

Foreign report

Mental health services in Nicaragua: ten years of revolution

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Nicaragua is celebrating ten years of revolution since the overthrow of the 45 year long Somoza dictatorship*. In this time, the Sandinista government has attempted to construct a more democratic society with considerable achievements in the area of health, welfare and education. Indeed, health care has been a priority in spite of severe economic difficulties caused by the United States economic blockade and by the need for defence against the war waged by the counter-revolutionaries (the *Contra*).

Mental health services are organised along progressive community-based lines with an emphasis on prevention and accountability. They are, therefore, of enormous interest to health care professionals in Britain. Furthermore, the existence of a unified national health system (SNUS) means that parallels with Britain are easily drawn.

What follows attempts to describe mental health services in Nicaragua in the context of a constantly evolving social system and economic situation. Some of the information was gathered on a personal visit to the country by the first author.

Principles of the health care system

In post-revolutionary Nicaragua, health was deemed a national priority, along with agrarian reform and education; and second only to defence. The new government inherited a health service in ruins. Hospitals had been bombed by Somoza in an attempt to cripple all vulnerable economic and health installations before he fled the country. The response was to create a unified national health service (SNUS) under the direction of the Ministry of Health

***Authors' note**

This paper was written before the Nicaraguan elections in February 1990 which were won by a coalition of opposition groups (UNO). The new government is considering the privatisation of health services.

(MINSAs). The aim of the health care system, including mental health, has been to provide free, accessible and decentralised services with an emphasis on primary prevention.

In 1980, six principles formed the basis of the organisation of health care:

- (1) Health is a right of every individual and the responsibility of the State and Popular Organisations.
- (2) Health Services should be free and accessible to the entire population geographically, economically and culturally.
- (3) Health Services should function to integrate the physical, mental and social dimensions of health and to address the conditions of work and residence as they affect health.
- (4) Health care should be delivered in a multi-professional team approach.
- (5) Health activities were to be planned.
- (6) The community ought to participate in all activities of the health system (MINSAs 1981).

The success of the health campaigns, such as mass immunisation against polio, was so great that in 1983 the World Health Organisation awarded Nicaragua its annual prize for the greatest achievements in health care by a Third World nation. Since then, however, 60 health posts have been destroyed by the *Contra* forces and many health workers killed. In October 1988 Hurricane Joan compounded the existing severe economic crisis and consequent shortages of basic items.

Background to Nicaragua's mental health system

Before the revolution

Before 1979, psychiatric and psychological services were scarcely accessible to the majority of Nicaraguans, and could only be obtained by a small

elite group who were able to afford the private fees (Kroese, 1987).

Those who were severely mentally ill were isolated in the psychiatric hospital in Managua. This hospital, the only one in the country, served as a 'dumping ground' for those not considered worthy of rehabilitation. Substandard conditions existed with no attempt at therapeutic intervention.

In addition, during the Somoza regime, the activities of psychologists were heavily restricted. For example, many were forced to serve the interests of the State by being used to intervene to suppress politically active students.

After the revolution

The Ministry of Health's mental health department was founded in 1979 by psychiatrist Dr Mario Flores Ortiz. Within the health service, mental health *per se* has not been a priority, largely for economic reasons, but it is clearly visible as a growing area of concern. One of the first decisions taken by the Sandinista government was to create multidisciplinary teams operating in the community. Like the general health system, mental health services have been organised in a participatory democratic manner, challenging many of the classic problems within both first and third world countries.

Relationship between the general health care and mental health care system

The health care system has a pyramidal structure with the smallest health centres at the bottom. It is the objective of the National Health System (SNUS) that mental health services should be integrated throughout the system, even in the smallest health centres.

Structure of the mental health care system

The mental health care system can best be described in three levels – popular, community and tertiary.

Popular level

At the bottom of the pyramidal structure of mental health services are grassroots volunteer health workers termed '*Brigadistas*' and the mass organisations.

In a unique 'Strategy for Popular Training in Primary Health Care' devised by the Division of Education and Popular Communications in Health within the Ministry of Health (DECOPS/MINSA, 1983), health educators provide extended training of volunteer health workers known as *multipliers*. The

multipliers, in turn, train the *Brigadistas* at a local level, rather like cascade training. The effect is quickly to disseminate health information and care throughout the country. The Primary Health Care Brigadista is recognised as being the principal point of contact between the community and the SNUS (Donahue, 1986).

