Community Mental Health Services in Latin America for People with Severe Mental Disorders

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ABSTRACT

Mental disorders are highly prevalent in Latin American countries and exact a serious emotional toll, yet investment in public mental health remains insufficient. Most countries of the region have developed national and local initiatives to improve delivery of mental health services over the last 22 years, following the technical leadership of the Pan American Health Organization/World Health Organization (PAHO/WHO). It is especially notable that PAHO/WHO facilitated the development of national policies and plans, as well as local programs, to deliver specialized community care for persons with severe mental disorders. Nevertheless, at present, the majority of Latin American countries maintain a model of services for severe mental disorders based primarily on psychiatric hospitals that consume most of the national mental health budget. To accelerate the pace of change, this article emphasizes the need to develop cross-country regional initiatives that promote mental health service development, focusing on severe mental disorders. As one specific example, the authors describe work with RedeAmericas, which has brought together an interdisciplinary group of international investigators to research regional approaches and train a new generation of leaders in public mental health. More generally, four regional strategies are proposed to complement the work of PAHO/WHO in Latin America: 1) to develop multi-country studies on community services, 2) to study new strategies and interventions in countries with more advanced mental health services, 3) to strengthen advocacy groups by cross-country interchange, and 4) to develop a network of well-trained leaders to catalyze progress across the region.

Key Words: Community mental health, community psychiatry, public health, Latin America, psychiatric epidemiology, global mental health

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INTRODUCTION

The care of people with mental disorders is a growing public health concern in Latin America. These disorders are highly prevalent and exact a serious emotional toll on individuals, families, communities and society at large. Community-based epidemiological studies in this region have estimated rates of lifetime prevalence of mental disorders among adults ranging from 23.7 percent to 39.1 percent and 12-month prevalence rates ranging from 11.6 percent to 20.1 percent.[1] Rodriguez et al estimated that mental and neurological disorders in Latin America accounted for over 20 percent of all Disability Adjusted Life Years (DALYs) in 2002[2]; in other words, these disorders account for over 20 percent of the total "disease burden" in Latin America. Yet almost all Latin American countries still invest far less in public mental health than in other public health problems with comparable disease burden. Moreover, a large part of public mental health resources are still used to maintain a system of mental hospitals that do not offer appropriate treatment.

In this paper, we focus on community mental health care for adults with severe mental disorders in the Latin American region. As in many other regions, individuals with severe mental disorders comprise a particularly vulnerable and disadvantaged group whose needs are often overlooked, whose human rights are often violated, and who do not receive sufficient services in the communities where they live. We briefly describe the history of this field, then review its current state, and conclude by offering some thoughts about future strategies for the development of research, human capacity, and services. Although other aspects of public mental health in Latin America are beyond our scope, we believe that they require similar attention. The countries of the Latin American region, broadly defined, are many and diverse. Here we focus on countries in which Spanish, Portuguese or French is the dominant language, and following a common convention, define them as the 20 countries listed in Appendix 1.

HISTORY

As early as the 1950s and 1960s, several researchers conducted epidemiological studies that used case ascertainment and random sampling methods to assess the prevalence of mental disorders among residents of different countries.[3-5] These studies prompted new public health approaches to addressing the high burden of mental disorders. The hegemonic role of mental hospitals as the main form of treatment began to be questioned,[6-8] and debates arose about alternatives models based on general hospitals and primary care centers, as well as the need to build day hospitals, group homes and sheltered workshops to facilitate the social integration of people with severe mental disorders. In some Latin American countries, there were early attempts to build mental health services in the community. Innovative pilot programs were established where psychiatrists, general practitioners and other health professionals put some of these ideas into practice.[6-8] Although the community model was never implemented in full, due to lack of political support and resources, these early experiences helped to raise awareness and generate learning about alternatives to mental hospitals.

