Physician-led primary care for mental health in Neuquén province, Patagonia region

Case summary
In the province of Neuquén, Argentina, primary care physicians lead the diagnosis, treatment and rehabilitation of patients with severe mental disorders. Patients receive outpatient treatment in their communities, where they enjoy the support of family, friends, familiar surroundings, and community services. Psychiatrists and other mental health specialists are available to review and advise on complex cases.

A community-based rehabilitation centre, the Austral, provides complementary clinical care in close coordination with primary care centres. It also serves as a training site for general medicine residents and practising primary care physicians.

The programme has increased demand for mental health care and allowed people with mental disorders to remain in their communities and socially integrated. The effectiveness of the programme is largely the result of teamwork, in which the primary care physicians lead the therapeutic process, but are supported by other team members such as nurses, psychologists and psychiatrists. Because psychiatrists are used sparingly and institutional care is avoided, costs are lower and access to needed services is enhanced.

1. National context
Argentina’s national context is summarized in Table 2.1. The country is a melting pot of different ethnic groups and its official language is Spanish. After a long period of growth and stability, economic reforms implemented in the 1990s triggered a profound economic and social crisis in 2001. Although the country’s economy is growing again, its population continues to face economic uncertainty. As of 2003, only 43% of women and 47% of men were participating in the paid labour force.1 Argentina’s main sector of employment and revenue is services.2
2. Health context

Argentina’s health context is summarized in Table 2.2. The leading causes of death in Argentina are heart disease and stroke, followed by lower respiratory infections and diabetes. In the 10–19-year age group, the leading cause of death in males is homicide, and in females, traffic accidents; the second leading cause in both sexes is suicide.

Estimates from 2005 indicate that 127,000 people have HIV/AIDS, among whom 60% are unaware of their serological status.

Table 2.2 Argentina: health context at a glance

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
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<tbody>
<tr>
<td>Life expectancy at birth:</td>
<td>60 years for males/63 years for females</td>
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<tr>
<td>Total expenditure on health per capita (International $, 2004):</td>
<td>1274</td>
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<tr>
<td>Total expenditure on health as a percentage of GDP (2004):</td>
<td>9.6%</td>
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Argentina’s health care system is composed of three sectors: the public sector, financed through taxes; the private sector, financed through voluntary insurance schemes; and the social security sector, financed through obligatory insurance schemes – see Table 2.3.
The Ministry of Health is responsible for determining the health sector’s objectives and policies, and for executing the plans, programmes, and projects under its jurisdiction, in accordance with directives from the Executive Branch. The Ministry also oversees the operation of health services, facilities, and institutions, and conducts overall planning for the sector in coordination with provincial health authorities.

By constitutional mandate, the provinces are responsible for providing health care to their population. The municipalities, especially those with the largest populations and greatest economic resources, also plan and implement health activities. All provinces and the autonomous city of Buenos Aires have a wide network of hospital and outpatient services, which are operated by both public and private providers. There are 17 845 health-care facilities in the country (split between the public and private sectors).  

### Mental health

The national-level prevalence of mental disorders in Argentina is unknown. A representative general population survey in Buenos Aires, published in 1982, found a point prevalence of 26%. Official mortality statistics show that suicide rates increased from 6.3 per 100 000 population in 1997, to 8.4 per 100 000 population in 2002. The suicide rate in 2002 was 16.65 per 100 000 population among males 15–19 years of age.

There are almost 16 000 public sector psychiatric beds in Argentina. Mental health reform is under way in some provinces and Buenos Aires to reduce bed capacity and improve community-based services. For example, reforms in Rio Negro province have reduced reliance on hospital care. Buenos Aires’ Law 448/00 calls for shifting mental health services from psychiatric hospitals to the overall health system. However, it has not yet been implemented, primarily due to resistance from mental health professionals. There is an overall trend towards acceptance of mental health reform, and national legislators from different parties are developing mental health laws. However, people with mental disorders still lack adequate health insurance and service coverage.
3. Primary care and integration of mental health

The 2004–2007 Federal Health Plan gave priority to primary care, and this was sustained in the current plan. It is believed that a primary care strategy will be the fastest and most effective way to reduce the social gap in health status following the country’s financial crisis. The plan calls for the gradual, systematic, and organized decentralization of health services. It also plans for local governments to implement the strategy by developing healthy policies, providing information, and undertaking mass media campaigns.

