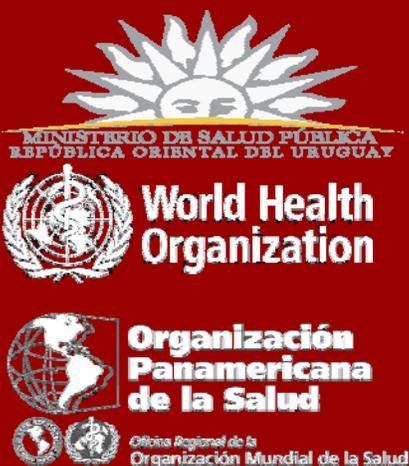


# WHO-AIMS

WHO-AIMS REPORT ON  
**MENTAL HEALTH SYSTEM**  
IN URUGUAY



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**IN URUGUAY**

*A report of the assessment of the mental health system in Uruguay  
using the World Health Organization - Assessment Instrument for  
Mental Health Systems (WHO-AIMS).*

*Montevideo, Uruguay*

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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](http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html)

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The WHO-AIMS project is coordinated by Shekhar Saxena.

## **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 Uruguay. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This will enable Uruguay 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.

Uruguay, as most countries of the Americas, has a mental health policy. Financing is mainly oriented towards mental hospitals. A human rights review body exists, but there were no inspection either in mental hospitals or in community-based psychiatric inpatient units during the last year. A specific effort in order to collect data on involuntary admissions, restraint and seclusion and to provide training on human rights to staff should be done.

In Uruguay, the mental health system has all types of mental health facilities; however some need to be strengthened and improved. A mental health authority exists in the public sector. The majority of beds are still provided by mental hospitals, despite the fact that during the last ten years the government has reduced the numbers of beds in mental hospitals and promoted the building of community based psychiatric inpatient units. The aim of the mental health authority is to reduce inpatient care and to improve the primary health care, which is weak. Few facilities are devoted to children and adolescents. Regarding treatment, psychotropic medicines are available in all facilities and 43% of the population has free access to them. There are not enough human resources to provide all patients psychosocial interventions.

Primary health care staff has poor undergraduate training in mental health. Refresher training is scarce, in particular for psychologists. There are 26.66 human resources per 100,000 population. Rates are particularly low for nurses and occupational therapists. The distribution of human resources between urban and rural areas is unfair. There are no consumer associations in the country. Family associations are present, but their involvement in policies, plans or legislation should be strengthened.

There are links with other relevant health and non-health department/agencies. Public education and awareness campaigns were focused only on the abuse of illegal drugs. Information campaigns about mental illnesses and the promotion/prevention activities performed in primary and secondary schools should be strengthened. There is a legislative provision for employment in the public sector, but no legislative or financial support for housing.

The mental health information system does not cover all relevant information in all facilities. There has been no research on mental health published in indexed journals in the last five years.

# WHO-AIMS COUNTRY REPORT FOR URUGUAY

## Introduction

Uruguay is a country with an approximate geographical area of 176215 square kilometres and a population of 3.439.000 (WHO, 2005). The language used in the country is Spanish. Uruguay is divided in 19 departments. Forty-two percent of the total population resides in the department of Montevideo, where the capital is located.

The proportion of the population under the age of 15 years is 24%, and the proportion of population above the age of 60 years is 17%. Seven percent of the population is rural. The life expectancy at birth is 71.67 years for males and 78.94 years for females. The healthy life expectancy at birth is 63.9 years for males and 69.4 years for females. The literacy rate is 97.3% for men and 98.1% for women.

The country is a lower middle income group country based on World Bank 2004 criteria. The proportion of the health budget to GDP is 10.8%. The public health system consists of two sectors: public and private. The public sector is made up of the institutions under the Ministry of Public Health. The private sector consists mainly of the collective health care institutions (mutual-aid system). There are 38.2 hospital beds per 100,000 population and 411 general physicians. Twenty-three percent of all hospital beds are in the private sector, which provide medical assistance to approximately half of the population.

