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Community mental health, primary health care, and health-promoting universities in Ecuador*

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ABSTRACT *The objective of this paper is to describe the current situation of mental health in Ecuador. In Ecuador, although the model of community mental health has been integrated into primary health care services for a decade, its implementation does not seem to have achieved the expected results. It is pertinent to explore the causes of this situation and to propose alternatives, taking into account the contributions of social medicine, collective health, and participatory action research as emblematic models in Latin America in the field of mental health. For an effective implementation of community mental health in primary care in Ecuador, the role of universities is central, specifically in projects linked to the community and in preprofessional practices in health science careers. These projects allow the promotion of community mental health at the first level of health care from a critical perspective, open to complexity and based on the principle that the community is the main active subject of social transformation.*

Key words Mental health; primary health care; community participation; universities; Ecuador

The mental health system in Ecuador has evolved over the past decade and is hailed as one of the main achievements of the country's integrated family, collective, and intercultural health care model (*modelo de atención integral de salud familiar, colectivo e intercultural* – MAIS-FCI). In this model, mental health is considered to depend not only on biological factors but also on living conditions. Furthermore, it recognizes the role of users, families, and social organizations, as well as the central role of health professionals, especially those who work in the primary care services (1).

Since 2007, the national government has sought to follow the principles agreed upon by the member states of the World Health Organization (WHO) at Alma-Ata 40 years ago—namely: to protect and promote the health of all the people of the world, with primary health care (PHC) as the guiding principle of an integrated health system. This model seeks to replace the medical-biologistic-curative approach with one focused on the promotion, care, and recovery of individual, family, and community health as a human right (2).

Other significant steps forward in this process have been the Strategic National Plan and the Mental Health Care Model 2015–2017, which have sought to replace the curative/hospital-focused model with a community care model. For this purpose, they have promoted the development of PHC services and coordination between these centers and the second level of care, facilitating the process of deinstitutionalization (3).

Despite the foregoing achievements, the mental health system in Ecuador has

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limitations that make it difficult to implement this new legislation. They include:

1. Insufficient funding in a budget that gives priority to supporting the second and third levels of care. In 2012, the total allocation for health was US$ 1,881,061,107, of which only 0.44% (US$ 8,308,210) was designated for mental health, and of this amount, 98.57% was for psychiatric hospitals. This trend continued in 2014, when only 1.46% of the health budget was set aside for mental health, and almost half was for investments in psychiatric hospitals (4).
2. The primary mental health care services do not have enough professionals or PHC centers to meet the needs of users. This situation often leads them to "self-refer" to institutions at the second and third levels of care (5).
3. Most of the professionals who work in the PHC centers lack resources, competencies, and expertise in the area of mental health—much less in community mental health. It is therefore quite challenging for them to meet the needs of users and comply with the terms in the Integrated Family Health Care Model (MAIS). As a result, they tend to refer users to facilities at the second and third levels of care.
4. At the same time, the mental health system in Ecuador continues to favor the biomedical model for evaluation, diagnosis, and interventions, omitting the family and community component. Because of this limitation, mental health care tends to focus on reducing symptoms in the individual without considering the family and community context. This is one of the reasons why the numbers of cases continues to rise in the health centers, along with psychosocial problems in the community. The current public health scenario is governed by a paternalist perspective (product of the disease-centered biomedical model), adopted long ago and deeply rooted in users and professionals, which continues to stand in the way of executing the mandates of the country's current legislation (6).

In summary, even though Ecuador's current mental health legislation promotes the PHC-integrated community mental health (CMH) model, the limitations described above are preventing its effective implementation. And there is still another highly important drawback: the existing academic and professional training programs are unable to prepare the human resources needed to meet the legal requirements for offering CMH within PHC. Even though recent years have seen progress in the development of higher education in this area, many health professionals in Ecuador do not have specific training in mental health at the undergraduate or graduate level. To compound the problem, pre-professional practices in the health science programs are based on the hospital-focused model (7). Furthermore, few academic or health institutions offer community-oriented in-service practicums in mental health, nor do university-level teachers have specific competency in health promotion. The exception is the graduate program in family medicine, which includes training in mental health, capacity-building to handle mental health problems, management of psychotherapeutic agents, and systemic psychotherapy, but the depth of the training varies among universities (8). Against this background, the specific objectives of this manuscript are to reflect on some ideas for integrating CMH into PHC; discuss the complexity of the issue from a critical perspective; and suggest the fundamental role that universities can play in improving health care in the context of pre-professional practices and outreach to the collectivity. In addressing social and community practices in health from this perspective, we rely on the rich theoretical output of the Latin American social medicine/collective health movement.

