

WHO-AIMS

WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
IN PANAMA



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*Report on the Assessment of the Mental Health System in Panama using the World
Health Organization Assessment Instrument for Mental Health Systems
(WHO-AIMS)*

Panama, 2006



*Ministry of Health of Panama
Pan American Health Organization (PAHO/WHO)
WHO Department of Mental Health and Substance Abuse*

This publication was produced by the PAHO/WHO Representation in Panama in collaboration with the Ministry of Health of Panama, the Pan American Health Organization Regional Mental Health Unit (PAHO /WHO) and the World Health Organization (WHO) headquarters. This work has received support from WHO, Geneva, by the Evidence and Research Team of the Department of Mental Health and Substance Abuse, Area of Non-communicable Diseases and Mental Health.

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Pan American Health Organization/World Health Organization, 2006

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Acknowledgement

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system of Panama.

This study was carried out by Yamileth Gallardo de Velasco, commissioned for this purpose, by the Pan American Health Organization (PAHO/WHO) offices in Panama. Technical support was provided by the Regional Unit of Mental Health and Specialized Programs of PAHO/WHO and the Evidence and Research Team of the Department of Mental Health, WHO in Geneva.

The development of this study has also benefited from the assistance of the National Institute of Mental Health, the Department of Psycho-educational Services of the Ministry of Education, the Department of the National Police for the Employees' Wellbeing, the Department of Analysis and Tendencies, the National Directorate of Health Services Provision of the Ministry of Health, the ANFAPEM Boards of Directors, and Yo Tengo Mi Espacio (*I Have My Space*).

The preparation and execution of the WHO-AIMS study would not have been possible without the contribution of the Ministry of Health and the Social Security Entity, particularly of the mental health teams from both institutions. Our special thanks to Juana Herrera and Fanía de Roach for their support; as well as the cooperation provided by the Pan American Health Organization representation in Panama.

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) has been conceptualized and developed by the Mental Health Evidence and Research Team (MER) of the Department of Mental Health and Substance Abuse (MSD), World Health Organization (WHO), in collaboration with colleagues inside and outside of the WHO.

Please refer to *WHO-AIMS* (WHO, 2005) for full information on the development of WHO-AIMS at the following website.
http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html

The project received financial assistance and/or seconded personnel from: The National Institute of Mental Health (NIMH) (under the National Institutes of Health) and the Center for Mental Health Services (under the Substance Abuse and Mental Health Services Administration [SAMHSA]) of the United States; The Health Authority of Regione Lombardia, Italy; The Ministry of Public Health of Belgium and The Institute of Neurosciences Mental Health and Addiction, Canadian Institutes of Health Research.

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The WHO-AIMS project is coordinated by Shekhar Saxena.

Forward

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) is a new tool that has been developed by the World Health Organization (WHO) for collecting essential data on the mental health systems of a country or region.

The assessment work using WHO-AIMS began in December 2005 and continued to the beginning of 2006. In order to increase reliability, available information was collected from different sources. Subsequently, there were numerous interviews and a national meeting was held to provide some additional validation.

This document contains the final report which identifies the principal limitations and problems of the mental health system of Panama. There is also information on the progress that Panama has made in mental health over the last several years.

It is worth mentioning that, among all Central American countries, Panama has made great progress with regards to mental health. Panama holds a prominent position in Latin America; in the “Regional Conference for the modification of mental health services, 15 years after Caracas”, held in Brazil, the Panamanian experience on the decentralization of mental health services was highlighted in the final statement.

Panama has shown encouraging progress in mental health, such as a 63% reduction of psychiatric beds at the National Institute of Mental Health (former Psychiatric Hospital) over the course of the last 5 years. Additionally, a specialized network of mental health services covers most of the national territory. Furthermore, human and financial resources are not concentrated in psychiatric hospitals, but have been distributed throughout outpatient services and psychiatric units in general hospitals. I believe that this situation provides the country with superb conditions to continue to progress in this important field.

From this point, the most important task will be to transform the assessment we have recently completed into a working tool for planning and implementing new action. PAHO/WHO representation in Panama is confident that this project will contribute to better mental health for the Panamanian population.

Dr. Guadalupe Verdejo
PAHO/WHO Representative

Executive Summary

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Panama. The goal is to improve the mental health system and provide a baseline for monitoring the change. This will enable Panama to develop information-based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

Panama does not have a current mental health policy; however a national plan on mental health has existed since 2003. Since then, the plan has been significantly implemented. In 2005 the Plan for Mental Health Protection was updated to include mental health in emergency and disaster situations. The country does not have legislation on mental health, however, there are numerous provisions on the subject scattered throughout different legal bodies. While certain legal provisions on mental health exist, such provisions are not always fully implemented.

It was estimated through this assessment that 3% of the Ministry of Health general budget is assigned to mental health, 44% of which is directed to the National Institute of Mental Health. Although the percentage of the health budget devoted to mental health is greater than other Central American countries, our goal is to increase expenditures on outpatient services as well as those services linked to primary health care.

Mental health services are organized by levels of care and complexity, forming a network under two public institutions providing health services (Ministry of Health and Social Security Entity). While they both provide basic coverage, the number of existing facilities is insufficient. In particular, day treatment and residential facilities are unevenly distributed throughout the Republic, and there is no forensic inpatient unit. Although there is a good balance of psychiatric hospitals and psychiatric services in general hospitals, it is necessary to increase the number of beds reserved for psychiatric patients in general hospitals.

Primary health care is strengthened by the presence of mental health teams, however we have to promote and formalize mental health training for staff that work at this level. Despite efforts made in the last few years, there are still insufficient human resources, especially in some of the territories in the interior of the country.

In Panama the mechanisms for human rights protection for patients with mental problems are not systematized. Mental health facilities are not regularly supervised; this responsibility should be exercised by the Ombudsman Department as an external health entity.

The concentration of human and institutional resources in the country's capital creates unequal conditions for access to mental health services by users from rural and indigenous areas. At present, there is no clear strategy to address this problem.

The Ministry of Health information system does not provide enough data for a systematic and comprehensive analysis of the mental health situation in the country, which would support evidence-based action.

We have detected the following critical barriers to the provision of mental health services:

- Lack of continuity of some processes, in particular the development of plans and services, because of government changes.
- The stigma, still present, expressed by the population's fear of any change in the traditional system of psychiatric care and in the integration of mental health patients in the community.
- Duality of functions and services among public health providers (Ministry of Health and the Social Security Entity), which supports poor distribution and use of resources directed towards mental health.
- Lack of standards and protocols related to mental health care as well as a regular monitoring and surveillance system.
- The Anita Moreno Hospital's psychiatric services do not meet the conditions for long stay patients. While efforts are being made to improve these conditions, these efforts should be increased to ensure a complete and definitive modification of these services.
- There are limitations and irregularities in the provision of essential psychotropic drugs to both mental health outpatient and primary health care clinics.
- Lack of community measures for long-term rehabilitation and treatment of patients with mental disorders.