Argentina’s commitment to primary care has been exemplified by its hosting of the recent international meeting marking the 30th anniversary of the Alma Ata Declaration, and the Minister of Health’s dedication to this approach.

There are 14,534 outpatient primary care facilities in the country. Services are delivered mainly through provincial public sector networks and the private sector.

Mental health

The integration of mental health into primary care is a central principle of Argentina’s plan to deliver mental health to all. However, it has not yet occurred in most regions. It is anticipated that more areas will integrate mental health services in the future. Already, health practitioners from outside Neuquén Province (see best practice) are receiving training, as part of plans to integrate mental health care into primary care in their regions.

4. Best practice

Local context

Neuquén Province is situated in Patagonia, in southern Argentina. It contains both rural and urban areas. Within the province, some people have lifestyles and wealth equivalent to those in developed countries, while others live in abject poverty and conditions similar to low-income countries. Neuquén Capital is a city of approximately 350,000 people. The city’s population has more than quadrupled in the past 20 years, as a result of a growing oil industry and an influx of residents from other provinces. The wealth of Neuquén attracts Mapuche Indians from rural communities and Chilean immigrants from the nearby western border, who frequently fall into the lower socioeconomic classes.

In 1970, the provincial government initiated a health-care reform that resulted in the province becoming one of the leading health care systems in Latin America. The health care structure closely resembles the service pyramid outlined in Part 1 of this report. The province is divided into six zones, each of which provides health care of varying levels of complexity. The majority of care is self- and family-care, or is provided by non-professional primary caregivers: sanitarios (health workers); and in many rural areas, curanderos (traditional healers). The next service level is primary care, which is provided in clinics or outpatient hospital settings. First-level hospital care comprises the next service level. In total, 16 area hospitals exist in the province, corresponding to the 16 political districts into which the province is divided. The next level is the secondary-level hospital, which offers critical care specialties. In total, three such hospitals exist in the province. Finally, the regional hospital, a tertiary care institution, is located in Neu-
quén Capital, where, in addition to the previously mentioned resources, other specialty clinics and consultants are available.

Primary care physicians are central to the system and liaise closely with service levels above and below primary care. These physicians, trained as general practitioners, treat a variety of illnesses and maintain responsibility for patients even if specialized care is required. Specialists serve as consultants to the general practitioners.

In urban areas, residents are usually served by a clinic and referred to secondary and tertiary care when needed. Remote rural communities are served by sanitarios who have undergone a three-month training programme in Neuquén Capital. Sanitarios make daily rounds to some of the 20 to 30 families in their areas. Families often live considerable distances from one another and so sanitarios usually travel by horse. Sanitarios often form links between the rural community and the rest of the health care system, reporting medical problems to physicians, who visit identified patients on rounds every two weeks. The Mapuche community of Ruca Choroi, for instance, is served by physicians from the nearby town of Alumine. Disorders that cannot be managed at the primary care level in Alumine are referred to the area hospital in San Martin or to the higher-level hospital in the city of Zapala.

Ninety per cent of the 39 provincial psychiatrists are in Neuquén Capital, which has only 35% of the province’s population. The majority of psychiatrists are in the private sector. There are two private psychiatric hospitals with 40 beds (employing 10 psychiatrists), and 15 other psychiatrists in outpatient private practice. The public sector has one psychiatric ward with 10 beds in the central hospital, and a detoxification unit with 8 beds. Fourteen psychiatrists serve these two units and the outpatient section of the hospital. One psychiatrist and one psychologist in Neuquén Capital are responsible primarily for responding to consultation requests from primary care physicians and psychologists throughout the province.