Community mental health and primary health care: a critical overview

As indicated above, CMH requires a detailed, substantive, and well-intentioned policy along with legal norms to regulate it. However, the policy will be empty words unless human and economic resources are available to put it into practice. Nor can it be effective unless it represents an epistemological break with the traditional medical-biologicist-curative model. It must be more than merely a localized outpatient remedy that connects the health care structure with users outside the orbit of hospital services. This "domesticated" version of CMH—the paternalist-curative approach proposed by public agencies—comes up short. From the perspective being proposed here, CMH is an innovative proposal within the panorama of the social and health sciences. Unlike the prevailing traditional models in psychiatry and clinical psychology, which prefer to focus on the study and treatment of disease, the integrated CMH proposal approaches its task from the perspective of health promotion and protection using an investigative methodology that includes community participation (9).

The increase in psychopathologies and psychosocial problems is all the more reason to seek an integrative approach that is not limited to working with individuals and their particular set of problems/psychopathology, but rather extends attention, evaluation, and prevention to the family and community level. The integrated CMH model encompasses problems in the community, including active engagement in social participation and the incorporation of mental health in PHC, with priority on the prevention of psychopathologies/psychosocial problems and the promotion of mental health (10).

Bearing in mind the above, we now turn to the proposals offered by the Latin American social medicine/collective health movement, especially its main authors in Ecuador, as basic theoretical, methodological, praxeological, and above all ethical and political references for rethinking and reformulating the country's current model and the community mental health policies, particularly within the context of primary health care. The Ecuadorian authors of this school of social medicine emphasize the importance of expanding the country's current vision of health. They point to the deterioration of services provided under the logic of the unicausal biomedical paradigm, which has clearly failed to solve growing health problems (11).

For these authors from the School of Public Health, it is essential to accept a new understanding of health as a process that interacts with all the spaces in which the individual lives and develops. They construct an alternative proposal, which they call *social medicine and collective health*. Essentially, it should: (a) break free of the traditional biologicist public health mold, incorporate advances in social epidemiology, integrate history in its real dimensions, recognize heterogeneous structural reality as a fundamental

determinant, and adopt social dynamics as the axis of interpretation; and (b) replace the empirical-positivist method with a dialectic and participatory approach to interpreting health problems (12).

This approach opens up the prospect of changing conventional public health, expanding its horizons, and studying the potential to reconstruct public health in a field of action that offers an alternative to the biomedical hegemonic model, moving forward in an integrated manner and allowing individuals and collectivities to generate their health on a daily basis while building their own proposals for supporting and promoting health, preventing diseases, and providing care (13).

It also tells us that the events that lead an individual to get sick affect more than one person and can potentially affect an entire community. It is not that they are generated within an individual space, family, or group and spread outward to others; rather, they are produced and spread within the collectivity as a whole and extend to all of society. Thus, when health is approached as a collective problem, it is necessary to propose an interpretation to transcend the linear and reductionist view of health as the effect of isolated causes in order to understand health in all its complexity (14).

The premise of the social medicine and collective health approach, which applies to CMH and PHC, is to intervene by promoting protective and healthy lifestyles, coupled with preventive measures aimed on countering the precipitating risk factors, in the knowledge that these measures are effective and that they encompass the three dimensions of the person's reality: individual, family-group, and community.

The community mental health model is also closely related to participatory action research (PAR) in that it departs from viewing mental health problems in the context of the biomedical model, under the control and domination of the institution and "expert" professionals, and turns the process into participatory reflection together with the community in order to construct knowledge and actions. This approach is based on the recognition that mental health is related to the well-being of society and the collective life of the community in a horizontal relationship between professionals and mental health users in which both produce and share wisdom and understanding (10).

In this sense, PAR is one of the most important resources for the community mental health model, as it involves all parties as protagonists in the production of appropriate knowledge for transformation of their reality. The participation of all actors is key, especially community participation. Thus, PAR is both an investigative approach and a methodology for social intervention applied to the study of the realities encountered in the various contexts of human life. In this intervention, the population is also aware of the objectives and participates actively with the investigator in the analysis of the situation and the consideration of concrete measures to change it. At the same time, PAR becomes a tool for promoting active cohesion in the community as a basis for participation, helping its members to discover problems and consider solutions. It is a process that includes the promotion and democratization of knowledge for the purpose of transforming and improving a community's situation (9, 15).

