may skew the data. Access is even more scarce in rural regions. Lastly, many of the diagnostic tools used in clinical practice and research are not validated in cross-cultural context and therefore may not be appropriately categorizing all affected patients. Some have attempted to address this problem by creating guidebooks for providers to better address the diagnosis of mental disorders in within a cultural context, such as *The Latin American guide for psychiatric diagnosis* (5)**.** This issue becomes more complex when considering indigenous communities within Latin American, as cultural and language differences and remote locations are more common in these groups (6).

Treatment gaps for mental disorders are estimated at as much as 70% in some areas of Latin America (7). There are several issues to contribute to limited access to healthcare. These include workforce shortages, limited funding, variable presence and enforcement of mental health policies, and stigma. According to the WHO, the rate of mental health workers in South America was 27.7 workers per 100,000 population and in Central America, Mexico and the Latin Caribbean was only 8.7 workers per 100,000 population (4). The majority of these workers are not highly trained healthcare providers. In Latin America and the Caribbean, there is a median of 2.1 psychiatrists, 6.0 nurses, and 4.2 psychologists per 100,000 population (8). This is in contrast to other parts of the world with much more robust mental health workforce. In parts of Western Europe with the most developed healthcare systems, the number of psychiatrists is as high as 30 per 100,000 (9).

Overview of Mental Health Care Systems in Latin America

As has been seen in many parts of the world, the system of mental healthcare in Latin America has undergone a transition from largely reliant on centralized psychiatric hospitals where patient

were often institutionalized for many years, to a healthcare system with more emphasis on community-based psychiatric services. This transition began in many countries in the 1960s and 1970s and has been a slow process. In 1990 the Pan American Health Organization (PAHO) created what has since been termed the Caracas Declaration, a guiding document that codified the international emphasis on community based, comprehensive, participatory mental health services with a focus on prevention and the human rights of those with mental illness. PAHO specifically recommended moving away from the psychiatric hospital as central and move toward primary-care integration. Latin American nations have realized this paradigm shift to a variable extent. Currently, while 81% of countries surveyed in the Americas have a stand-alone plan for mental health, only 34% have legislation that is partially or fully implemented and has a satisfying compliance with human rights standards (4).

PAHO further developed a plan of action on Mental Health 2015-2020 which enumerates several strategic points of action for mental health reform:

1. Develop and implement policies, plans, and laws in the field of mental health and mental health promotion, to achieve appropriate and effective governance.
2. Improve the response capacity of systems and services for mental health and the care of psychoactive substance-related disorders, to provide comprehensive, quality care in community-based settings.
3. Prepare and implement promotion and prevention programs in the area of systems and services for mental health and for the care of alcohol- and substance related disorders, with particular attention to the life course.
4. Strengthen information systems, scientific evidence, and research.

Countries have had varying degrees of success in implementation of these initiatives. Approximately 80% of nations in the Americas have created national mental health care policies but only 34% have partially or fully implemented and has a satisfying compliance with human rights standards (4). While the vision of ideal mental healthcare has been clarified, strategies for creating these systems are still very much a work in progress.

Innovative solutions

There are many Latin American communities working to find innovative solutions to the treatment gap in mental health services. Three approaches show promise at reaching the most underserved communities, including utilization of community health workers, innovative use of technology, and primary care integration.

Utilization of Community Health Workers:

The shortage of psychiatric medical providers in Latin America demands that communities use creativity in workforce development. Community health workers are a viable option to address this human resource shortage. These workers are laypeople with special training in community mental health who can assist with identification of patient in the community in need of further services, referral and care coordination, and medication administration and adherence monitoring. They can also play a role in community education and outreach to reduce stigma and increase understanding of mental illness. Benefits include cultural and language competency, rapport with the community, and much less investment in training and salary than psychologist and psychiatrists. Clearly, these workers need to be appropriately trained and supervised, ideally in a team-based model where care for patients is shared. The mental health system of Río Negro Province in Argentina provides a nice example of this team-based care. The health department and the department of psychiatry have created multidisciplinary teams that include community health workers which they call operadores, in addition to core psychiatrists, nurses, and therapists

(10). They employ 60 of these integrated team members who provide day to day services directly to patients. As part of a comprehensive program, the Río Negro Province has made great progress toward more robust community-based mental health services.

Utilization of Technology:

Mental health services are amenable to voice and video technologies, more so than other aspects of medicine, where physical exam and laboratory testing is necessary. Several groups have attempted to take advantage of this, and use videoconferencing technology to provide mental health services. The advantage to this approach is that providers can reach patients in remote locations where services are scarce. One randomized trial in Brazil assessing efficacy of home-based videoconferencing for depression found this intervention feasible and as effective as in-person care (11).

Enlace Hispano Americano de Salud (EHAS), a foundation focused on improving health-care services in rural areas of developing countries through use of information technology, has described many innovative uses of technology including tele-stethoscopes and ultrasound (12). Particularly relevant to our discussion is their project in the Napo River area in Loreto, Peru. The Project deployed a telecommunications network to connect health technicians with supervising physicians and general physicians with consulting specialists. The tools were also used to provide distance training to health workers in their home communities. This type of network would have great use in tele-psychiatry.