Description of services offered

In Neuquén Province, primary care physicians lead the diagnosis, treatment and rehabilitation of patients with severe mental disorders. Psychiatrists and other mental health specialists are available to review and advise on complex cases. A community-based rehabilitation centre, the Austral, provides complementary clinical care in close coordination with primary care centres. It also serves as a training site for general medicine residents and practising primary care physicians.

The model for mental health care is based on four key elements.

1. **Primary care physicians.** Diagnosis, treatment and rehabilitative services for severe mental disorders are provided by a team of health service providers, under the leadership of a primary care physician who is trained for that responsibility. In addition, primary care physicians frequently address life stressors and family conflicts, which they manage with brief, problem-oriented psychotherapy.

2. **Outpatients.** People with mental disorders receive outpatient treatment in their communities, where they enjoy the support of family, friends, familiar surroundings, and community services.
3. *Holistic care.* Patients receive holistic care, which is responsive to both mental and physical ailments.

4. *Specialist support.* Psychiatrists are available to review and advise on complex cases. They also train primary care physicians and nurses.

Because psychiatrists are used sparingly and institutional care is avoided, costs are lower and access to needed services is improved.

Neuquén’s *sanitarios* and *curanderos* are often the first point of contact for people with mental disorders. In some cases, patients go from *curanderos* to formal primary care. However in rural areas, self-care and informal care are used most frequently and the family’s supportive role is seen as fundamental.

Psychologists are distributed among health centres around the city and consult where needed. They are not affiliated to any particular clinic, but rather serve a number of health care settings. Psychologists address psychosocial complaints in addition to severe mental disorders.

Patients with mental disorders are sent to the provincial hospital if required. The limited number of public sector psychiatric beds in the province (10) sometimes complicates the treatment of acutely ill patients. Severely ill, violent, or suicidal patients requiring long-term care are sent to the psychiatric hospital in Buenos Aires.

**The process of integration**

Identifying the best way to integrate mental health into primary care

When the primary care model of health care was developed and implemented in Neuquén Province, mental disorders were meant to be handled similarly to other health problems. The few psychiatrists were meant to serve as consultants and receive referrals of complex cases from primary care physicians.

In reality, not all physicians believed that integration would be the best way to improve mental health care in the province. Most primary care physicians were disinclined to apply the same treatment and rehabilitation standards to patients with schizophrenia and other mental disorders as they did to patients with physical health problems. Some reported insufficient training in the use of psychotropic medications, and hence preferred not to use them. Others were reluctant to be responsible for the complete health care of patients with mental disorders.

Nonetheless, it was a group of primary care physicians who initially identified the need for mental health integration. They recognized that a number of their patients needed mental health care, but that they were ill-equipped to deal with these problems and there were too few specialists for routine referral. Moreover, specialists were often far from patients’ homes, and seeking services resulted in substantial travel expenses and isolation from family and friends. The primary care physicians realized that they needed training in the management of mental disorders. They also requested better coordination with psychiatrists, nurses, psychologists and social workers, to provide optimal support to patients and families.
Gaining political commitment

In 1996, the Subsecretary of Health for the province created a commission on mental health. The commission’s goal was to develop an integrated mental health programme for the province. Previous attempts to integrate mental health into primary care had failed for several reasons: planning was not systematic; primary care physicians were reluctant; specialist trainers and supervisors were not made available; and local government support was limited. This time, barriers were addressed through the involvement of the Subsecretary, as well as through the formation of the commission and the provision of training and financial resources from outside the province. The programme objectives were: to develop norms for diagnosis and treatment; to construct a referral and consultation network; to prepare a group of health professionals to implement and oversee the programme; and to train primary care physicians and nurses in remote regions so that mental health services could be provided on site.