Data was collected in 2005 and is based on the year 2004.

## **Domain 1: Policy and Legislative Framework**

### **Policy, plans, and legislation**

Uruguay's mental health policy was last revised in 1986 (two years after the end of the dictatorship) and it was signed by the Public Health Ministry, the Medicine Faculty, the Psychiatric Uruguayan Society and the Psychological Co-ordinator. It includes the following components: developing community mental health services, downsizing large mental hospitals, developing a mental health component in primary health care, human resources, involvement of users and families, advocacy and promotion, human rights protection of users, equity of access to mental health services across different groups and quality improvement.

In addition, a list of essential medicines is present. These medicines include: antipsychotics, anxiolytics, antidepressants, mood stabilizers and antiepileptic drugs.

The last revision of the mental health plans was in 1986. This plan contains the following components: developing community mental health services, downsizing large mental hospitals, reforming mental hospitals to provide more comprehensive care, developing a mental health component in primary health care, human resources, involvement of users and families and quality improvement. In addition a budget and specific goals are mentioned in the last mental health plan. Some of the goals identified in the last mental health plan have been reached within the last calendar year (i.e. the reduction of beds in mental hospitals).

There is no disaster/emergency preparedness plan for mental health.

The last piece of mental health legislation was enacted in 1936, which focused on: access to mental health care including to the least restrictive care, rights of mental health service consumers, family members and other caregivers, voluntary and involuntary treatment, accreditation of professionals and facilities, law enforcement and other judicial system issues for people with mental illness, mechanism to oversee involuntary admissions and treatment practices and mechanism to implement the provisions of MH legislation.

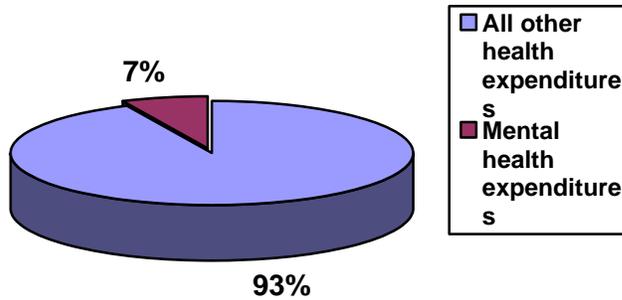
### **Financing of mental health services**

The 7% of health care expenditures by the government health department are directed towards mental health (graph 1.1). Of all the expenditures spent on mental health, 72% is directed towards mental hospitals (graph 1.2).

43% of the population has free access (at least 80%) to essential psychotropic medicines. For those that pay out of pocket, the cost of antipsychotic medication is 14% of the one day minimum wage and of antidepressant medication is 10%. All mental disorders and all mental health problems of clinical concern are covered in social insurance schemes.

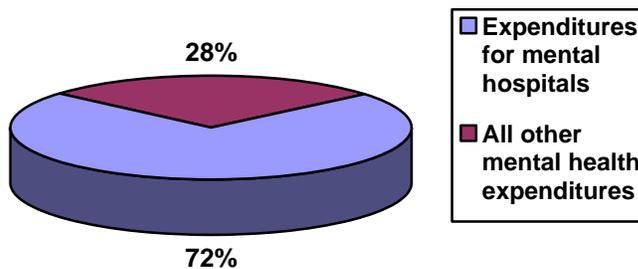
Graph 1.1: Expenditures on mental health as proportion of total health expenditures

**GRAPH 1.1 HEALTH EXPENDITURE TOWARDS MENTAL HEALTH**



Graph 1.2: Expenditures on mental hospital as proportion of total mental health care

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



### **Human rights policies**

A national human rights review body (the "*Inspector General del Psicopata*") exists which has the authority to: oversee regular inspections in mental health facilities, review involuntary admission and discharge procedures, review complaints investigations and to impose sanctions. No mental health facility have had at least one review/inspection of human rights protection of patients in the year of assessment and no mental health staff had at least one day training, meeting, or other type of working session on human rights protection of patients in the year of assessment.