Most of these innovative programs were subsequently downsized or shut down by the dictatorships that plagued much of the region during the 1970s and 1980s. Instead, more mental hospitals were built, until their number surpassed 250, with over 150,000 long stay beds. The majority of these hospitals were located outside urban centers and lacked sufficient staff and resources to provide meaningful care. Patients often were cut off from their environment with no rehabilitation programs, and subjected to intensive use of physical restraints, pharmacological sedation and other human rights violations.[8,9] In some countries, these mental hospitals became virtually the only mental health service accessible to the general population.

The return to democracy in many Latin American countries was accompanied by a new cultural and political atmosphere. Many social movements and some governments were eager to finally begin addressing long-ignored social problems. In this context, the community orientation for delivering mental health services found a receptive audience. The work of Benedetto Saraceno in Nicaragua[9] and Franco Basaglia in Brazil[10] were particularly influential. Notably, Basaglia had previously been a leader in the Italian movement toward psychiatric reform that flourished in the 1970s and 1980s. Among their signal contributions was the support their work generated for two key premises: first, that it is possible to transform the asylums into a network of community centers, and second, that patients could become citizens with equal rights to other persons.

The transformation of ideas about mental health care was soon given concrete expression in policy recommendations of the Pan American Health Organization/World Health Organization (PAHO/WHO). Arguably, the landmark event was the Regional Conference for the Restructuring of Psychiatric Care in Latin America, convened with the support of multiple global institutions and held in Caracas, Venezuela in 1990. The conference brought together key stakeholders and generated an influential position statement, the Caracas Declaration, which set forth the principles that served as the conceptual framework for the reform movement that unfolded in Latin America in the ensuing years.[11,12] With respect to the development of community mental health services in Latin America for people with severe mental disorders, the Caracas Declaration was especially significant and influential.

In the Caracas Declaration, the conference attendees endorsed a commitment to transform antiquated hospital-based mental health delivery systems into comprehensive community care systems. The Declaration regarded primary care as the main vehicle for delivering mental health services, also calling for the adoption of the Local Health Systems Model and the integration of social and health care networks. In addition, the Declaration called for legislative action aimed at anchoring the reform process in a legal framework and protecting the human rights of people with mental health problems.[12]

The momentum generated in Caracas was sustained through the PAHO/WHO Initiative for the Restructuring of Psychiatric Services. This Initiative was also launched in collaboration with a large number of countries, international organizations, and experts.[13] Its primary goal was to promote and support mental health reform initiatives in Latin America. Furthermore, the principles of the Caracas Declaration have been ratified, expanded and operationalized with numerous other political and technical specifications over the years through additional documents issued by PAHO/WHO, such as the CD43.R10 Resolution of the PAHO Directive Council in 2001,[14] the Brasilia Principles on the Development of Mental Health Care in the Americas,[15] and the Strategy and Plan of Action on Mental Health approved by the 49th Directive Council of PAHO in 2009.[16] Also, several cross-country regional initiatives to promote reform along the lines of the Caracas Agenda were implemented by PAHO/WHO after 2003, including, among others, the creation of posts of subregional mental health advisers in Central America, South America, and the English Caribbean, the creation of subregional mental health forums, and the development and funding of projects involving several countries.[17,18]

CURRENT STATE

The Caracas Declaration and further efforts to improve psychiatric services in the region, as described above, set a clear agenda for mental health reform in Latin America. We now need to consider the ways in which this agenda (henceforth termed the "Caracas Agenda") has and has not been put into practice. We therefore turn to the present state of community mental health services in the region.

Political will. The implementation of the Caracas Agenda is not uniform across the region and depends upon the political will to reform and scale up mental health services. Thus, it requires that decision makers and political leaders understand the population's mental health needs, recognize their importance, and prioritize actions to address them.[19] Governments express their political will on a particular issue through official documents (national policy, strategy, plan, or program), legislation and resource allocation, where they demonstrate their understanding, recognition and priority. The WHO has collected information on these three indicators of political will from the majority of countries worldwide through the Project Atlas: Resources for Mental Health. Although Project Atlas data are currently the best available source for gauging political will across the region, we note that it offers only a broad overview; the development of more refined measures would be an important contribution.