The following highlight are some of our achievements:

- Ongoing development and strengthening of decentralized mental health services, mainly primary care in the country's urban areas.
- Reduction in the number of beds in the National Psychiatric Hospital and an organized integration of many patients in the community.
- Reorganization and transformation of the National Psychiatric Hospital into the National Institute of Mental Health in 2004.
- Resolution of the Technical Council (2003) that prohibits the application of electroconvulsive therapy without anesthesia and provides standards for its application.
- Creation and sustainability of intersectoral networks, such as the "Network for the prevention of depression in the work environment" established in 2003.
- Progressive strengthening of user and family associations that are playing more active roles in human rights protection of patients with mental disorders.

INTRODUCTION¹

The Republic of Panama is located in the Central American isthmus with a geographic area of approximately 75,040 square kilometers and a population of 3,172,362 million (population density of 42.27 people per square kilometer). 50.5% of the total population are males, and 63% of Panamanians live in urban areas.

The national territory is divided into 9 provinces, 75 districts or municipalities, 620 counties (two are indigenous areas) and 3 indigenous regions. Indigenous people (Kuna, Embera and Wounaan, Ngobe Buglé, Teribes and Bri Bri) have a well-defined history, ethnicity, geography and jurisdiction, and constitute nearly 9% of the population. The indigenous people of Panama exhibit social exclusion, and poverty levels within these regions exceed 90%. The official language is Spanish, and there are other languages spoken in the indigenous regions. An estimated of 93% of Panamanians are Catholics and another 6% belong to other Christian confessions.

53.1% of the population in Panama is in the reproductive age group (15 to 49 years), 18.7% are adolescents (10-19 years), 8.6% are young people (20-24 years) and 10% are preschool children (0-4 years). The population under the age of 15 has decreased from 41% in 1980 to 31% at the present time. In summary, Panama is a country under demographic transition. In the future most of the Panamanian population will be of economically productive age, but there will also be a high number of older people that will raise new social and health demands. The aging rate is the highest in Central America. At present, life expectancy at birth for the general population is 75 years (77.6 for females and 72.5 for males).

The Ministry of Health and the Social Security Entity are the principal health care providers in Panama. In 2004 62% of the population was covered by the Social Security Entity. There are 852 health facilities in the public sector, 42 of which are hospitals. There are .0018 beds per 100,000 population.

With regards to human resources there are 1.32 doctors, 1.13 nurses and .26 dentists per 100,000 population. Human resources are unevenly distributed throughout Panama.

According the World Bank, Panama is a middle to high income country. 37.2% of the population live below the poverty level. Social expenditure is relatively high and represents approximately 45% of the public expenditure and 20% of the GDP. Social expenditure during the last decade has showed sustainable growth, however the country has not been able to significantly reduce social inequalities.

Data collection began in December 2005 and continued through the beginning of 2006, and is based on the year 2004.

¹ Basic Indicators of Health. Panama 2005. Published by the Ministry of Health in collaboration with PAHO / WHO. Analysis of Health Condition in Panama. Published by the Ministry of Health in collaboration with PAHO / WHO. Panama, 2005.

Domain 1: Policy and Legislative Framework

Policy, plans and legislation

Panama does not currently have a national mental health policy. However it has a National Plan on Mental Health, which was drafted in 2003. This plan consists of the following components: developing mental health services in the community, downsizing large mental hospitals, reforming mental hospitals to provide more comprehensive care, developing a mental health component in Primary Health Care (PHC), developing human resources, enhancing the involvement of users and families, defense and protection of human rights of people with mental disorders, financing of services, quality improvement and a monitoring system.

Panama has a contingency plan for mental health in disaster and emergencies, which was completed in 2005.

A current essential drugs list, both at the Ministry of Health and the Social Security Entity, includes anti-psychotics, anxiolytics, antidepressives, mood stabilizers and antiepileptic drugs.

Panama does not have legislation on mental health as such, but there are several subjects in different codes, laws and resolutions that make reference to mental health. Therefore, the last legal documents on mental health were passed in 2003. Below you may find some of the most important codes, laws and resolutions:

- Criminal Code of Panama containing specific aspects in connection with the non-culpability due to mental disorders, alcoholism and drug addiction. (Chapter III, articles 23, 24, 25, 26, 27, 28 and 29 of the Criminal Code).
- Law 68 as of November 20, 2003 delineates the rights and obligations of patients regarding information and free and informed decision; however, this law has not been implemented yet.
- Resolution No 4 as of July 29, 1993 approving General Psychiatric Residence.
- Resolution No 1 as of April 7, 2003 recognizing the suitability of child and adolescent psychiatrists.
- Resolution No 4 as of September 2, 2003, prohibiting the application of electro-convulsive therapy without anesthesia and vital support provided by a qualified clinical team in public and private health facilities.
- In addition, there are also references and guidelines on mental health and psychiatric care in the Family and Minor Code, the Sanitary Code and the Administrative Code of the Republic of Panama.
- Currently the recognition of sub-specializations in psychiatry by the Technical Health Counsel is in process.

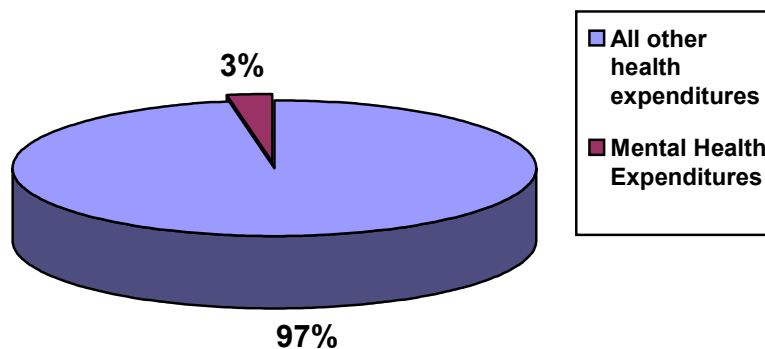
Financing of mental health services

Approximately 3% of the Ministry of Health's total budget is directed towards mental health. 44% of all the financial investment in mental health is directed towards the National Institute of Mental Health, known previous to 2004 as the National Psychiatric Hospital.

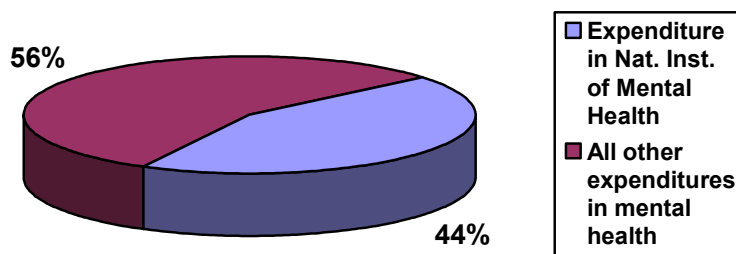
61% of Panama's population has free access (at least 80% covered) to essential psychotropic medicines as they are covered by social security schemes. Furthermore, all mental disorders and all mental health problems of clinical concern are covered. For those who pay out of pocket, the cost of antipsychotic medication is USD \$0.81 per day and the cost of antidepressive drugs is USD \$0.76 per day. As the minimum wage is USD \$8.80 per day, medicine expenditure for both antipsychotic and antidepressive drugs represents 9% of the minimum wage.

