

# 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 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 deinstitutionalization 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

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