Integrated primary care for mental health in the Macul district of Santiago

Case summary
Following Chile's national mental health plans of 1993 and 2000, which specified the need to integrate mental health into general health care, a family health centre in the urban municipality of Macul undertook primary care integration. In this centre, general physicians diagnose mental disorders and prescribe medications where required; psychologists provide individual, family and group therapy; and other family health team members provide supportive functions. A mental health community centre provides ongoing support and supervision. Clear treatment pathways, with lines of responsibility and referral, assisted all members of the multi-disciplinary family health teams.

Health service data show that, over time, more people with mental disorders have been identified and successfully treated at the family health centre. User satisfaction also has improved.

1. National context
Indicators of Chile's overall national context are displayed in Table 2.10. Chile has made great progress in alleviating poverty. It was the fastest growing economy in the Latin American region during 1990–2004, doubling its income and halving the proportion of its population below the national poverty line (from 30% to 15%). Chile's main employment and revenue sector is services, and its national language is Spanish.
2. Health context

Important health indicators for Chile are shown in Table 2.11. Chile is experiencing a demographic and epidemiological transition. Its population is ageing: by 2010, an estimated 9% of the population will be aged 65 years and older. Infant and adult mortality have decreased significantly, and the major causes of death are now heart disease and stroke, followed by lower respiratory infections and stomach cancer.

People at lower socioeconomic levels suffer from higher rates of illness and mortality. Inequalities in health care access and quality are present between rich and poor, urban and rural inhabitants, younger people and the elderly, and men and women.

In 2005, Chile undertook a broad-based health system reform. The main principles of this reform were the right to health, equity, solidarity, efficiency in the use of resources, and social participation in health. National health objectives and goals were formulated for the year 2010. An overall health authority was created for regulation of public and private providers; regional health authorities were also created; the 28 public health districts (Servicios de Salud) were given more autonomy; and national and regional public health plans were formulated. The
most visible step of this reform was the implementation of a system of health that guaranteed access, opportunity, quality and financial protection.5

**Mental health**

Surveys in Chile indicate that between 13% and 23% of adults suffer from a current mental disorder. The most common lifetime diagnoses are agoraphobia, major depressive disorder, dysthymia, and alcohol dependence.6, 7

In 1993 and 2000, Chilean national mental health plans specified the incorporation of mental health in primary care. This was motivated by a desire to increase overall access to treatment. In addition, psychiatric hospital-based care – typical prior to reform – was recognized by authorities as outmoded and fraught with human rights violations.

The implementation of the National Mental Health Plan of 20005 achieved major improvements for the mental health services in Chile through:

- facilitating intersectoral exchange of information and economic resources;
- implementing community-based services in place of psychiatric hospitals;4
- strengthening the role of primary care centres in providing mental health treatment and care.

Among the 56 health problems that have been granted guarantees of access, quality and financial protection, three are mental disorders: schizophrenia (since 2005), depression (since 2006), and substance abuse and dependence (since 2007). Other disorders are likely to be added in time.

### 3. Primary care and integration of mental health

As part of overall health reform, primary care is changing towards a family health model, which is characterized by:

- prioritization of the family, rather than individuals, as the focus of health attention;
- multidisciplinary family health teams (general physician, dentist, nurse, obstetric nurse, nutritionist, social worker, psychologist, and nursing aide);
- emphasis on patient health education and self-management support;
- prioritization of early detection of risk factors, as well as early diagnosis and treatment;
- inclusion of rehabilitation and palliative care as part of family health services;
- regular monitoring of users’ satisfaction.

Primary care exists only in the public health sector, which provides services for approximately 70% of Chile’s total population. It is organized through a network of facilities (see Table 2.12).

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4 Between 1999 and 2004, the proportion of the total mental health budget attributed to psychiatric hospitals decreased from 57% to 33%; while the proportion of the budget attributed to community-based services increased from 43% to 67%.
Most primary care facilities are operated by municipalities. Their budgets are assigned from the Ministry of Health based on capitation. People covered by public health insurance must enrol in a primary care centre. The per capita budget for family health centres is slightly higher than those for other health centres.

**Mental health**

Some health promotion and prevention activities are conducted in schools and communities, but most primary care-based mental health services are focused on the treatment of people with mental disorders. The most frequent mental disorder treated in primary care is depression; which is explained by the high prevalence of this disorder in Chile, as well as the implementation of a national depression programme since 2001. Around 90% of people with depression are treated in primary care, and only 10% are referred to specialists. On the other hand, people with psychosis are typically referred to specialist centres. Recently however, family physicians and their teams have started to oversee long-term maintenance treatment for people with schizophrenia.