More recently, Brigadistas have been trained in psychological skills such as relaxation exercises, setting up self-help groups and dealing with the widespread problem of 'frozen-grief' (the somatisation of unresolved bereavement). The Marie Langer team (see below) also contributes to their training with information on family therapy, crisis intervention and so on.

Popular participation in the health sector mirrors participation of the people in defence, the economy and education. In fact, the government created mass organisations in order to facilitate participation in its programmes. Popular organisations such as the National Women's Organisation (AMNLAE), the street-based Sandinista Defence Committees (CDS) and the Sandinista Youth (JS) (recently seen handing out condoms on the streets of Managua at the launch of the AIDS prevention campaign) are involved in the execution of the Popular Health Work Days organising nationwide mass drug administration and sanitation campaigns.

The mass media are also widely used, for example, by the Nicaraguan Psychology Association (ANIPS) to broadcast TV and radio programmes on mental health and sex education. The advice column, 'A Letter to the Psychologist' is now a regular feature in *Barricada*, the daily newspaper of the ruling party, FSLN. A typical problem is that of a woman adapting to a new social role since the revolution, balancing a new career or university training with domestic commitments often against the wishes of her more traditional husband.

Community level

The primary unit for mental health services at the community level is the psychosocial care centre (CAPS), next to health centres of which there were about 17 throughout the country by 1986. Five of these are in the capital city, Managua. In that they are decentralised they go some way towards making mental health services more accessible to all members of the community. The aim is to make the CAPs a viable alternative to the hospital. These are day centres with group admission interviews, taking place on certain weekdays. A new client will attend an introductory group session in which diagnosis will take place. New clients will then meet for short-term dynamic group work lasting about 12 sessions. Referral to tertiary services such as neurology is also a possibility.

The psychosocial team typically comprises psychologists, a social worker, occupational therapists, a nurse and a psychiatrist. The staff provide out-patient assessment and treatment to individuals, groups and families; training of other professionals including Brigadistas and community liaison. They also carry out research.

In Managua, the staff include 14 workers from the Italian organisation, Group for Transcultural Relations, again reflecting the high degree of international support for Nicaragua's endeavours and the Italian influence on the development of mental health services.

In addition, team members travel to health posts in villages close to the CAPS. During these visits they will train and supervise Brigadistas, hold clinics, make home visits and collect statistical information. Following the emphasis on group work and the understanding of problems in a social context, most of the therapeutic intervention happens in a group setting with individual therapy a rarity (Kroese, 1987).

Children

Bedwetting, aggressive behaviour, sleep disturbances and school problems are the most reported problems in children. These are usually dealt with via a family intervention by the CAPs (where children make up 10% of patients) or by psychologists working for The Ministry of Education.

There are also 23 therapeutic day-centres in Managua to cater for children between 6 and 15 years who are not in residential facilities. A multidisciplinary team of teachers, psychologists, social workers and art therapists is employed. The centres also attempt to organise parent's groups in order to advise them on child management and family problems (Kroese, 1987).

Other community institutions

Schools, factories and rural productivity centres are also served by psychologists. At the work-place, psychologists are involved in the selection and promotion of personnel, as well as the provision of clinics for stress and other mental health problems. However, occupational psychology with a very different flavour to its first world Western counterpart is being developed. In rural productivity centres, for example, the Ministry of Agrarian Reform has been employing psychologists to work with rural peasants. The rural economy has been reorganised into co-operatives, but the ideological framework necessary for successful functioning has been lacking. Psychologists are part of a multidisciplinary team of agronomists and others, who train peasants for co-operative farming. They are facilitating the transition of peasants from being a hired hand under

the Somoza regime, to being a producer, following the post-revolutionary radical agrarian reforms.

Tertiary level

The tertiary level of services includes the psychiatric hospital in Managua, psychiatric wards in general hospitals, national facilities for abused and abandoned children and for the rehabilitation of war wounded and some national programmes organised at Ministry level.