The information collected by Project Atlas for Latin American countries enables us to review the progress toward the Caracas Agenda in Latin America over the past decade. As shown in Table 1, for the years 2001,[20] 2005[21] and 2011,[22] Project Atlas included 18, 20, and 14 of 20 targeted Latin American countries (listed in Appendix 1) respectively. Between the years 2001 and 2011, the proportion of countries that had formulated and officially approved a mental health national policy increased from 40.0 percent to 66.7 percent. During this same time period, the proportion with a national plan for implementation increased from 47.7 percent to 72.2 percent. The proportion that promulgated mental health legislation increased from 20.0 percent to 35.3 percent. Finally, the proportion that spent over 1.4 percent of the total health budget on mental health increased from 25.0 percent to 40.0 percent. Thus, it is clear that significant progress has been made in these areas.

But it is also clear that the political will to implement the Caracas Agenda remains quite incomplete. To underscore this point, we can compare Latin American countries with countries in other regions classified either as low and middle income countries (LMIC) or as high-income countries according to World Bank criteria. These comparisons are exhibited in

Figure 1. The great majority of Latin American countries are lower-middle (N=6) or upper-middle (N=13) income (see Appendix 1). It is therefore not surprising that compared with high-income countries outside of Latin America,[23] Latin American countries overall score lower on all the indicators of political will described above, especially in regard to legislation and budget. It is also not surprising that compared with LMIC overall,[23] the Latin American countries score higher for mental health policies and plans (67 percent versus 54.7 percent and 72.2 percent versus 66.4 percent, respectively). What may be surprising is that compared to LMIC overall, a *lower* percentage of Latin American countries have mental health legislation (47.1 percent compared with 54.1 percent of world LMIC).

Table 1

Indicators for political will to scale up mental health services in Latin American Countries

	2001	**2005**	**2011**
Number of Latin American countries reporting information to Project Atlas	18	20	14
Countries with a policy sanctioned during the previous 10 years (%)	40.0	75.0	66.7
Countries with a national plan sanctioned during the previous 10 years (%)	47.7	58.3	72.2
Countries with legislation promulgated during the previous 10 yrs (%)	20.0	45.0	35.3
Countries spending over 1.4% of the total health budget on mental health	25.0	50.0	40.0

Source: WHO's Project Atlas: Resources for Mental Health 2001, 2005 and 2011.[20,21,22]

The deficiencies in political will are brought into sharper relief when one considers the financing of mental health services in finer detail. In Figure 2, countries are divided into low income, lower-middle income, upper-middle income, and high income. As noted above, most though not all Latin American countries are classified by the World Bank as lower-middle or upper-middle income. When Latin American countries are compared with countries in their same income group, it is evident that they spend a smaller percentage of their health budget on mental health. The median percentage in Latin American countries is 1.20 percent in the lower-middle income group, and 1.52 percent in the upper-middle income group, compared with 1.90 percent and 2.38 percent respectively for other countries in these same income groups (see Table 1, Figure 1, and Figure 2).[23]

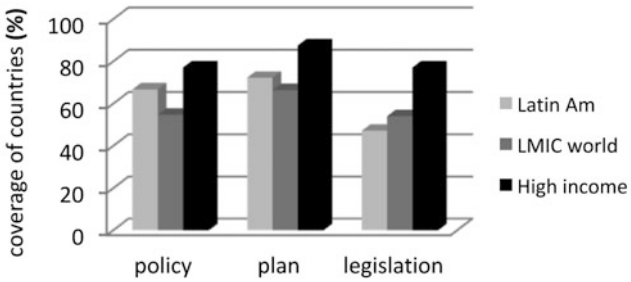

Fig. 1. Presence of mental health policy, plan and legislation in Latin American countries and world low-and-middle income (LMIC) and high income countries.
Source: WHO's Project Atlas: Resources for Mental Health 2011.[20,21]