The potential involvement of experts from North America raised concern among certain physicians, who felt that “colonial” models were being forced on them. The primary care model in Neuquén Province had achieved a great deal in preventive and general medicine, based on a foundation of well-trained physicians. It was felt that “outsiders” might interfere and undermine these achievements. However, after it was clarified that consultants would assist only where requested, and would not impose anything on the Neuquén system, their participation was accepted.

Awareness raising and training activities

In 1996, the province and its international consultants held a conference for primary care physicians throughout the province. Around 50 people participated; most were primary care physicians although some nurses, social workers and sanitarios also attended. The conference focused on training physicians to diagnose and treat severe mental disorders, in particular psychosis. It was felt that education about psychosis would enable primary care physicians to leverage existing skills in managing chronic conditions such as hypertension, cardiac disease, and diabetes, and extend these skills to the management of chronic mental disorders. Additionally, patients with acute psychotic disorders were often disruptive, causing distress for physicians, other medical staff, and families, and hence it was felt that physicians would be particularly motivated to learn management strategies for these disorders. Finally, it was believed that it would be useful for physicians to master the management of one relatively rare mental disorder, before beginning to treat more common disorders.

Trainers came from Argentina, Chile, England, Guatemala, the United States of America, and Uruguay and included nurses, psychiatrists, primary care physicians, clergy, social workers, and attorneys.

Topics included epidemiology, diagnosis, pharmacotherapy, patient education, family involvement, and rehabilitation of people with psychotic disorders. Clinical management skills were streamlined to a few simple steps: maintaining close contact with the patient’s family; managing medications; and determining when consultations were needed. Lectures were complemented by role plays and case discussion.

Following the conference, the mental health commission became the driving force for integration. It supervised additional training activities for physicians and medical residents, and
because the commission included both mental health and primary care representatives, it became a forum for ongoing dialogue between these groups.

In addition, monthly meetings between primary care physicians and curanderos were established in some clinics. These meetings encouraged open communication to facilitate coordinated treatment of certain disorders, enhance the community’s trust in physicians, and prevent the dangerous effects of combining contraindicated herbs with medications.

In 1997, a second training conference was convened. The topic was the recognition and management of depression in primary care. Many primary care physicians who attended the first conference also attended this second one. New participants included nurses and residents in general medicine. The conference programme consisted of formal presentations and case presentations. Cross-cultural issues became an important part of the discussion. The physicians, products of a Eurocentric professional education, had adapted their practice styles to address the belief systems of the communities in which they worked. The conference provided an opportunity to discuss these adjustments and seek common ground with the traditional psychiatric approach.

Again, after the conference, the mental health commission actively coordinated follow-up and training. Two North American consultants made an extended visit to one region of the province, where they met with local psychologists, answered questions, and participated in joint consultations with primary care physicians to provide on-site training.

Although fewer than 5% of physicians in the province attended, these two meetings were crucial in developing interest in primary care for mental health. The meetings led directly to additional training of primary care physicians within the Austral (see below) but also, perhaps most importantly, to an agreement with the Subsecretary of Health that general medicine residents would also be trained there.

The Austral

The Instituto Austral de Salud mental rehabilitation programme (the Austral) is a non-governmental organization that serves as a major training centre for primary care physicians. Importantly, the training focuses on primary care, rather than hospital-based care. Since 1996, numerous professionals have been trained, including senior general physicians and general medicine residents from the public health system, psychiatry residents, psychologists and psychology students, and nursing students. Professionals’ training at the Austral lasts between one month and one year.

Since 2000, at least two general medicine residents are trained at the Austral at any given time. Thus far, around 40 residents have been trained, most of whom are now in general practice in Neuquén Province. Initially, their training lasted one month, but due to interest, it was extended to three months. Formal research has not been conducted, but anecdotally residents report that the training conveys skills, experience, and confidence to treat people with mental disorders in primary care. Training also expands their holistic approach to health care and enables them to be sensitive to possible psychosomatic complaints. Rather than referring patients with depression, stabilized psychosis and anxiety disorders, they treat these patients themselves. As there is no established mental health programme for referral, other than hospital-based services,
many practitioners who have trained at the Austral continue to consult the team after they are established in general practice.