Table 2.13 displays the different mental disorders treated in primary care.

### Table 2.12 Chile: type and number of primary care facilities, 2007*

<table>
<thead>
<tr>
<th>Type of facility</th>
<th>Principal characteristics</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family health centre</td>
<td>Multidisciplinary teams working with a sector of the population and applying a family health approach.</td>
<td>144</td>
</tr>
<tr>
<td>Community family health centre</td>
<td>A small, decentralized version of the family health centre with participation of community agents.</td>
<td>74</td>
</tr>
<tr>
<td>Urban general health centre</td>
<td>Multidisciplinary teams working with the total population and applying an individual approach (in a large city).</td>
<td>214</td>
</tr>
<tr>
<td>Rural general health centre</td>
<td>Multidisciplinary teams working with the total population and applying an individual approach (in a small rural town).</td>
<td>142</td>
</tr>
<tr>
<td>Rural health post</td>
<td>A small health centre in an isolated rural area and usually staffed only by a nursing aide.</td>
<td>1168</td>
</tr>
<tr>
<td>Primary care emergency service</td>
<td>A physician-based centre for mild and moderate health emergencies at nights and at weekends.</td>
<td>159</td>
</tr>
<tr>
<td><strong>Total number of primary care facilities</strong></td>
<td></td>
<td>1901</td>
</tr>
</tbody>
</table>

### Table 2.13 Chile: number of new cases treated in primary care, 2006*

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Number of cases</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and drug problems</td>
<td>29 227</td>
<td>8.9</td>
</tr>
<tr>
<td>Victims of domestic violence</td>
<td>21 013</td>
<td>6.4</td>
</tr>
<tr>
<td>Attention-deficit/hyperactivity disorder</td>
<td>15 465</td>
<td>4.7</td>
</tr>
<tr>
<td>Depressive episode</td>
<td>179 943</td>
<td>54.9</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>55 947</td>
<td>17.1</td>
</tr>
<tr>
<td>Personality disorders</td>
<td>7 183</td>
<td>2.2</td>
</tr>
<tr>
<td>Other disorders</td>
<td>18 936</td>
<td>5.8</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>327 714</td>
<td>100</td>
</tr>
</tbody>
</table>
Increasingly, primary care professionals are trained on mental health issues. They are also visited once per month by psychiatrists and other mental health specialists. Psychologists have been incorporated progressively into primary care centres, and at present, almost all family health centres and urban and rural general health centres have at least one psychologist among their staff.

4. Best practice

Local context

The Felix de Amesti family health centre (FHC) is one of three FHCs in the urban municipality of Macul (south-east sector of Santiago). The centre has four multidisciplinary family health teams, each of which has two general physicians, one dentist, one nurse, one obstetric nurse, one social worker, one nutritionist, one psychologist (part time) and three nursing aides. Each team is responsible for one fourth of the population enrolled at the centre.

The population served at the FHC has the following main features:

- total clinical population: 38 936 people (22 258 women and 16 678 men), representing 56.6% of the people living in the geographic area;
- clinical population under the age of 15 years: 23.7%, above the age of 60 years: 17.6%;
- clinical population below the national poverty line: 13.7%, with lower-middle income: 74.9%;
- clinical population receiving FHC services free of charge: 70%; the rest pay a small user fee;
- declining birth rate (below 14 for 1000 inhabitants);
- overall mortality of 5.5 for 100 000 inhabitants, and infant mortality of 8.0 for 1000 births.

The FHC is responsible for a range of issues and conditions, including mental disorders, cardiovascular diseases, respiratory diseases, cancer, dental health, and environmental health.

In addition to the mental health services provided through the FHCs, Macul has one Mental Health Community Centre (MHCC), which provides ambulatory specialty care. People with severe mental disorders and those who are a danger to themselves or others are referred to the day hospital or to a short-term inpatient unit in a general hospital, which serves the eight municipalities of East Santiago health district.

The overall Macul mental health programme has the following priorities.

- Child mental health:
  - child physical abuse;
  - conduct and emotional disorders;
  - attention-deficit/hyperactivity disorder;
  - life skills for 1st and 2nd grade schoolchildren.
- Adolescent mental health:
  - alcohol and drug problems;
  - child physical abuse and domestic violence;
  - mood disorders.
• Adult mental health
  – depression;
  – domestic violence;
  – alcohol and drug dependence and abuse;
  – severe mental disorders;
  – victims of military dictatorship.