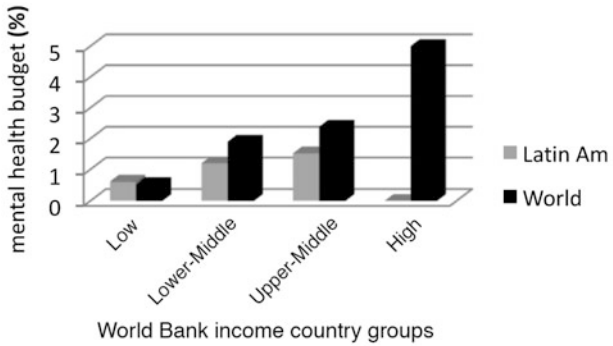

Fig. 2. Median percentage of health budget allocated to mental health in Latin American countries and world countries by World Bank income groups.
Source: WHO's Project Atlas: Resources for Mental Health 2011.[20,21]

We can also apply the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) mechanism to contribute to our assessment. The WHO-AIMS data complement those of WHO Project Atlas described above; similar to Project Atlas, these data offer only a broad overview but are currently the best available regional data. The application of the WHO-AIMS confirms the limitations of political will in the region.[24] WHO-AIMS has revealed that unfortunately some of the national policies, plans and legislation in this region are not sufficiently explicit to support and facilitate the delivery of community mental health services. Moreover, even when they are explicit, their implementation is usually inadequate.

The WHO-AIMS studies have also confirmed the persistence of historical funding patterns that give low priority to mental health. Perhaps most troubling is that the mental health budget allocation in most Latin American countries continues to be far below the level that would reflect the population's health needs according to the current epidemiological evidence.[24] Even in Brazil, where progressive mental health policies and legislation have been quite striking, the health budget allocation for mental health decreased slightly between 2001 and 2011 (from 2.50 percent to 2.38 percent).[20-22,25,26] Fortunately, at least some countries have been increasing their allocation to mental health. In Chile, for example, the percentage of the health budget allocated to mental health increased from 1.49 percent to 2.78 percent during that same period.[20-22,27]

National organization of services. Among the cornerstones of the Caracas Agenda are promotion of self-care and informal care, inclusion of mental health into primary care (especially for common mental disorders), decentralization of specialized outpatient care for severe mental illness, development of day care programs and psychosocial rehabilitation, and integration of mental health services in general hospitals (Figure 3).[24,28] These features have been increasingly incorporated in national policies, plans and legislation. By now, most Latin American countries have some community mental health initiatives. Also, most countries have tried to downsize and improve the psychiatric hospitals, either nationally or in some localities (see Figure 3).[13,29]

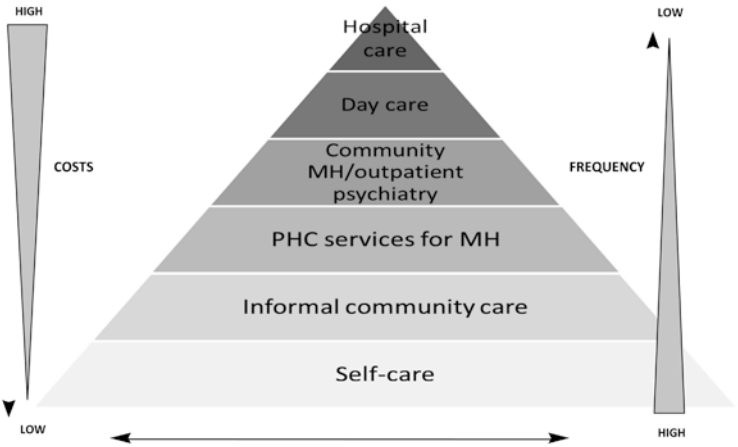

Fig. 3. Model for organization of mental health services in Latin America.
Source: Adapted from Funk et al.[28]