Addressing all these elements, along with the sociological, clinical, and epidemiological implications of mental health problems, means that the culture of PHC professionals will have to change. Above all, it will be essential to increase their sensitivity for working in the psychological and social dimensions, their competency in health promotion and in the prevention, diagnosis, and treatment of the most prevalent mental health problems, and their community involvement and capacity to promote the coordination of the health and non-health resources involved in the care process. All this is necessary because the integrated practice of CMH within PHC extends beyond the specific field of psychopathology. Some studies, such as those by Ciompi, have shown that learning a patient's history and working with them on a shared vital endeavor are more effective than medicines or hospitalization (16).

The community mental health model applied to primary health care provides a practical strategy for promoting mental health in the case of Ecuador, as well as an opportunity to reflect on its origin, foundation, objectives, and implementation in policies and practices. This leads us to the important role of the country's public university system in assuring the quality and relevance of the education provided and in developing the practical and theoretical competencies in community mental health that the professionals who work in the PHC centers should possess. Although few universities offer undergraduate or graduate programs in CMH and PHC, there is no lack of initiatives and projects under way that seek to carry out the mandate we have inherited from Alma-Ata.

Health-promoting universities

These universities offer opportunities to carry out projects aimed at greater connection with the collectivity and pre-professional practices that are not geared toward the biomedical curative/hospital-focused model. A single school, serving society through community-linked activities and pre-professional practices, can start the shift from the current disease-based health sciences to health-based sciences. There are a number of examples in Ecuador's universities, including many higher education institutions in the Ecuadorian Network of Universities Promoting Health and Well-being (*Red Ecuatoriana de Universidades Promotoras de Salud y Bienestar* – REUPSB), such as community-linked activities and pre-professional practices in CMH conducted by the Psychology Department of the Eloy Alfaro Lay University of Manabí (ULEAM) following the earthquake of 16 April 2016, which we describe below.

In the context of disasters, it is clear that that the most meaningful function of the university—its raison d'être, its social relevance—is to attend to the needs of the collectivity and lend assistance in finding solutions. And that is what all of us in the academic community at ULEAM set out to do just minutes after the earthquake struck at 6:58 p.m. on 16 April 2016.[2]

The community-linked project "Community Strengthening in Rural Areas Affected by the Earthquake in the province of Manabí" (*Fortalecimiento comunitario de las zonas rurales afectadas por el terremoto en la provincia de Manabí*), conducted by students and faculty form the Psychology Department at ULEAM and a team from

[2] One of the most devastating events in the history of Ecuador occurred on 16 April 2016, when an earthquake at 7.8 degrees on the Richter scale resulted in 663 deaths and the disappearance of nine other persons. As of mid-May 2017, 7,633 families, or a total of 28,775 individuals, were still living in temporary shelters.

the International Committee for the Development of People (*Comitato Internazionale per lo Sviluppo dei Popoli* – CISP), was one among the many components of the macro project "Reconstruction of Manabí" carried out by ULEAM in coordination with various entities at the canton, provincial, national, and international levels, and, of course, with the people affected by this terrible event.

Through this project, individual, family, and community psychological care was provided in a number of rural and periurban areas that had not received any other aid since the disaster struck. The project gave people the opportunity to express their emotions and talk about their experiences through active listening and to receive psychological first aid. As for CMH and PHC, ULEAM had already begun to work within the disaster framework long before the project began. However, since the earthquake had presented a situation for which the ULEAM team was unprepared, they could only try to do their best and learn as they worked with the affected population, building a relationship of assistance focused on the emergency response. As a result of this project, we feel that the ULEAM Psychology Department developed a more organized presence. It also showed that it is able to provide care that focuses on meeting emergency needs, which was necessary at the outset. Furthermore, after this initial phase, it also managed to position itself as a serious actor, demonstrating that it operates in an organized manner and plans ahead, taking into account the needs of the population while at the same time using supervised resources and methods designed specifically for use in the field. No longer providing therapy and encouraging emotional discharge, it shifted to bringing out the potential of communities from a more integrated social, no longer simply clinical, perspective, with the goal to empower community members to adopt resilient positions, attitudes, and practices.