**Description of services offered**

Generally, mild and moderate mental disorders are treated in the FHC, while severe disorders are referred to the MHCC, which is responsible for ambulatory specialty care. However, more recently patients with severe mental disorders such as schizophrenia are being back-referred from specialist centres to FHCs for long-term maintenance treatment. While all members of the family health team assist in the detection of mental health problems, treatment is managed principally by general physicians and psychologists. General physicians devote two hours daily for mental health issues; they diagnose mental disorders and prescribe psychotropic medicines where required. Psychologists conduct individual, family and group psychosocial interventions. In addition, several types of group therapy are available and any member of the team can make home visits if needed.

A number of other health workers assist the family health teams in different ways. In addition to the general physicians, a few part-time physicians manage patients presenting with acute symptoms. They see up to eight people with acute mental health problems every day. University students, including specialists in children with learning difficulties, undertake clinical rotations at the FHC. In addition, each family health team has a few health volunteers, who are recruited from women treated for mental disorders at the FHC. The volunteers help identify people in their neighbourhoods with mental health problems, or those who are victims of domestic violence. They also make home visits to patients who have failed to keep their appointments.

A psychiatrist, a psychologist and sometimes another professional from the MHCC meet monthly with the family health team at the FHC. The purpose of this meeting is to discuss patients with difficult-to-treat mental disorders, and to improve the ability of the family health teams to treat these disorders. In addition, treatment pathways have been developed for some mental disorders (see Figure 2.2).

**The process of integration**

**The establishment of the Macul mental health community centre**

The establishment of the Macul MHCC in 1992 was important for building mental health services. The MHCC team sensitized municipal authorities and the community on mental health issues, and demonstrated how mental health programmes and interventions satisfy population need. They were also essential for training the FHC teams and supporting their mental health functions. As described previously, MHCC professionals meet monthly with FHC staff to provide mental health consultations. They also jointly evaluate the functioning of the municipal mental health network and resolve administrative issues. A representative from the municipal health department is included in these latter discussions once every three months.
The first national mental health plan

Following the directives of the first national mental health plan in 1993, two mental health programmes were initiated in 1994.

Emotional disorders programme: This programme was focused on women with anxiety and depressive disorders. Its main components were psychosocial group interventions, lasting for approximately 12 sessions and conducted by social workers; and medical treatment by general physicians, who usually prescribed oral benzodiazepines and antidepressants.

Alcohol problems programme: Problem drinkers were detected using a seven-item questionnaire. People with alcohol dependence were treated for two years with medication, group therapy and support groups. People with alcohol abuse received an educational intervention that lasted a few months.

These programmes helped sensitize municipal authorities, health professionals and the community about the importance of mental health problems and the need to provide interventions at primary care centres.
Transformation to a family health centre

In 1999, the Felix de Amesti centre evolved from a primary care facility to a FHC. This evolution, which favoured the development of mental health services within the centre, involved the adoption of a family medicine model, division of the geographic area into four sectors, and creation of one multidisciplinary family health team for each sector. The operational budget was also increased.

The second national mental health plan

As part of the implementation of the second national mental health plan (2000), Macul was selected by the Ministry of Health to pilot a national depression programme. New resources were allocated from the Ministry of Health to the health district, and in turn to the FHCs. With these resources, clinical guidelines and group intervention manuals were developed, FHCs professionals were trained, a part-time psychologist was hired, and first line psychotropic medications were introduced into the FHCs.

Expansion of services offered

In 2001, a domestic violence programme was initiated. Although additional resources were not provided, the programme was conducted through reassigning resources inside the FHC. Sensitization workshops were held in schools and community settings. Detection of victims of violence was improved. Treatment was provided at the FHC for mild to moderate cases, while severe cases, as well as all aggressors, were referred to the MHCC.

The mental health programme for children began in 2002. No new resources were made available; a child and adolescent psychiatric team from a general hospital provided mental health consultations to the FHC. These consultations helped sensitize the family health teams about child mental health problems, and helped to improve their skills to detect child physical and sexual abuse, conduct and emotional disorders, and attention deficit hyperactivity disorder.