With the current accounting systems it is difficult to breakdown the budget assigned to mental health, with the exception of the National Institute of Mental Health. This facility is part of the global budget for the health ministry, which is prepared according to expenditure targets and not to programs. Furthermore, the percentage of mental health expenditures by the government health department does not include funding allocations to social security or to programs implemented by health regions through the Work Fund.

**GRAPH 1.1 HEALTH EXPENDITURES
TOWARDS MENTAL HEALTH**



**GRAPH 1.2 MENTAL HEALTH EXPENDITURE
TOWARDS MENTAL HOSPITALS**



Human rights policies

The Ombudsman Department is the national review body responsible for human rights surveillance and has the authority to carry out systematic reviews and inspections of mental health services, as well as to supervise or execute complaints and appeals investigation processes. However it does not have the authority to impose sanctions other than moral. The Human Rights Commission of the National Assembly also exercises this responsibility, but neither of these two entities has established regular and systematic supervisions to cover all mental health facilities.

The National Institute of Mental Health that until April 2004 was known as the National Psychiatric Hospital has received some visits and inspections to evaluate the human rights of patients, but there is no systematic ongoing program in place. The Anita Moreno Regional Azuero Hospital, as a community based hospital with a psychiatric unit, faces a similar situation. The remaining general hospitals' psychiatric services have not received any inspection or supervision on this matter. In the year of this assessment (2004), none of the facilities were inspected to evaluate human rights protection.

In 2004, All National Institute of Mental Health (INSAM) staff had at least one day training, meeting or other type of work session on human rights protection of patients. Staff from community based psychiatric inpatient units, however, did not receive any training on human rights protection.

In Panama, the reorganization of psychiatric care has been a long and difficult process spanning the last 15 years, with the integration of long-term patients from the mental hospital to the community. This transition has required special attention to ensure that the human rights of all patients are protected.

Domain 2: Mental Health Services

Organization of mental health services

Mental health services in Panama are regionalized. The Republic is divided into 14 health regions, each of which has a Mental Health Coordinator who is the mental health authority in that specific region. These authorities are involved in the planning, management and coordination of mental health services.

The Ministry of Health (MINSa) created a National Commission of Mental Health in 2002 and their responsibilities are currently under revision. The Social Security Entity (CSS) also has a national authority of mental health that coordinates mental health services throughout their facilities

The Mental Health Teams are integrated under the General Health Services of each of the health regions. In the interior of the country, mental health teams work at both levels (hospitals and primary health care centers). Health regions in Panama City (Metropolitan and San Miguelito) have mental health services at both the hospital and primary care levels, each with its own human resources. As a result, some problems in the coordination of the different levels of services provision have arisen.

The integration of services between the public providers, MINSa and CSS, is more effective and operational in the interior of the country, in contrast to in the capital, where services are segmented. The national mental hospital is organizationally integrated with all of Panama's mental health outpatient facilities.

Mental health outpatient facilities

There are 103 mental health outpatient facilities or services available in the country, of which two are for children and adolescents only. These facilities treat 18,648 users (estimated number based on contacts) or of 587.83 users per 100,000 population (general population). Of all users treated in mental health outpatient facilities 57% are females and 33% are children and adolescents.

The users treated in outpatient facilities are primarily diagnosed with neurotic disorders, associated with stress and somatoform disorders (33%) and mood disorders (23%). The total number of contacts (cases seen) was 93,239, and the estimated annual average of number of contacts per user is 5.

None of the outpatient facilities provide follow-up care in the community on a regular and formal basis. There are also no mental health mobile teams; however this is a goal for some of the country's regions.

In terms of available treatments, 21% to 50% of the outpatient facilities provide psychosocial treatment and 70% of the mental health outpatient facilities have at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic,

and antiepileptic medicines) available in the facility or a near-by pharmacy all year round.

Day treatment facilities

There are three mental health day treatment facilities, none of which are for children and adolescents only. These facilities treat 201 cases or 6.34 users per 100,000 population. Of all the users treated in day treatment facilities 47% are female. These facilities do not provide treatment for patients under the age of 18. The average length of treatment for patients in mental health day treatment facilities is 21 days.

Community-based psychiatric inpatient units

There are 8 community-based psychiatric inpatient units (psychiatric services in general hospitals) that have a total of 284 beds, or 8.95 beds per 100,000 population. Three percent of the total number of beds in these units are reserved for children and adolescents only. These psychiatric services correspond with regional and national general hospitals. Private hospitals do not have an area assigned to psychiatric admissions and admissions to these facilities for psychiatric patients is based on whether there are available beds when one is needed.

61% of admissions to community-based psychiatric inpatient units are female and 6% are children or adolescents. The diagnoses of admissions were primarily from: mood disorders (49%) and schizophrenia (17%). On average, patients spent 15.7 days per discharge.

It is estimated that between 51% and 80% of patients in community-based psychiatric inpatient units received one or more psychosocial interventions in the last year. All of the community-based psychiatric inpatient facilities have at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility all year long.

Community residential facilities

There are no community residential facilities for patients with mental disorders in Panama.

Mental Hospitals

The National Institute of Mental Health (INSAM) is an entity that provides inpatient services and, until 2004, was known as the National Psychiatric Hospital. For the purposes of this study it is a mental hospital. INSAM has 200 beds, or 6.3 beds per 100,000 population. It is important to mention that there has been a 63% reduction in the number of beds in the last five years.

INSAM is part of the public services network, of which the mental health outpatient units are also an important component.

INSAM does not have beds reserved for children and adolescents only, as it only receives adult admissions. However, there is a program in the Center of Studies and Addiction Treatment (that is part of the hospital) that offers treatment to youngsters with addictive behavior. In general,

children and adolescents are referred by school centers or brought in by family members. Six percent of the admissions to INSAM were children and adolescents and 39% of total admissions were female.

This hospital treated 710 patients in the year of study (2004), or 22.4 cases per 100,000 population. Admitted patients belong primarily to the following diagnostic groups: schizophrenia (33%) and affective disorders (26%).

The average length of stay in the mental hospital was 72.91 days per patient. When evaluating inpatients it was determined that 32% of them spend less than one year and 68% have spent more than 10 years at the hospital. Patients who have spent more than 10 years are those who could not be integrated into the community, many of whom are elderly patients in the geriatric unit.

With regards to available treatments, 100% of the patients in INSAM received at least one or more psychosocial interventions in the last year. INSAM has at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility all year round.