The pace of change has, however, been very slow in most countries, as shown in Figure 4. At the national level, only three Latin American countries, Brazil, Chile and Panama, have truly transformed the mental hospital-based model.[20-22,30-32] The average reduction of mental hospital beds in the other countries of the region during the past ten years was only 23.9 percent.[33-37] In contrast, in Brazil, Chile and Panama, the number of hospital beds was reduced (for the three countries combined) by 62.2 percent in the last ten years. Brazil and Chile have also developed an increasing number of community group homes for people with severe mental disability and low or no family support; there are now more than two beds per 100,000 people in Brazil[32] and more than eight per 100,000 people in Chile.[30] In these three countries, there are also users and family organizations that frequently participate in the elaboration of policies, plans and legislation. To achieve this change, all three countries have increased significantly the percentage of public mental health expenditures allocated to general hospitals, outpatient facilities and community services (an increase of 67.7 percent in Brazil, 88.0 percent in Chile, and 56.0 percent in Panama). The rates of psychiatric beds in general hospitals, outpatient facilities and day facilities (day centers and day hospitals) are two to seven times higher in Brazil, Chile and Panama than in other Latin American countries (Figure 4 and Table 2).

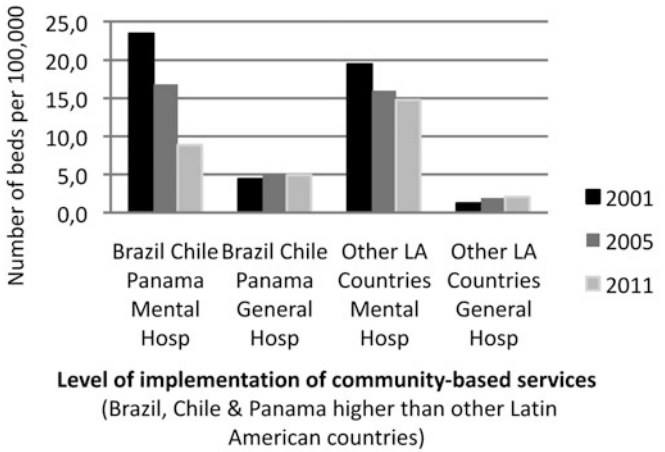

Fig. 4. Average rate of psychiatric beds in Latin America 2001-2011 by level of implementation of comunity-based services and type of hospital (per 100,000 population).[18-20,29-44]

Table 2

Average number of psychiatric outpatient and day facilities (by 100,000 population) in Latin American countries and level of utilization[20-22,30-37]

	Brazil, Chile & Panama	Other Latin American countries
Outpatient facilities	1.41	0.72
Outpatient users in one year	1945.65	1389.05
Day facilities	0.36	0.18
Day facilities users in one year	31.45	4.36

Although we have focused on the 20 countries in Appendix 1, we should also note an important development in Belize, an English Caribbean country that is within the Latin American region. Belize has achieved significant reforms that have had influence on some other countries. This has included the downsizing of mental hospital beds (a decrease by 55 percent) in a similar period of time as Brazil, Chile and Panama.[38] Confronting the national reality of a small number of psychiatrists and psychologists, Belize has opted for a decentralization of mental health care based on the training of primary care psychiatric nurses in each health district.[39]

Country-specific initiatives. There are some country-specific programs that represent significant progress toward the Caracas Agenda. With regard to specialized ambulatory care for persons with severe mental disorders, Brazil has developed a system of psychosocial care centers (known by their Portuguese acronym of CAPS) that has been the cornerstone of the transformation of the mental hospital-centered approach in Brazil. Modeled after the community mental health centers in Italy, many of the CAPS have been effective in the treatment, rehabilitation and follow up in the community of people with psychosis and other severe mental disorders, including brief admissions for psychosocial crises.[40-43] Cuba has developed a mixed model of mental health care, where 23 psychiatric hospitals (with 56.7 beds per 100,000 population) coexist with a highly decentralized community care system. The Cuban centers are closely articulated with primary care teams and deliver a comprehensive set of interventions, ranging from promotion and prevention to treatment and rehabilitation, based on local epidemiological diagnoses, strong community participation, and inter-sectoral coordination.[37,44,45] Also using a mixed model approach, Uruguay decided to incorporate community mental health teams into primary care facilities instead of separated specialized centers, developing a rich experience on interdisciplinary work and social networks.[46,47] Initially

in Chile, psychiatric outpatient care developed in multispecialty clinics attached to general hospitals, but in recent years the implementation of community mental health centers has been prioritized, which has allowed a greater decentralization, coordination with primary care, and local intersectoral resource utilization.[48,49]