Psychiatric hospital – Hospital Docente de Atención Psicosocial

There is still only one psychiatric hospital in Nicaragua, in Managua, which is described as lacking facilities and understaffed, but still a vast improvement on pre-Sandinista days. It lacks qualified staff due to high turnover. In 1989, there were eight psychiatrists, seven psychologists, five social workers, ten qualified nurses and 66 nursing assistants. Apparently, there are only between one and four graduates each year from the postgraduate course in psychiatry which was established in 1983. In November, 1988 it housed 150 patients.

An official policy of deinstitutionalisation was introduced in 1981. Admission to the psychiatric hospital is used as a last resort. Indeed, the Director of the hospital has proposed its eventual closure within six to eight years. However, some psychiatrists are still opposed to such a closure on ideological grounds.

In an attempt to challenge the social isolation of mental illness, patients will firstly be placed in general hospitals and will be admitted to the psychiatric hospital only under strict diagnostic criteria. These include emotional or organic psychosis, severe epilepsy and severe alcoholism, although more recently it has been stated that the majority of in-patients comprise alcoholics and people suffering from minor reactive disorders (Barricada International, 1988). Within the psychiatric hospital a ward has been set up for acute cases where intervention is carried out as soon as possible so as to return the patient back into society. The Mexico group (see below) has tried to infuse the psychiatric hospital with a critical awareness of the implications of psychiatric labelling as well as a scepticism of the traditional medical model. However, Kovel (1988) reports that traditional psychiatric practices with somewhat arbitrary prescribing of psychotropic medication, still prevail.

More recently, the Italian model of Basaglia, which totally rejects institutionalisation of psychiatric patients, has begun to have an influence at the psychiatric hospital. Indeed the number of beds was reduced from 600 at the time of the Revolution to 170 by July, 1986 (Kovel, 1988). Outside the capital, for

example, in Region 6, Esteli, acute psychosis is treated in the community with the multidisciplinary team at the Mental Health Centre in Esteli teaching families how to cope with the patients.

INSSBI Centre for 'Protection and Prevention'

This is a residential centre for children in Managua run by the Ministry for Social Security and Welfare (INSSBI) for children who have been abused, abandoned or who have special needs (mental, physical or sensory disabilities). There are four psychologists employed in the centre, who assess approximately 100 children, develop individual programmes and advise residential staff and children (Kroese, 1987).

A national children's mental health centre: 'Guadeloupe Ruiz Rios' reopened in Managua in early 1989. The Director is a psychologist – the first to hold such a post. It has also received material assistance from the Italian government and six Italian workers are based there in addition to the Nicaraguan staff.

Rehabilitation

Victims of the military defence against the Contra are treated with consideration of their psychological needs. A war victim with psychological problems will receive priority at the CAPS and other mental health services. But the Aldo Chavarria Rehabilitation Hospital in Managua is the only facility of its kind in Nicaragua. Here, psychologists undertake group assessments, run psychotherapy groups, provide individual psychotherapy and give psychosexual counselling. They are also involved in the Mobile Team (Equipo Movil) which serves the whole country and functions to reintegrate the patient back into their community. Home-based assessments are made and support and training work is carried out with the family. There is little equipment and no neurologists or neuropsychologists are employed in the hospital (Kroese, 1987).

International solidarity

Nicaragua has received advice and material support from a wide range of countries and groupings, but a major influence within the area of mental health is the 'Mexico Group', now called the 'Marie Langer Internationalist Group'. As part of the reconstruction of Nicaragua the new government invited this group to work and teach there. Since 1981, 2–3 members of the group, based in Mexico City, have been travelling to Nicaragua every month for a period of ten days. They have been involved in the following:

- (a) training psychiatrists, psychologists and social workers in group and family therapy techniques

- (b) restructuring the curriculum of the Faculty of Medicine
- (c) cascade training of Brigadistas and multipliers in therapeutic techniques to tackle the major mental health problems of frozen grief, burn-out and post-traumatic stress disorder and to set up self-help support groups
- (d) evaluation of government projects.

The team has a radical psychology tradition, drawing from psychoanalysis, systems theory and Marxism, with the assumption that psychological practice cannot be separated from political practice. Their stated goal has been the democratisation of services.