Psychosocial interventions with parents and with children (individually and in groups) were started by the FHC psychologist with the help of university students. Psychology, psychopedagogy, occupational therapy and social work students focus significantly on child mental health in their final year of training and were hence an important resource to the FHC, while at the same time providing them with practical experience.

A referral system for children was developed between the FHC and the MHCC. Children with severe disorders were treated at the MHCC, while others received shared care with the participation of professionals from both facilities.

After 2002, the mental health programme at the FHC expanded gradually, which resulted in more people with mental disorders being detected and treated. A new psychologist was incorporated in 2004, and in 2007 a third psychologist was hired. Henceforth, a psychologist was part of each family health team.

Explicit directives for the treatment of depression were incorporated into the FHC in 2006. This allowed the treatment of adults with depression at the FHC, and expedited specialist referral when needed. Additional resources were allocated to the FHC for this purpose.
People with severe mental disorders started being treated in their homes rather than in hospitals. Within this model, a nurse made home visits every day, while a general physician and a psychologist visited on alternate days. A nutritionist was also available when needed. The model's implementation has been limited due to the lack of resources, but the health team believes it could successfully treat a larger number of people with severe mental disorders if additional professionals were involved.

**In-service education and training**

The FHC health professionals attended several mental health training activities organized by the Health District, as well as training sessions hosted by other institutions. Moreover, the health department of Macul Municipality organized two important training workshops (see below).

Integrating mental health: This workshop targeted multidisciplinary teams. The main topics were: interviewing skills; family interventions; domestic violence; child sexual abuse; mental health issues in older people; child behavioural problems and diagnosis of attention-deficit/hyperactivity disorder; depression; bipolar disorders; panic attacks; and personality disorders. The workshop was 24 hours in total and was offered twice in 2005. During that year, 51 professionals participated (including general physicians, dentists, nurses, obstetric nurses, nutritionists, social workers, and psychologists).

Mental health tools for primary care: This workshop targeted nursing aides and administrative staff. Its main objectives were to teach the principal features of mental health problems in adults and children; to develop skills to deal with “difficult patients”, to resolve conflicts and to work in a team; and to apply self-care and stress prevention strategies. This workshop was 14 hours in total and was offered twice in 2006. In total, 59 staff members participated.

Similar to other facilities in the East Santiago health district, the Felix De Amesti FHC has been part of a systematic and continuous policy to improve the registration of mental health interventions, including a referral and back-referral system between the different levels of the health service. Professionals have participated in workshops and vast improvements in mental health evaluation and planning have been observed.

**Involvement in mental health planning**

The Felix de Amesti FHC has been influential in placing mental health as one of the priorities for the Macul municipality. The FHCs and the MHCC jointly design the annual mental health programme as part of the Macul health plan. This has created greater efficiency and solidarity in the use of mental health resources, and has facilitated the inclusion of psychosocial factors as part of the municipality's health promotion work.

**Senior leadership and support**

Mental health integration would not have occurred without the support and involvement of the mayor of the Macul municipality and the head of the Macul health department. Both were highly receptive to new ways of meeting the mental health needs of the population, and both provided material as well as moral and political support throughout the process.

The director of the Felix de Amesti FHC was also very supportive of the mental health programme. She was essential in facilitating the efficient management of new resources, and helpful with the hiring of psychologists and the training of family health teams.
Two mental health professionals, who are national leaders of the community mental health movement in Chile, have worked successively as directors of Macul MHCC, from 1997 to 2001. Subsequently, both became Directors of Mental Health at the East Santiago health district, from 1999 to 2004. From both positions, they have been influential in supporting the development of mental health work in Macul’s FHCs.

5. Evaluation/outcomes

Services available

The health information system in Chile has included the number of people with mental disorders receiving treatment only since 2003. The system does not allow the differentiation of the number of people detected from the number treated.

At the Felix de Amesti FHC, the number of people receiving treatment increased by a factor of 2.5 from 2003 to 2006 (see Table 2.14).

| Table 2.14 Felix de Amesti family health centre: number of people with mental disorders receiving active treatment on December 30 |
|-------------------------------------------------|--------|--------|--------|--------|
| Alcohol and drug problems                      | 0      | 39     | 115    | 0      |
| Victims of domestic violence                   | 104    | 87     | 183    | 137    |
| Attention-deficit/hyperactivity disorder       | 12     | 81     | 69     | 30     |
| Depressive episode                             | 361    | 384    | 721    | 757    |
| Anxiety disorders                              | 116    | 277    | 130    | 326    |
| Personality disorders                          | 0      | 62     | 53     | 234    |
| Other disorders                                | 20     | 130    | 77     | 50     |
| **TOTAL**                                      | **613**| **1060**| **1348**| **1534**|