In order to improve the rehabilitation and social inclusion of people with disability secondary to mental illness, most countries have developed interventions to strengthen families and their organizations in order to encourage people with severe mental disorders to continue living at home, taking advantage of the strong social support role played by families in Latin America.[50-53] In addition, however, Brazil and Buenos Aires Province in Argentina have implemented programs that provide monthly financial support for users with long stays in mental hospitals once they return to their homes.[54,55]

Several countries have developed group homes for people with disabilities who do not have the support of a family. They are known by different names across countries (e.g., community residences, half-way homes, sheltered homes) but share similar characteristics, and usually four to eight people live in these homes with the support of full- or part-time caregivers. Based on the limited evidence available, it appears that group homes are feasible to implement in Latin America, cheaper than staying in mental hospitals, most of the time well accepted by the neighborhood, and tend to have positive impact on users' quality of life and social functioning.[54-58]

Innovations at the local level. In parallel with these national efforts, many local initiatives have emerged, some of which have been highly innovative as well as influential. Here we discuss two programs that adopted the key elements of the Caracas Agenda. These two programs were established in adjacent provinces in the Patagonia region of Argentina, and yet were developed independently of one another. In fact, it seems somewhat remarkable that the two programs were initiated separately within the same remote region, and that both developed into influential models cited by international organizations such as WHO and the World Mental Health Federation.

In the Province of Rio Negro, Hugo Cohen led a bold initiative to replace institutional care in mental hospitals with community-based mental health services.[59-61] This was one of the earliest attempts to radically transform public mental health services in Latin America, and helped to galvanize the process across the region. Backed by community participation and legislation, the mental health program has developed a comprehensive network of community services in the public sector, through 27 years of experience. The main components of this network are primary care teams,

general hospitals with specialized interdisciplinary mental health teams, psychosocial rehabilitation with strong inter-sectoral links, group homes, and social firms to offer employment to people with mental disability.

In the Province of Neuquén, José Lumerman established in the 1990s what is essentially a non-governmental organization (NGO) to provide community mental health services.[62-64] There were few inpatient beds in Neuquén (most patients with severe and chronic mental illness were sent to El Borda Hospital in Buenos Aires), but also virtually no community mental health services. Initially Lumerman attempted to create such services within the public system, but his efforts were blocked by government agencies. He then went outside the public sector to set up a community-based program that was supported primarily by reimbursements for care from the Seguridad Social (a form of health insurance accessible to most but not all people). Since there were very few psychiatrists or other specialized resources, the program was built with the local resources that were available, using an approach that would now be called "task shifting". For example, the Province did have an excellent public health system and a large number of general doctors; hence general doctors were recruited and trained to lead mental health teams. The program also recruited people from outside the health professions, such as artists and actors, to participate in the rehabilitation process. This program has sustained its progress, and with continual expansion and improvement, it now offers high quality care to virtually all people in the city of Neuquén, and is affiliated in various ways with the public health system.

To understand why these two excellent programs have proved sustainable, one in the public sector and the other outside it, we suggest that it is related to the enormous and ongoing efforts made by both programs to sustain relationships with all key stakeholders. These include not only the government health sector, but also education, justice, and other sectors, the families and patients themselves, the general doctors of the province, the local media, the governing party of the Province, and (in Neuquén) the administrators of the local Seguridad Social. For example, the governing party of these Provinces changed often, and each time, new relationships had to be developed and sustained. It was only possible to do so because the programs had become embedded in the community by the involvement and support of such a wide range of stakeholders.

Finally, it should be noted that despite the many promising local initiatives exemplified by these two programs, there are some domains in which only a few local initiatives have gained experience (the two programs described are among the few). These domains include supported employment, job placement and social enterprises. Some programs targeted to these domains

have reported promising initial results. Their number is still very limited, however, and these programs have not yet been adequately evaluated.[61,62]

LOOKING AHEAD: REGIONAL INITIATIVES

There are many new country-specific programs that aim to improve delivery of mental health services in Latin America. Several of these have been described above. Looking ahead, we believe it will be equally important to develop cross-country *regional* initiatives that promote reform along the lines of the Caracas Agenda and that complement the regional work of PAHO/WHO. A welcome recent development is the emergence of some promising regional initiatives.