Clinical approaches

No single model of mental health care is used in Nicaragua. All approaches are being evaluated in order to assess which might be the most relevant to that particular social and economic reality. It is worth remembering that the revolution is only ten years old and the first steps are still being taken. Furthermore, because such a large proportion of the national budget needs to be spent on defence, little funding is available for mental health services. By the mid-eighties, there were only 14 psychiatrists for a population of 300,000 people. The main emphasis is on primary health care for mental health.

For psychiatric diagnosis, the DSM-III is used in the psychiatric hospital. Kovel (1988) attributes this to "the heritage of colonialism", believing that the practice of some of the doctors "within medical psychiatry has estranged them from the Revolution". Nevertheless, Dr Flores Ortiz, psychiatrist and founder of the mental health department of MINSAs, is an activist in the ruling party, FSLN. Psychologists, on the other hand, appear to have participated more centrally at all stages of the revolutionary process, developing a radical, new psychological theory and praxis from the beginning.

Psychotropic medication is apparently rarely used partly for ideological reasons but also because little is available due to the shortage of medical supplies. There has been a decline in its use over the last eight years. Kovel (1988) however, does report the administration of minor and major tranquillisers in the Managua psychiatric hospital. Electroconvulsive therapy has been reduced from 3000 applications a year during the 1970s to less than 30 a year at present (Barricada International, 1988). The prescribing doctor is required to administer it personally, in line with the policy of the mental health department of the SNUS.

Multidisciplinary work is seen as essential and mental health work is also integral to the general health structure. Such teams are non-hierarchical. In view of the high incidence of psychosomatic

disorders, there is a strong emphasis within the general health care system on the emotional aspects of physical health. In rural health posts, up to 50% of women patients have psychosomatic problems.

Much of the psychological distress in Nicaragua is a result of the war situation with a large proportion of the population suffering from post-traumatic stress disorder, frozen grief, total burn-out from stress in civilian occupations, geographical displacement and the full range of physical trauma. In studies conducted between 1985 and 1988 to investigate the relationship between the war and anxiety, 32% of the population were found to have a significant level of anxiety (Whitford, 1988).

But, cases of schizophrenia or depression, widespread in developed countries, are minimal according to Dr Evelin Kraude, assistant director of the psychiatric hospital (Barricada Internacional, 1988). Such claims are supported by Kovel's observation that the vast population of homeless people with mental health problems seen in US cities are "missing from the streets of Managua". This has been attributed both to the stronger sense of community in third world, Latin American countries and to the binding effect of the revolution: "For the masses there is simply less aloneness".

Since psychological distress is seen in a social context, there is an emphasis on group approaches. Individual therapy is almost never used (except occasionally for post-traumatic stress disorders) and is always brief. Rational therapy, behavioural approaches and Marxist approaches to psychotherapy are used. There are insufficient resources for long-term psychoanalytic treatment. Occupational therapy is limited by a lack of qualified staff. Every attempt is made to reduce the social isolation of the patient with mental health problems.

Comment

This paper has presented the model of Nicaraguan mental health care services as it has developed since 1979 when the Sandinistas came to power. It is difficult to provide a fully comprehensive picture given the dynamic nature of the country and the severe lack of systematic information.

The Nicaraguan system is putting into practice principles of participatory democratic mental health which are the goal of progressive mental health workers throughout the world. Some of the most inspiring aspects of the Nicaraguan model are precisely those which Britain lacks or is presently losing. Firstly, a comprehensive, national mental health plan, co-ordinated with other national sectors such as education. Priority is given to prevention and to arrangements which encourage the community to

participate in the health care system. Popular organisations have been created to facilitate this. Social factors are emphasised in the aetiology of disease and health problems with a consequent attention to ameliorating social and economic causes of mental health problems. This has informed the development of group or social interventions rather than the individualisation of problems. The service is accessible and decentralised and there has been an effort to enhance health status through more equal access to goods and services. Moreover, there is a process of popularisation and demystification of psychological knowledge. The widespread training and use of lay-people is under way. Finally, there is the gradual destigmatisation of psychiatric patients and their integration into the community.

The conclusion is that an impoverished third world country with few material resources but with many progressive ideas can introduce innovations in the structure and the functioning of mental health care services, providing models for industrialised countries like Britain where services have been established for much longer.

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A full list of references is available on request to the authors.