Another important byproduct of this experience was the Psychology Department's decision to redesign its curriculum, incorporating courses in emergency management and disaster response from the perspective of clinical psychology, community psychology, and the social sciences.

In addition, a community mental health research group was formed, bringing together teachers, students, and various social actors. Based on the participatory action research (PAR) model, one of its main objectives was to identify and characterize a resilient population profile that would encourage healthy organization, psychoeducation, and approaches to problem-solving, not only in emergencies. The group also proposed community health and mental health approaches, methodologies, and practices, including community-linked projects integrated and coordinated with research, teaching, and pre-professional practices, that can be carried out in PHC centers in Ecuador.

It is important to emphasize that this intervention demonstrated the need to include CMH in health policies and university academic programs for the development of future PHC professionals.

Mutual support and articulation between professionals at the primary and secondary levels of care.

Finally, it appears that Ecuador now has the necessary political will and technical strength to implement a model for CMH integrated into PHC, even though the funds available for this area are limited and the biomedical curative/hospital-focused model continues to prevail. As we have shown in this article, despite the challenges and needs that have been mentioned, a new perspective on CMH and PHC is possible if the postulates of social medicine, collective medicine, and PAR are taken as theoretical, methodological, and praxeological referents, as has been demonstrated in various studies conducted elsewhere the Region (17, 18).

An effective idea for supplementing the limited investments in Ecuador's mental health system might be to reorganize the current services and human resources available to universities that promote health, especially if they receive support from government agencies or international organizations such as the World Health Organization or the Pan American Health Organization (19).

The experience of integrating CMH into PHC in the project carried out by the ULEAM Psychology Department shows that this process is possible in Latin American countries, and that it can make an important contribution toward improving availability and accessibility in a scenario of insufficient resources (20). The experience generated some lessons for the Region, among them that a national mental health policy and/or plan can play an important facilitating role, and that it will be necessary to allocate additional resources to support the provision of mental health services in PHC and generate mechanisms to encourage its implementation.

Conflicts of interest. None declared.

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Salud mental comunitaria, atención primaria de salud y universidades promotoras de salud en Ecuador

RESUMEN

El objetivo de este trabajo es describir la situación actual de la salud mental en Ecuador. En Ecuador, aunque el modelo de salud mental comunitaria está integrado en los servicios de atención primaria de salud desde hace una década, su implementación no parece tener los resultados esperados. Resulta pertinente indagar sobre las causas que determinan esta situación y proponer posibles alternativas, tomando como referencia los aportes de la medicina social, la salud colectiva y la investigación de acción participativa como modelos emblemáticos en América Latina en el ámbito de la salud mental. Para la implementación eficaz de la salud mental comunitaria en la atención primaria en Ecuador es trascendental el rol que poseen las universidades, en particular en los proyectos de vinculación con la comunidad y en las prácticas preprofesionales de las carreras de ciencias de la salud. Estos permiten incorporar prácticas de promoción de salud mental comunitaria en el primer nivel de atención de salud desde una perspectiva crítica, abierta a la complejidad y basada en el principio de que la comunidad es el principal sujeto activo de transformación social.

Palabras clave Salud mental; atención primaria de salud; participación de la comunidad; universidades, Ecuador.

Saúde mental comunitária, atenção primária à saúde e universidades promotoras de saúde no Equador

RESUMO

O objetivo deste artigo é descrever o estado atual de saúde mental no Equador, um país onde embora o modelo de saúde mental comunitaria está integrado em atenção primária à saúde por uma década, sua implementação parece não ter os resultados esperados. É pertinente indagar sobre as causas que determinam essa situação e propor possíveis alternativas, tomando como referência as contribuições da medicina social, da saúde coletiva e da pesquisa-ação participativa como modelos emblemáticos na América Latina no campo da saúde mental. Para a implementação efetiva da saúde mental comunitária na atenção primária no Equador o papel das universidades é crucial, particularmente em projetos ligados à comunidade e nas práticas pré-profissionais das carreiras das ciências da saúde. Estes permitem incorporar práticas comunitárias de promoção da saúde mental no primeiro nível de atenção à saúde sob uma perspectiva crítica, aberta à complexidade e baseada no princípio de que a comunidade é o principal sujeito ativo da transformação social.

Palavras-chave Saúde mental; atenção primária à saúde; participação da comunidade; universidades; Equador.