Training of former residents continues through different channels. A journal club, attended inter alia by previously-trained primary care physicians, is coordinated by a psychiatrist from the Austral. The club discusses the clinical literature pertinent to the primary care practice. In addition, guest speakers sometimes give talks on relevant subjects. The consulting psychiatrist from the Austral also provides ongoing training through telephone consultations concerning cases that have been back-referred to the former residents for ongoing management.

Community-based rehabilitation

The Austral not only offers training, but also community-based crisis intervention, maintenance care, and rehabilitation. While it has not been possible to establish similar services outside Neuquén Capital, this service illustrates the potential for general physicians to become involved in community-based rehabilitation.

The treatment team at the Austral consists of community-oriented caseworkers, a nurse, consulting psychiatrists (one psychiatrist who is also the director, and one part-time psychiatrist who mainly sees children), and primary care physicians (six as of 2007). The programme is centred on the primary care physician and the primary care infrastructure. The physicians serve as team leaders in the treatment of patients. When patients with mental disorders visit the institute, they see their primary care physicians, just as they would if they were being treated for any other condition. Primary care physicians make initial diagnoses in consultation with the psychiatrist, and provide patients and families with education and support concerning medication maintenance and coping with life stressors. They treat their patients in a holistic manner, addressing both mental and physical health issues.

After patients have been stabilized, the Austral seeks to reintegrate people into the community and help them achieve economic independence. The clinic venue, a former private home in the centre of downtown, was chosen so that patients were not isolated and stigmatized, but rather received care in a central area. One of the most important achievements of the Austral has been to involve artisans, artists, farmers, educators, and other community members in the rehabilitation programme. An example of this is a work group of people with schizophrenia, who learnt farming skills and after two years were able to buy the land they farmed and construct a nursery. In addition, after receiving carpentry and other classes, the same group started selling good-quality wood products at the local market.

Financing the model

Argentina’s social security sector pays for services provided by the Austral team to public sector patients. Public sector primary care physicians’ salaries and training are also funded largely by the state. Services provided by the Austral team to patients with private health insurance are reimbursed separately through these schemes. Practitioners are remunerated similarly for treatment of mental and physical health problems.

Cost analyses have not been conducted, however it is obvious that community-based care is no more expensive, and in all likelihood less expensive per patient compared with the previous hospital-based service. Also, because their treatment is community based, patients are able to participate in income-generating activities. Previously, patients with mental disorders were
transferred to Buenos Aires, 1200 kilometres from Neuquén Province. Many patients stayed in the hospital for extended periods and became institutionalized, with little community contact and no opportunity to earn incomes.

**Overcoming resistance to the model**

Psychiatrists, psychologists, and psychiatric nurses in the province initially resisted the integrated model. They felt that it would be dangerous to patients and "a second class alternative". Concern for both patients' well-being and their professional status contributed to their resistance. Resistance was overcome eventually through demonstration of the programme's success.

The conviction and commitment of the team were fundamental to the survival and growth of the model. Strong leadership in times of crises, for example when resources were not provided by the state, was crucial in focusing the team on the importance of their work. Most importantly, pressure from patients and families kept the service alive through difficult times.

Through the various crises, the team learned valuable lessons. Alternatives were found that increased their efficiency and enabled them to assist even more patients. For example, a range of therapeutic groups was started that allowed support services to more than double the number of people seen. In addition, they realized that the more general practitioners they trained and supported the fewer patients were sent to them for referral.

**5. Evaluation/outcomes**

The mental health integration model has increased demand for mental health care and allowed people with mental disorders to be better stabilized and socially integrated.

According to the Director of the Austral, the effectiveness of the programme is largely the result of teamwork, in which the primary care physicians lead the therapeutic process, but are supported by other team members such as nurses, psychologists and himself as the psychiatrist.