Here we describe one new regional initiative in which the authors have been engaged by way of providing an example. It is known as RedeAmericas or simply as "RA".[65] The more formal name is RedeAmericas: Network for Mental Health Research in the Americas. It is one of five such initiatives that have recently been funded by the National Institute of Mental Health (NIMH) in Latin America, Africa, and South Asia. RA brings together an interdisciplinary group of investigators from urban centers in Argentina (Buenos Aires, Córdoba, and Neuquén), Brazil (Rio de Janeiro), Chile (Santiago), Colombia (Medellín) and also from New York City in the United States. Representatives from all sites have decades of experience in developing and adapting interventions in a Latin American context. The overarching objective is to improve the conditions of life for people with mental disorders. Given limited resources, the primary focus of the RA at present is on adults with severe mental disorders. Its vision is broader, however, and offshoots are extending the work to children, to adults with common mental disorders, and to other arenas such as the impact of violence and civil conflict on mental Health.

The work of RA is built on four key premises. The first is that a *regional* approach is feasible and most likely to lead to wide-scale and sustainable change. Thus approaches need to be developed and tested that are feasible in many countries in the region and yet can be adapted to local contexts. We are presently piloting a regionally led randomized controlled trial of a psychosocial intervention for people with severe mental disorders, Critical Time Intervention-Task Shifting (CTI-TS), in three cities (Buenos Aires, Rio de Janeiro, and Santiago). Although adapted from an intervention previously tested in high income countries as Critical Time Intervention (CTI),[66,67] CTI-TS has been targeted to the Latin American context[68,69] and has been designed so that the same core principles could be applied, with local adaptation, across many locales in the region.

The second premise is that *community-based mental health services* should be prioritized, at least for children and adults with severe mental disorders. Not all community mental health services are *community-based* mental health services under the definition of the term used by RA and implied by the Caracas Agenda. To be so, they need to be close to the communities that use them, be accessible to all affected people and their families, include but not be limited to primary care, be developed with the active involvement of affected individuals, their families, and their communities (as well as other stakeholders), and include *in vivo* services provided in the locations where people live (not only at clinic sites). The CTI-TS intervention, for example, meets these criteria. It gives especially high priority to strong ties between primary care and secondary mental health services, provision of *in vivo* services, and active involvement of users and families. RA proposes that this kind of approach is most likely to foster social integration.[70,71]

The third premise is that a *public mental health discipline* and training program is an essential platform for the future. It should be multidisciplinary and at a minimum integrate public health and psychiatry. Accordingly, most of the RA sites are led by an integrated team of investigators from psychiatry and public health (and when possible, other disciplines). These teams have launched programs to train and nurture a new generation of leaders in public mental health across the region. One part of this capacity-building work entails a training program for Awardees from all sites who, we hope, will become leaders of public mental health in the next generation.

The fourth premise is that we need to *actively combat stigma and discrimination* associated with having a mental disorder.[72,73] We believe that this will help generate the social movements for mental health reform that are essential to address the lack of political will described above. RA is doing this in multiple ways, including rigorous studies to document and understand stigma and discrimination, efforts to identify and remedy violations of human rights, and the inclusion of persons who have themselves had the experience of severe mental illness as paid workers with full status in the CTI-TS intervention. The latter is somewhat novel in Latin America. It is based on the proposition that "Peer Support Workers" have special expertise to contribute to the recovery process, and that it is important to demonstrate that people who have mental disorders can be afforded human respect and dignity and participation in civil society.[74-77]

This brief description of RA is not intended to convey the full scope of its work. Moreover, we do not wish to single out RA as the only important new regional initiative. It does, however, offer an example of the kind of efforts that could promote the acceleration of change in the coming decades.