The number of new cases of mental disorders detected and treated also increased significantly (1.8-fold) between 2003 and 2006 (see Table 2.15), demonstrating that the increased number of people receiving treatment was not only due to the accumulation of chronic cases.

| Table 2.15 Felix de Amesti family health centre: number of new cases receiving treatment every year |
|-------------------------------------------------|--------|--------|--------|--------|
| Alcohol and drug problems                      | 0      | 39     | 75     | 0      |
| Victims of domestic violence                   | 244    | 106    | 209    | 205    |
| Attention-deficit/hyperactivity disorder       | 32     | 80     | 102    | 145    |
| Depressive episode                             | 648    | 878    | 1192   | 997    |
| Anxiety disorders                              | 364    | 246    | 354    | 577    |
| Personality disorders                          | 0      | 84     | 143    | 275    |
| Other disorders                                | 24     | 129    | 95     | 184    |
| **TOTAL**                                      | **1312**| **1562**| **2170**| **2383**|
The number of mental health interventions at the Felix de Amesti FHC also increased between 2003 and 2006 (see Table 2.16). This was due mainly to the increased number of individual sessions conducted by psychologists (5.2-fold). The proportion of cases referred to specialist care was low during this period, with an average of 9.5%.

Table 2.16  Felix de Amesti family health centre: number of mental health sessions in one year by different professionals

<table>
<thead>
<tr>
<th>Professional</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>General physician</td>
<td>1663</td>
<td>1736</td>
<td>1951</td>
<td>1926</td>
</tr>
<tr>
<td>Psychologist (individual sessions)</td>
<td>1380</td>
<td>3595</td>
<td>4239</td>
<td>7244</td>
</tr>
<tr>
<td>Psychologist (group sessions)</td>
<td>201</td>
<td>227</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other professionals</td>
<td>230</td>
<td>217</td>
<td>461</td>
<td>192</td>
</tr>
<tr>
<td>TOTAL</td>
<td>3273</td>
<td>5548</td>
<td>6852</td>
<td>9589</td>
</tr>
</tbody>
</table>

Felix de Amesti FHC teams have also improved the quality of treatment through systematic use of treatment guidelines and development of additional innovative interventions, such as group therapies and community volunteers.

**Patient satisfaction**

An external evaluation showed high user satisfaction with the health service at Felix de Amesti FHC. The proportion of users “satisfied” or “very satisfied” increased from 79% to 86% between 1999 and 2006. Ninety-two per cent of users were highly satisfied with the way they were treated by the professional in charge of their treatment; only 2% expressed criticism.

Users valued the service improvements and the good general health attention they received at the FHC. Regarding aspects to be improved, they highlighted the need to reduce waits and delays, and to improve the treatment they received from administrative staff.

**6. Conclusion**

Following Chile’s national mental health plans of 1993 and 2000, which specified the need to integrate mental health into primary care and general health care, significant progress was made around the country. The example of the Felix De Amesti FHC in the Macul district of Santiago highlights several important lessons. Changes required significant political and professional support. The leadership of the mayor, the head of Macul health department, and the director of the Felix de Amesti FHC was crucial to the success of the programme. The establishment of the Macul mental health community centre was equally important in setting the foundation and providing training and support to integrated mental health care.

**Key lessons learnt**

- Significant political and administrative support is essential for securing additional funding and human resources, and for integrating mental health into general health care.
- A mental health community centre is crucial to provide ongoing support and supervision. In this example, support included monthly mental health consultations to staff at the FHC;
meetings once per month to evaluate the functioning of the municipal mental health network and to resolve administrative issues; and the training and clinical support of the FHC team.

- Clear treatment pathways, with lines of responsibility and referral, assist all members of the team.
- A successful service requires both medical and non-medical interventions. In particular, group therapy can be very successful. The availability of a multidisciplinary team is extremely useful.
- Volunteers from the community can detect mental health problems and refer people to services, as well as conduct home visits.
- Support and guidance from the national level is very important.

References – Chile

4 Los objetivos sanitarios para la década (Health objectives for the decade). Santiago, Chile Ministry of Health, 2002.
9 Santiago, Chile Ministry of Health, Department of Statistics and Health Information.