Forensic and other residential facilities

Panama does not have any facility that could be considered a forensic psychiatric unit. Prisoners requiring specialized care are admitted to general hospital units that are not strictly for mental health care. However, a technical cooperation agreement exists between the Ministry of Government and Justice and the Ministry of Health for the treatment of these patients, both for outpatient and inpatient care.

There are other residential facilities that admit users from different categories (destitute, behavior disorders, elderly patients, mentally retarded, substance addition patients, etc.). Among these facilities are *Hogares CREA*, *REMAR*, *Teen Challenge Foundation*, *el Hogar THYANA* and *el Centro de Recuperación y Rehabilitación Herbruger*, which represent a total amount of 1,190 beds. They are not formally considered mental health facilities and do not meet the requirements for treating patients with long-term mental disorders; however a considerable part of their inpatient population has been diagnosed with mental disorders.

Human rights and equity and access to services

The proportion of involuntary admissions to community-based inpatient psychiatric units is unknown, as this information is not registered and is not reported by other means. The mental hospital (INSAM) made an estimate through a selected sample which showed that 83% of admissions to this institution are considered involuntary. The main causes for such involuntary admissions were psychotic states and violent behaviors that require urgent and immediate attention.

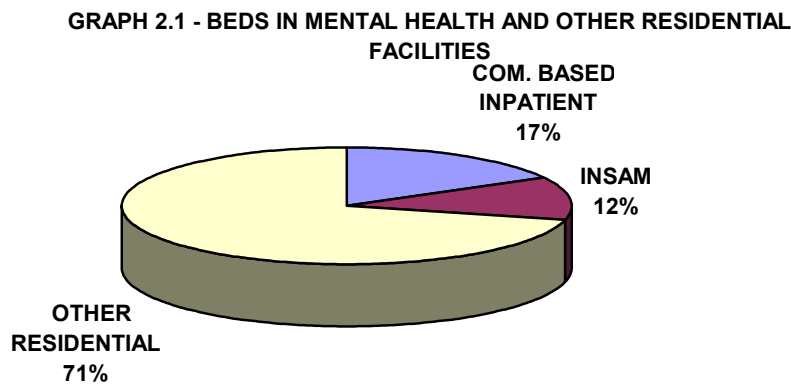
It was also estimated, through a selected sample that 51% of patients admitted to INSAM in 2004 were physically restrained or secluded at least once during their stay. There is no data regarding community-based inpatient facilities (not reported).

53% of psychiatric beds in the country are located in or near the largest city (Panama City). Such an uneven distribution of beds limits access to mental health services for rural users. Moreover, rural users are substantially under-represented in their use of outpatient services.

Inequity of access to mental health services for other minority groups including linguistic and ethnic minorities (particularly indigenous people), cannot be evaluated because there are no available data at this time. Currently, there is no specific strategy to ensure that ethnic and linguistic minorities have access to mental health services in their own language.

In Panama, Law 68 (November 20, 2003) delineates the rights and duties of patients regarding information and free and informed decision, involuntary admissions and informed consent to treatment. At present, however, the law has not been implemented. There is also Law 42 as of August 27, 1999, by which equal opportunities for the disabled, including mental disability, have been established.

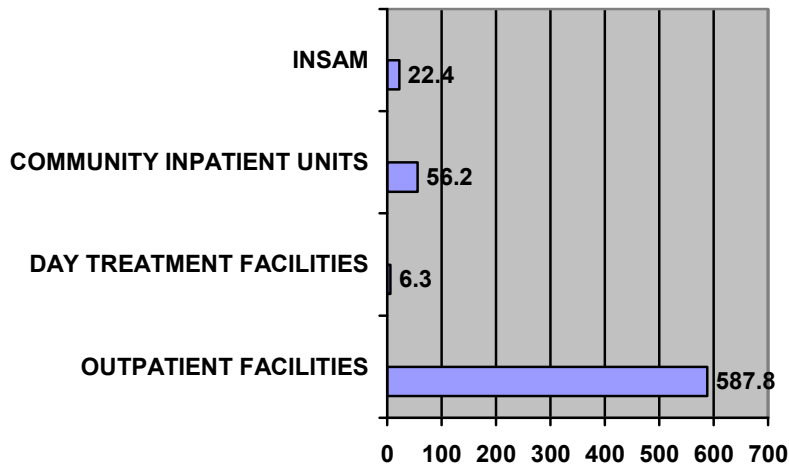
Summary Charts



Summary for Graph 2.1

Most of the beds for psychiatric patients in the country are located in other residential facilities, which are not explicitly for patients with mental disorders.

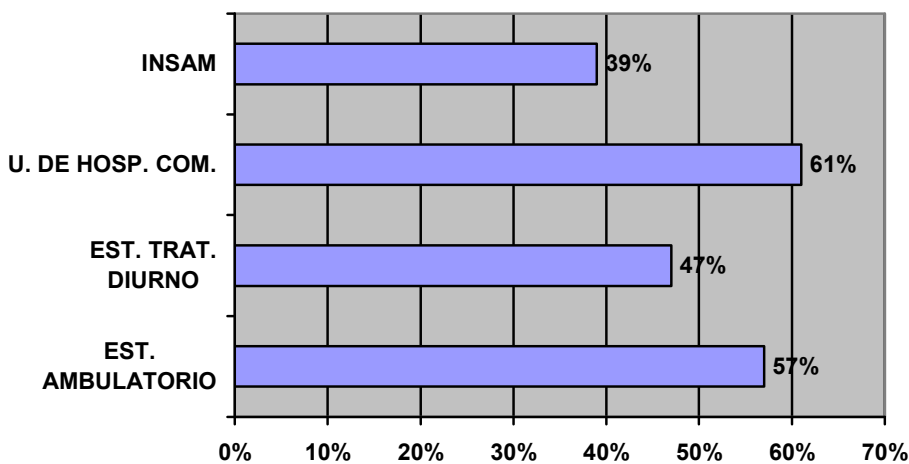
GRAPH 2.2 - PATIENTS TREATED IN N MENTAL HEALTH FACILITIES (rate per 100.000 population)



Summary for Graph 2.2

The majority of patients are treated in outpatient facilities (587.8 per 100,000 population). Among the mental hospital, community inpatient units and day treatment facilities, community inpatient units treat the greatest number of patients per 100,000 population.