**Services available**

Statistics have not been kept on the number of people with mental disorders seen by general physicians. Nonetheless, it is well-known that previously, only people with highly disruptive and severe mental disorders were treated – and then only in centralized psychiatric hospitals. Now, thousands of people are treated within the province, mainly within primary care practices. The consultant psychiatrist at the Austral estimates that at least half of the primary care physicians in the province now use basic instruments to detect depression and psychotic disorders. Identified patients are either treated or referred, typically to local mental health facilities or to practitioners with mental health training.

Between 1997 and 2006, the Austral's general physicians provided mental health care to 3200 people. Including families, around 12 000 people have benefited from the service. Among those who have received treatment at the Austral, 80% have remained stabilized within the community.

Since the model's implementation, only 5% of patients with mental disorders have required care in a psychiatric hospital. Many have been subsequently back-referred to the primary care service following stabilization.
Patient satisfaction

Patients’ self-esteem and independence have improved as a result of the programme. Many are now regarded by their families and communities as functional, capable individuals.

6. Conclusion

In Neuquén Province of Argentina, primary care physicians lead the diagnosis, treatment and rehabilitation of patients with severe mental disorders. Patients receive outpatient treatment in their communities, where they enjoy the support of family, friends, familiar surroundings, and community services. Psychiatrists and other mental health specialists are available to review and advise on complex cases.

The integration of mental health into primary care in Neuquén Province was driven by practical, theoretical and human rights considerations.

- On a practical level, there was a dire shortage of mental health specialists, while primary care physicians were relatively abundant. By building these physicians’ skills (with the initial help of trainers from outside the province), local mental health specialists were able to better utilize their time by attending only to more complex cases. Most importantly, it enabled far more people to access treatment for mental disorders.
- From a theoretical level, all patients are now assessed and treated holistically, with consideration of both physical and mental health issues. Most physicians acknowledge that this approach has produced better health outcomes for their patients.
- From a human rights perspective, the community-oriented approach is humane and shows respect for people’s dignity and human rights. Previously, most people with severe mental disorders were sent far from home to long-term institutional care. Many patients became institutionalized rather than treated, and lost contact with their families and communities.

Community-based rehabilitation services complement primary care for mental health. The two service components are highly linked: health professionals from the community-based rehabilitation centre (the Austral) are responsible for training and supervising primary care physicians. Difficult-to-treat patients are sent to the Austral for assessment and treatment – hospital-based care is reserved as a last resort. Many primary care physicians spend extended periods at the Austral, where they provide physical and mental health care and also gain valuable experience in treating mental disorders under the supervision of a psychiatrist.

Key lessons learnt

- Where there are few mental health specialists, they can be leveraged most effectively by refocusing their work from clinical care to training, supervision and management of complex cases.
- With training and ongoing support, general medical practitioners can provide integrated mental health care.
- High-level political commitment and the establishment of a national mental health commission contributed to the success of this integration effort.
- Primary care physicians identified the importance of primary care for mental health, and hence were highly active and enthusiastic in the overall reform.
• Extending and reinforcing mental health training for residents and practising primary care physicians were essential for the success of the programme.
• Integrated primary care is important, but most effective when complemented by community-based rehabilitation. In this example, primary care physicians led the creation of an important community-based programme – the Austral – which resulted in fewer relapses and improved the quality of life for patients.
• As demonstrated in this example, collaboration between the public health sector (primary care clinics) and a partially state-funded nongovernmental organization (the Austral) can be effective for providing comprehensive mental health care.
• Community-based rehabilitation paid dividends, socially and economically. Patients relapsed less often and hence needed less hospital care; in addition they remained integrated with families and friends and were able to start income-generating projects.
• Experts from outside Argentina were useful in sharing experiences and providing training. However, it was important that they did not try to impose their views or prescribe solutions to the local health team.

References – Argentina

This best practice example draws heavily on two articles published in the International Journal of Mental Health:

Other references are as follows.