Primary Care Integration

Many mental health conditions are quite treatable in the primary care setting, such as depression and anxiety disorders, which are the most common psychiatric illnesses. While still in short supply in rural Latin America, generally access to primary care is greater than access to psychiatric services. It is reasonable then, to explore the possibility of treating mental health conditions in primary care. Additionally, providing services for mental health in a primary care setting is easier for patients, as they can receive their services in one location, and it gives an opportunity to capture a population and provide a full complement of important preventative and chronic disease management services.

Several counties have made strides in primary care integration. Many successful programs piggy-back on robust, universal systems of primary medical care, such as are seen in Cuba and Brazil. These governments have invested heavily in creating strong health systems, and mental health care has benefitted from these structures. Other nations have made different attempts at primary care integration. One such example is in Chile, where the Ministry of Health created a program for standardization of diagnosis and treatment of depression in primary care (10). The program components included adding psychologists into general health teams; using standardized diagnoses; providing patient education, use of antidepressant medications and group psychosocial sessions, provider training, and evaluation of the program's effectiveness. This program has been successful at improving depression symptoms amongst treated patients (13). In addition, very few of their patients required referral to a higher level of care.

Health departments may be interested in standardized models for training primary care providers in mental health. The WHO Mental Health Gap Action Programme (mGAP) provides resources that may be of great use to health systems aiming to increase mental health services in primary care. mGAP is an initiative to address the treatment gap in mental health, neurological and substance abuse disorders. In 2010 the programme has published a comprehensive guide that teaches basic diagnosis and treatment of mental disorders (14). It is aimed at healthcare providers in non-specialist settings and is a potentially very helpful tool for training primary care doctors, nurses and health workers. It is readily available and could quickly be implemented in a variety of settings.

Conclusions

We have seen that psychiatric illness is common, affecting up to 25% of the population of Latin America, and massive gaps exist in access to proper diagnosis and treatment. Limited healthcare resources, remote location, and cultural barriers all contribute to these gaps. There is a global movement toward comprehensive, community-based mental health care that is slowly changing the way in which mental health care is provided in Latin America. Health departments and communities interested in improving mental health services will need to re-envision how mental health care fits into their health systems. Creative solutions that focus on integration of primary care, use of technology and team-based care are the most likely to succeed in meeting the great need for mental health services in Latin America.

References

1. Andrade L, Caraveo-Anduaga JJ, Berglund P, Bijl R, Kessler RC, Walters E, et al. Cross-national comparisons of the prevalences and correlates of mental disorders. Bulletin of the World Health Organization. 2000; 78 (4).
2. Fisher J, Cabral de Mello M, Izutsu T. Pregnancy, childbirth and the postpartum period. In: Mental health aspects of women's reproductive health: a global review of the literature. [Internet]. WHO publication. Geneva. 2009.
3. Kisely S, Katarzyna Alichniewicz K, Black E, Siskind D, Spurling G ,Toombs M. The prevalence of depression and anxiety disorders in indigenous people of the Americas: A systematic review and meta-analysis. Journal of Psychiatric Research. 2017; 137 (152).
4. Pan American Health Organization. Regional Mental Health Atlas December 2015. [Internet]. PAHO Publication. Washington DC. 2016.
5. Berganza CE1, Mezzich JE, Otero-Ojeda AA, Jorge MR, Villaseñor-Bayardo SJ, Rojas-Malpica C. The Latin American guide for psychiatric diagnosis: A cultural overview. Psychiatric Clinics of North Am. Sept 2001; 24(3): 433-46.
6. Pan American Health Organization. Promoting Mental Health in Indigenous Populations: Experiences from Countries. PAHO publication. [Internet] Washington DC. 2016
7. Kohn R. Treatment Gap in the Americas. [Internet]. PAHO Technical Document. Washington DC. 2013.
8. Pan American Health Organization. WHO-AIMS: Report on Mental Health Systems in Latin America and the Caribbean [Internet]. Washington DC. 2013.
9. World Health Organization European Region. Mental Health Data and Statistics [Internet]. Cited 3/21//17. Available from: http://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/data-and-statistics
10. Collins P. Argentina, waving the mental health revolution banner: Psychiatric reform and community mental health in the province of Rio Negro. In: Caldas de Almeida JM and Cohen A, ed. Innovative mental health programs in Latin America and the Caribbean. PAHO Publication. Washington DC. 2008.
11. Hungerbuehler I, Valiengo L, Loch AA, Rössler W, Gattaz WF. Home-Based Psychiatric Outpatient Care Through Videoconferencing for Depression. Journal of Medical Internet Research. 2016; 3 (3).
12. Prieto-Egido I, Simó-Reigadas J, Liñán-Benítez L, García-Giganto V, Martínez-Fernández A. Telemedicine networks of EHAS Foundation in Latin America. Frontiers in Public Health. 2014; 15 (2).
13. Rubén A, Graciela R. Evaluación de la efectividad del Programa de Detección, Diagnóstico y Tratamiento Integral de la Depresión en la Atención Primaria. Santiago, Chile. Rev Med Chile. 2011; 139: 592-599.

14. World Health Organization. mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: Mental Health Gap Action Programme (mhGAP). [Internet]. WHO Publication. 2010.