GRÁFICO 2.3 - PORCENTAJES DE USUARIOS DE SEXO FEMENINO ATENDIDOS EN ESTABLECIMIENTOS DE SALUD MENTAL

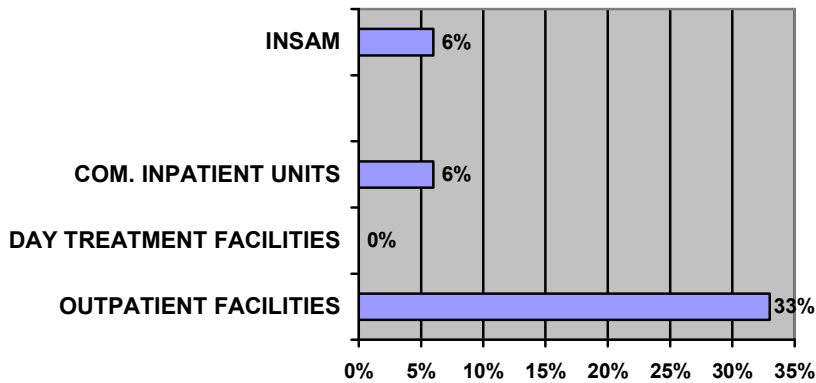


Summary for Graph 2.3

Female users make up 51% of patients in all mental health facilities in the country. The proportion of female users is highest in community-based psychiatric inpatient units and

outpatient facilities, and lowest in day treatment facilities and the National Institute of Mental Health.

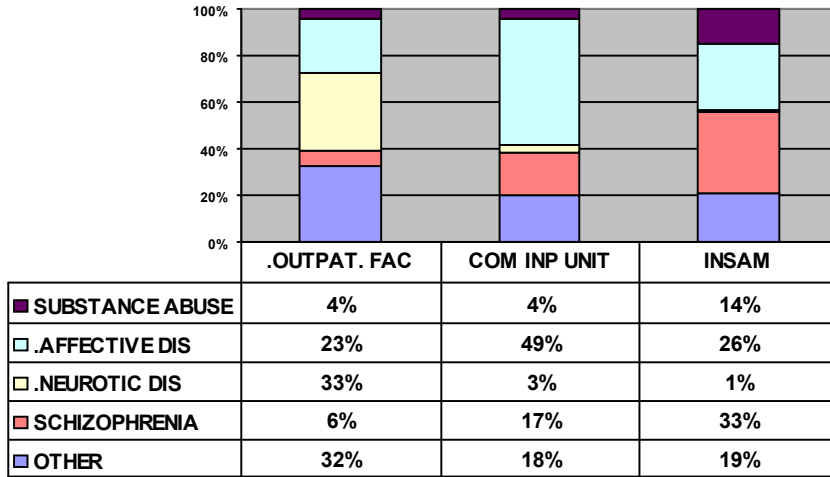
GRAPH 2.4 - PERCENTAGES OF CHILDREN & ADOLESCENTS TREATED IN MENTAL HEALTH FACILITIES



Summary for Graph 2.4

In Panama, 33% of the patients who receive treatment in outpatient facilities are children. In community-based inpatient units (psychiatric services in general hospitals), only 6% are under the age of 18. In INSAM (mental hospital) 6% of the cases belong to adolescents who are treated in the Center of Studies and Addiction Treatment (from this unit). There are no day treatment facilities for children and adolescents.

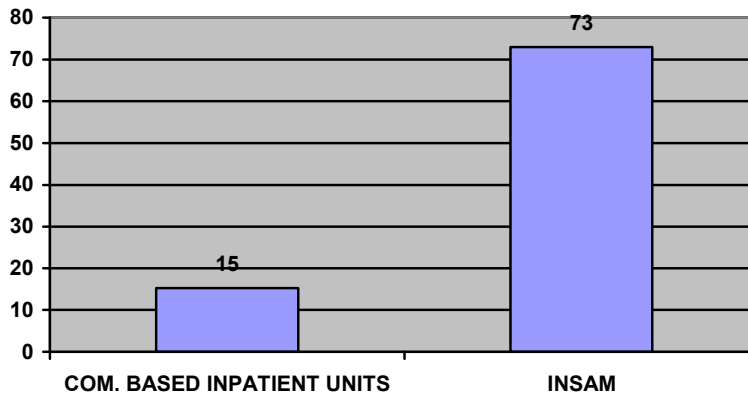
GRAPH 2.5 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS



Summary for Graph 2.5

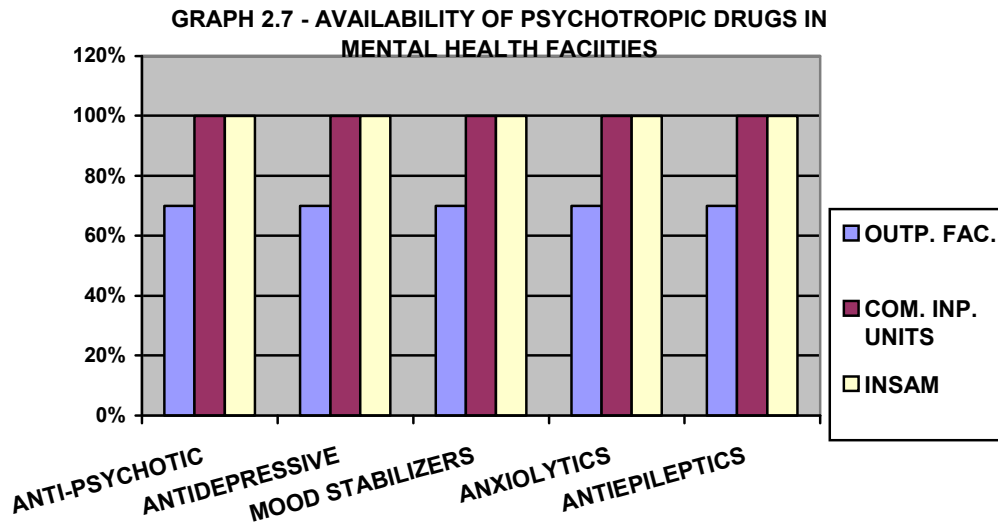
The distribution of diagnoses varies across facilities. In outpatient services neurotic and affective disorders are the most common; in community-based psychiatric inpatient units, affective disorders and schizophrenia are the most frequent diagnoses; and in INSAM schizophrenia and affective disorders are the main diagnoses.

GRAPH 2.6 - LENGTH OF STAY IN INPATIENT FACILITIES



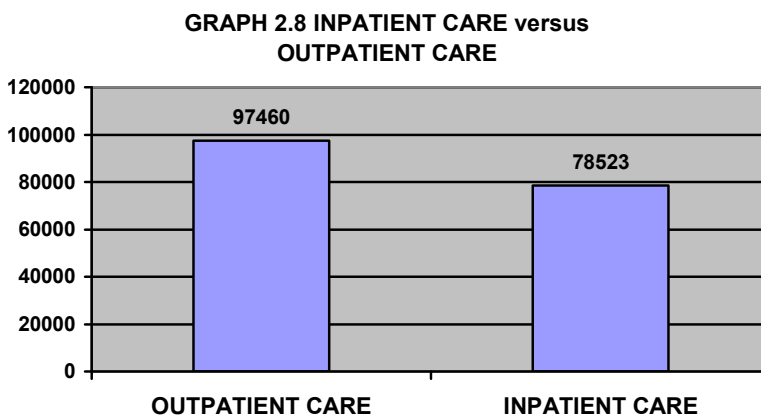
Summary for Graph 2.6

The longest length of stay for users is in INSAM, since many long-stay patients (more than 10 years) have remained in this hospital after the integration process. The length of stay in community-based psychiatric inpatient units is approximately 15 days.