CONCLUSION

We have noted many examples of considerable progress toward the Caracas Agenda in the countries of Latin America. Nevertheless, 22 years after the Caracas Declaration, the majority of the countries of the region maintain a model of services for severe mental disorders based primarily on psychiatric hospitals that consume most of the national mental health budget. If the pace of downsizing of mental hospitals and increase of community services remains the same as in the last ten years, it could take over 50 years to develop community mental health services in Latin America along the lines of the Caracas Agenda. Indeed, there are examples of health reforms in some countries that have arguably set back the agenda for mental health reform.[78] This slowness occurs despite Brazil, Chile and Panama having demonstrated that a transformation from hospital to community mental health services can be achieved within a 20-year period, and by available indicators, have thereby improved the quality of life of the affected individuals. At the same time, substantial knowledge and experience has been generated in numerous local experiences in different countries of the region.

To accelerate the pace of change, it is important to identify and address key factors that are impeding progress. We have documented some of these in our review: a weak political will to implement reforms to which countries have made commitments, a low allocation to mental health within health budgets, absence of legislation to protect the human rights of people with mental disorders, and the persistence of inappropriate but costly systems of hospital care. There are also other factors not covered in this review. Probably another important factor is that the shift from a mental hospital-model to community model requires an initial investment of funds for some community mental services before starting the process of downsizing hospitals. Yet another is the insufficiency of human resources, that is, people who are trained in the delivery, evaluation, and wide-scale implementation of community mental health services.[79]

It is, of course, easier to demonstrate the need to accelerate change than to bring it about. The efforts of PAHO/WHO across the region to address the factors noted above have been very substantial and yet not sufficient. Clearly, progress depends upon sustaining these efforts of PAHO/WHO, but they need to be complemented by other means. We propose that cross-country regional initiatives have a special role to play in this regard. They can not only help to catalyze country-specific reforms, but also can create a synergy among country-specific reforms that may accelerate the overall process of change.

We conclude by proposing four strategies that may prove fruitful in regional initiatives to complement the work of PAHO/WHO in Latin America: First, we now have the opportunity to develop multi-country studies that help to better identify factors hindering and favoring the implementation of community services and the downsizing of mental hospitals. Second, the countries that have made major advances now have appropriate conditions in which to study the incorporation of new strategies and interventions that eventually further improve access, quality and equity of community-based services. These new strategies can be planned with their potential for regional application in mind, so that they could be taken up by other countries in the future. Third, the strengthening of advocacy groups and their broadening into social movements for mental health reform could have a major impact on political will and on the reduction of stigma.[80] Both advocacy and social reform movements are strengthened by cross-country interchange. Fourth, the development of a strong and self-sustaining regional network of well-trained leaders in public mental health could catalyze progress across the region.

Appendix 1

Latin American Countries and Classification of Economies

Countries	**Classification of Economies***
Argentina	Upper-middle Income
Bolivia	Lower-middle Income
Brazil	Upper-middle Income
Chile	Upper-middle Income
Colombia	Upper-middle Income
Costa Rica	Upper-middle Income
Cuba	Upper-middle Income
Dominican Republic	Upper-middle Income
Ecuador	Upper-middle Income
El Salvador	Lower-middle Income
Guatemala	Lower-middle Income
Haiti	Low Income
Honduras	Lower-middle Income
Mexico	Upper-middle Income
Nicaragua	Lower-middle Income
Panama	Upper-middle Income

Paraguay	Lower-middle Income
Peru	Upper-middle Income
Uruguay	Upper-middle Income
Venezuela	Upper-middle Income

* Upper-middle Income N=13; Lower-middle Income N=6; Low Income N=1

Source: World Bank List of Economies (July 2012). Available from URL: http://muse.jhu.edu/about/order/wdi2012.pdf (Accessed 16 April 2013).

Acronyms List:
CAPS = psychosocial care centers, Brazil
CTI-TS = Critical Time Intervention-Task Shifting
PAHO/WHO = Pan American Health Organization/World Health Organization
RA = RedeAmericas = Regional Network for Mental Health Research in Latin America
WHO-AIMS = WHO Assessment Instrument for Mental Health Systems

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