Summary for Graph 2.7

Psychotropic drugs are available in the mental hospital (INSAM) and in all psychiatric inpatient units. However, only 70% of mental health outpatient facilities have at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) all year round.



Summary for Graph 2.8

The ratio between outpatient/day care contacts and days spent in all the inpatient facilities (mental hospitals and general hospital units) is an indicator of extent of community care: in Panama the ratio is 1.24:1.

Domain 3: Mental Health in Primary Health Care

Training in mental health for primary care staff

2% of the training for medical doctors is devoted to mental health, in comparison to 12% for nurses and 8% for non-doctor/non-nurse primary health care workers.

In terms of refresher training, 7% of primary health care doctors have received at least two days of refresher training in mental health in the last year, while the figure for both nurses and other PHC workers is unknown. There is no record of training in human resources at the national or regional level.

In Panama, the Primary Health Care networks have strengthened over time with the incorporation of psychiatrists, psychologists and nurses in health facilities throughout the country. However, there is no regular or formal ongoing education program directed towards primary health care workers at a local level. Such programs typically depend upon regional initiatives.

Mental Health in Primary Health Care

The primary health care outpatient facilities network consists of:

- **Health Posts:** Facilities with the lowest degree of complexity and resolution capacity. Health care is provided by a health assistant who has received training to provide health promotion, prevention and first aid services.
- **Health Care Sub-Centers:** First level facilities. Health workers perform activities that are similar to those of the health posts, but with a higher degree of complexity. They are not staffed with doctors, but are assisted by auxiliary or permanent nurses.
- **Health Care Centers:** Perform promotion and prevention health activities, diagnosis and treatment of health problems, and are assisted by a general doctor.

The country has 259 physician-based primary health care (PHC) centers and 519 non-physician based primary health care sub-centers and health posts. There are no assessment and treatment protocols for key mental health conditions in physician-based or non-physician based primary health care centers. The Ministry of Health is currently working on the preparation of such protocols.

The majority (51-80%) of the physician-based Primary Health Care centers make at least one monthly referral to a mental health professional. The percentage of physician-based PHC that make one referral to a higher level of care is unknown

The external consultation units of mental health teams in health centers, policlinics or in hospitals receive referrals from the primary care network. Patients who request mental health care may reach this service spontaneously or may be referred by other health professionals. There is a Ministry of Health resolution on an Exclusive System of Referral and Back-Referral. Indicators and regulations for this system were also defined and are now in the implementation

process. However, the efficiency of the referral and back-referral mechanisms is not optimum, as irregularities exist throughout the country.

As for professional interaction, the majority (51-80%) of primary health care physicians have interacted with a mental health professional at least monthly in the last year. At the same time, it is estimated that few (1-20%) of the physician-based primary health care centers have had any interaction with a complementary/alternative/traditional practitioner (such as indigenous healers or others) in the last year. It is also estimated that few (1-20%) non-physician-based primary health care centers have had such interaction, and none of the mental health inpatient facilities have had this type of interaction.

In Panama there are psychosocial rehabilitation initiatives in PHCs. The National Institute of Mental Health (INSAM) has worked to develop a proposal for rehabilitation services in the community, which is currently in the stages of promotion, dissemination and targeting potential users. There is a need to strengthen the rehabilitation process within the community or natural environment and outside hospital institutions.

Prescription in primary health care

As authorized by Panama's health code, primary health care doctors are allowed to prescribe psychotropic medications without restrictions. Nurses and non doctor/non nurse primary health care workers are not allowed to prescribe psychotropic medication under any circumstance. In the social security schemes there are minimum restrictions for PHC doctors in the prescription of some psychotropic medications (medicine not included in the essential drug list).

As for availability of psychotropic medicines, some (21-50%) physician-based PHC clinics have at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic), in contrast to non-physician-based PHC clinics, where these medicines are completely unavailable. According to Panamanian law, a health professional (certified pharmacist) needs to be in the health facility pharmacy as well as a physician to authorize the provision of psychotropic medications.

Domain 4: Human Resources

Number of human resources in mental health care

The total number of human resources working in public mental health facilities or private practice per 100,000 population is 16.58. The breakdown according to profession is as follows: 110 psychiatrists (3.47 per 100,000 population), 5 other medical doctors not specialized in psychiatry (0.16 per 100,000 population), 139 nurses (4.38 per 100,000 population), 95 psychologists (2.99 per 100,000 population), 48 social workers (1.51 per 100,000 population), 3 occupational therapists (0.09 per 100,000 population), and 129 (4.07 per 100,000) other health or mental health workers.

5% of psychiatrists work only for government-administered mental health facilities, 6% work only for NGOs, for profit mental health facilities and private practice, while 89% work for both sectors. The number of psychologists, social workers, nurses and occupational therapists working in various mental health sectors is unknown.

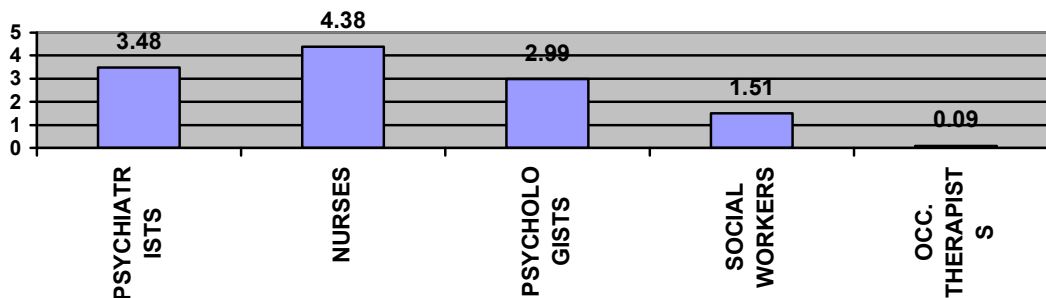
Regarding the workplace, 63 psychiatrists work in outpatient facilities, 31 in community-based psychiatric inpatient units and 16 in the mental hospital. As for other medical doctors (i.e. those not specialized in mental health), there are five working in the mental hospital/INSAM (three medical doctors, an internist and a neurologist).

As for nurses, 73 work in outpatient facilities, 30 in community-based psychiatric inpatient units and 36 in the mental hospital. 121 psychosocial workers (includes psychologists, social workers and occupational therapists) work in outpatient facilities, 15 in community-based psychiatric inpatient units, and 10 in the mental hospital. Finally, regarding other health or mental health workers, 129 work in INSAM and the number working in outpatient facilities and in community-based psychiatric inpatient units is unknown.

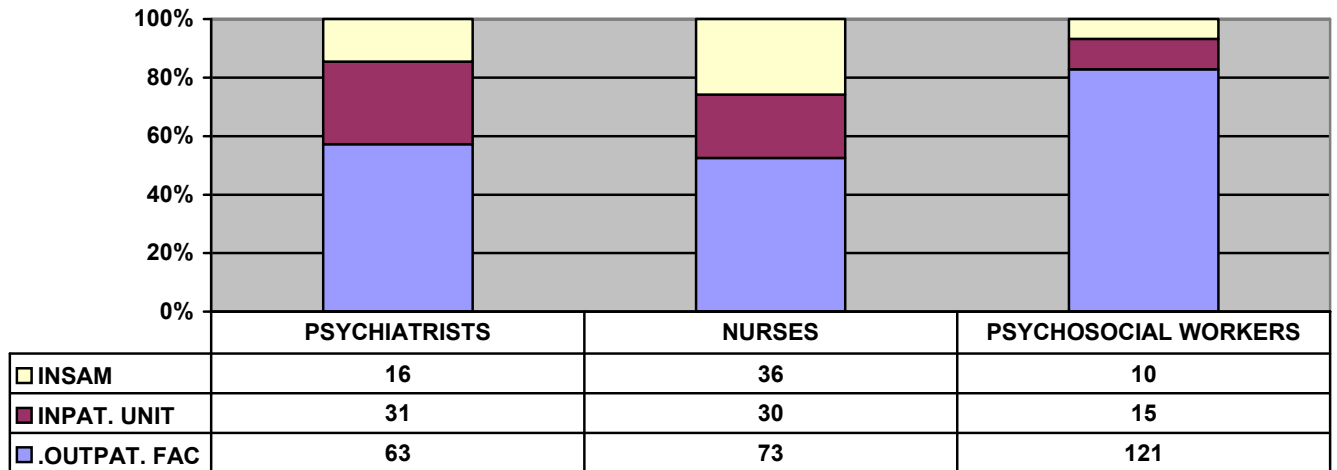
In terms of staffing in inpatient facilities, for psychiatric patients, there are 0.11 psychiatrists per bed in community-based psychiatric inpatient units, in comparison to 0.08 psychiatrists per bed in INSAM. As for nurses, there are 0.11 nurses per bed in community-based psychiatric inpatient units, in comparison to 0.18 per bed in INSAM. Finally, for other mental health care staff (e.g., psychologists, social workers and occupational therapists), there are 0.05 per bed in both the community-based psychiatric inpatient units and the mental hospital.

The distribution of human resources between urban and rural areas is disproportionate. In the capital city (metropolitan area) there are 8.18 psychiatrists per 100,000 population in comparison to the whole country, where there are 3.47 psychiatrists per 100,000 population (2.36 times greater). There are also more nurses per capita in urban areas; the ratio of nurses working in mental health facilities based in urban areas as compared to the whole country is 1.87.

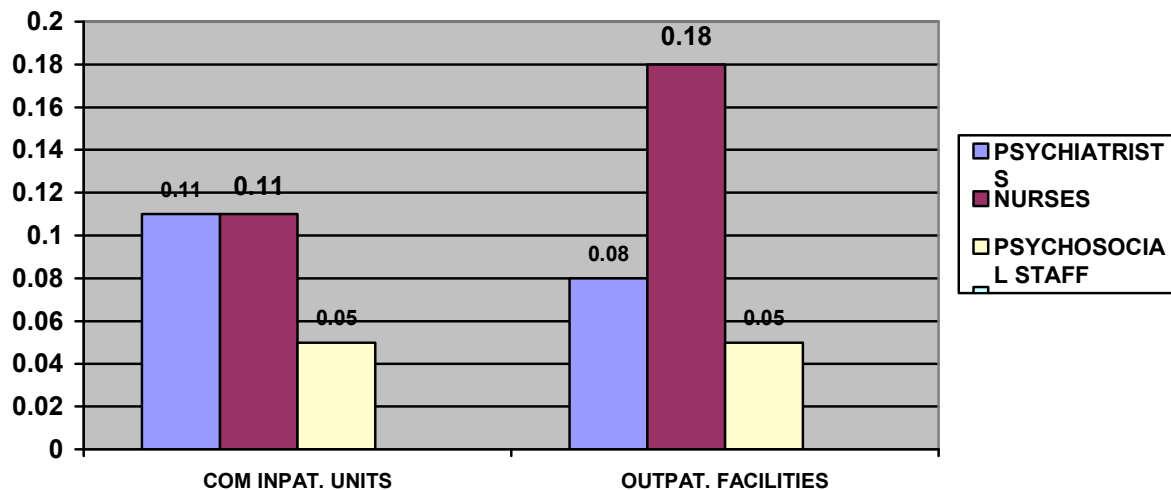
GRAPH 4.1 - HUMAN RESOURCES IN MENTAL HEALTH
(rate per 100.000 people)



GRAPH 4.2 - STAFF WORKING IN DIFFERENT MENTAL HEALTH FACILITIES
(percentage in the graph, number in the table)



GRAPH 4.3 - RATIO BETWEEN HUMAN RESOURCES / BEDS



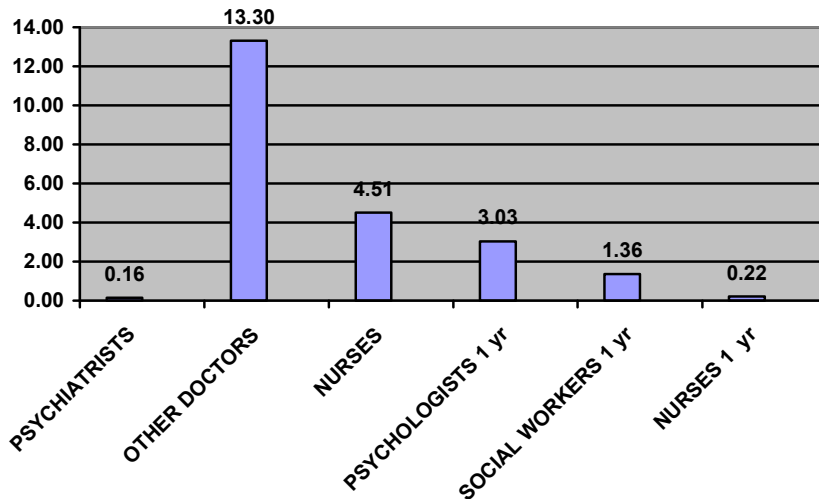
Training professionals in mental health

The number of professionals graduated in 2004 in academic and educational institutions per 100,000 population is as follows: 0.16 psychiatrists (5), 13.30 medical doctors (422), 4.51 general nurses (143) and 0.22 nurses with mental health university degree training in nursing (with at least 1 year training in mental health) (7), 3.02 psychologists (96) and 1.36 social workers (43). In Panama there is no training for occupational therapists.

Only two educational institutions in the whole country provide training in psychiatric specialization; The National Institute of Mental Health of the Ministry of Health (former National Psychiatric Hospital) and the “Dr. Arnulfo Arias Madrid” Metropolitan Hospital Complex of the Social Security Entity. The rest of the mental health professionals receive training in both public and private universities.

According to estimates, only 1% of psychiatrists have emigrated to other countries within five years of the completion of their training. The percentage of PHC staff with at least two days of refresher training on the rational use of medications, psychosocial interventions or mental health of children and adolescents is unknown. There are reports of some isolated, brief courses being provided, but such courses do not meet the WHO-AIMS threshold of two days.

GRAPH 4.4 - PROFESSIONALS GRADUATED IN MENTAL HEALTH (rate per 100.000 population)



Consumer and family associations

There are two consumer associations, the Association of Relatives, Friends and Patients with Schizophrenia and other Mental Disorders (ANFAPEM – acronym in Spanish) and Yo tengo Mi Espacio (*I Have My Space*), with a total of approximately 80 members (also includes family members of patients). The government does not provide financial support for these associations.

Consumer associations have been involved in the formulation or implementation of mental health policies, plans, or legislation within the past two years. The few (1-20%) interactions between consumer associations and mental health services are mainly at the mental hospital level.

In addition to consumer and family associations, there are seven non-governmental organizations (NGOs) in the country involved in mental health: Fundación Piero Rafael Martínez, Cristo para todas las Naciones (*Christ for every Nation*), FUNDAMUJER, CEDEM (Center for Women Development), Cruz Blanca Panameña, PRIDE and CAAM (Center of Support for Abused Women). These NGOs are involved in individual assistance activities such as counseling, education and orientation, as well as providing support for mutual help groups.

Domain 5: Public Education and Links with other Sectors

Public education and awareness campaigns on mental health

There is one coordinating body that oversees public education and awareness campaigns on mental health and mental disorders. This coordinating body, the National Directorate of Promotion, Ministry of Health, receives technical support from specialized staff and institutions, such as the National Institute of Mental Health.

Government agencies, NGOs, professional associations, private trusts and foundations, and international agencies have all promoted public education and awareness campaigns in the last five years. These campaigns have targeted the following groups: the general population, children, adolescents, women, trauma survivors, ethnic groups and other vulnerable groups.

In addition, public education and awareness campaigns have targeted the following professional groups: health care providers, teachers, social service workers and others.

Legislative and financial provisions for people with mental disorders

Law No. 42, enacted since August 27, 1999, establishes equal opportunities for the disabled, including mental disability. Legislative provisions exist concerning the legal obligation for employers to hire a certain percentage of employees that are disabled. Law 42 also contains a provision concerning protection from discrimination at work (dismissals, low wages) solely on account of mental disorder. Unfortunately, these legal provisions are not enforced on a regular basis. At the present time, there is no legislative or financial provision concerning priority in state housing and in subsidized housing schemes for people with severe mental disorders.

Links with other sectors

In addition to legislative and financial support, there are formal collaborations with the departments/agencies responsible for primary health care/community health, STD-HIV/AIDS, sexual and reproductive health, child and adolescent health, adult health and elderly health (within the Ministry of Health), as well as other external bodies outside of the health sector, such as those devoted to child protection, education, social assistance and criminal justice, among others.

In terms of support to child and adolescent health, 1% (24 of 3,295) of primary and secondary public schools have either a part-time or full-time mental health professional. Some (21-50%) primary and secondary schools have school-based activities to promote mental health and prevent mental disorders.

The proportion of prisoners with psychosis or mental retardation is unknown. At the present time the Ombudsman Department is in process of conducting a census of all prisoners. Regarding mental health activities in the criminal justice system, 1-20% of prisons have at least one prisoner per month in treatment contact with a mental health professional.

As for training some (51-80%) police officers, and a few (1-20%) judges and lawyers have participated in educational activities on mental health in the last five years. In terms of financial support for users, none of mental health facilities have access to programs outside the mental health facility that provide outside employment for users with severe mental disorders. There are

no formal employment opportunities for people with mental disabilities. However, there are some government and private institutions that have hired people with long-term mental disorders. Finally, 35% of people who receive social welfare benefits have received such benefits on account of their mental disability.

Domain 6: Monitoring and Research

A formally defined list of individual data items that ought to be collected by all mental health facilities exists. As shown in the Table 6.1, the extent of data collection is consistent among mental health facilities.

There are two national databases in the Ministry of Health that show psychiatric morbidity according to the ICD-10, the General Morbidity of External Consultation and the Admission-Discharge. No independent mental health information system exists. Some studies have been performed based on a proposal from the Sub-System of Mental Health Information, as part of the development of the Information System of the Ministry of Health together with the Social Security Entity.

Since the information system of the Ministry of Health is insufficient, a systematic analysis of all data necessary for the support of evidence-based activities is not possible.

The Ministry of Health and the Social Security Entity received data from all mental health facilities or services in the country. Based on this information, an annual report is published but it does not include analytical comments on mental health. In addition, there are some statistic bulletins produced at the regional and hospital level.

In terms of research, 7% of all health publications in the country in the last five years were on mental health. Few professionals are involved in mental health research; however some psychiatrists, nurses, psychologists and social workers are involved. Research was focused on epidemiological studies in community and clinical samples as well as non-epidemiological clinical assessments and services research.

Table 6.1 - Percentage of mental health facilities collecting and compiling data by type of information

	INSAM	Psychiatry services in general hospitals	Outpatient facilities
N° of beds	100%	100%	100%
N° of inpatient admissions/users treated in outpatient facilities	100%	100%	0%
N° of days spent/user contacts in outpatient facilities	100%	100%	100%
N° of involuntary admissions	0%	0%	0%
N° of users physically restrained or secluded	0%	0%	0%
Diagnoses	100%	100%	100%

This assessment is based on information from the mental health system in Panama in 2005. Information was collected using the World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS).

The assessment revealed that there are 103 outpatient facilities, three day treatment facilities, eight community-based inpatient facilities and one mental hospital. Forty-four % of the mental health budget goes to the mental hospital and the majority of the patients at the mental hospital have been there for over ten years. A national plan for mental health has been in existence since 2003 and the plan has been significantly implemented. The long term goal of rehabilitating patients in the community remains a priority. However, the mental health system of Panama lacks sufficient legislation and protocols to protect the rights of patients with mental illness.

The study also revealed that the mental health system of Panama has made considerable progress over the last five years. There has been a dramatic decrease in inpatient services and an increase in comprehensive community-based services. There have also been improvements in the quality of care for patients with mental illness in Panama and an increase in the number of consumer and family associations. Ultimately, the results of the WHO-AIMS study will be used to develop new policies and practices which will improve mental health services for the people of Panama.