## **Domain 2: Mental Health Services**

### **Organization of mental health services**

In the public sector, the Public Health Ministry controls the entire health system. A national mental health authority (the national co-ordinator) exists which provides advice to the government on mental health policies and legislation. The mental health authority also is involved in planning, management, co-ordination, monitoring and quality assessment of mental health services. In the public sector, mental health services are organized in term of catchment/service areas. There are two mental hospitals, but only one is organizationally integrated with mental health outpatient facilities.

### **Mental health outpatient facilities**

There are 35 mental health outpatient facilities available in the country. In general, mental health teams are formed by psychiatrists, psychologists, nurses, social workers and child psychiatrist. There are no facilities specifically for children and adolescents available in the country.

These facilities treat 1666 users per 100,000 general population. Of all users treated in mental health outpatient facilities, 54% are female and 11% are children or adolescents. The average number of contacts per user is 3.28.

All outpatient facilities provide follow-up care in the community, while none of the facilities have mental health mobile teams. In terms of available interventions, a few (1–20%) mental health outpatient facilities offer psychosocial interventions. All facilities had 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 31 day treatment facilities available in the country, which provide rehabilitation. No day treatment facility is available for children and adolescents only.

These facilities treat 20,8 users per 100,000 general population. 25% of all users treated in day treatment facilities are female.

### **Community-based psychiatric inpatient units**

There are 25 community-based psychiatric inpatient units (9 public and 16 private), available in the country for a total of 17,1 beds per 100,000 population. It was estimated that five percent of these beds are reserved for children and adolescents only.

Time spent in community-based psychiatric inpatient units per discharge is estimated to be approximately 15 days.

A few (1-20%) patients in community-based psychiatric inpatient units received one or more psychosocial interventions in the last year. All community-based psychiatric inpatient units had 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**

Data on community residential facility are not available.

### **Mental hospitals**

There are 2 mental hospitals available in the country for a total of 34,9 beds per 100,000 population. Three percent of these beds are reserved for children and adolescents only. The number of beds has decreased 25% in the last five years.

37% of all users are female and it was estimated that 10% are adolescents. The accurate prevalence of children and adolescent users is not available. The diagnoses of admission to mental hospitals belong primarily to the following two groups: schizophrenia (44%) and mood disorders (20%).

Referring to the proportion of long-stay patients, the two mental hospitals present some differences. In one of the hospitals the majority of users stay less than one year, in the other the majority of patients are chronic and stay more than 10 years.

A few (1-20%) patients in mental hospitals received one or more psychosocial interventions in the last year. All mental hospitals had 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.

### **Forensic and other residential facilities**

In addition to beds in mental health facilities, there are also 191 beds in forensic inpatient units, all in mental hospitals.

There are also 2 residential facilities specifically for people with mental retardation and 6 facilities for people with substance abuse.

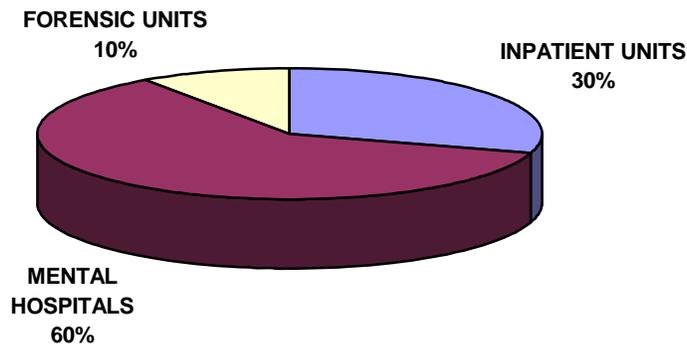
### **Human rights and equity**

It was estimated that the proportion of patients who were restrained or secluded at least once within the last year in community-based psychiatric inpatient units and in mental hospitals is between 11 and 20 percent.

Seventy-seven percent of psychiatry beds in the country are located in or near the largest city. Such a distribution of beds prevents access for rural users. Inequity of access to mental health services for other minority users is not an issue in the country.

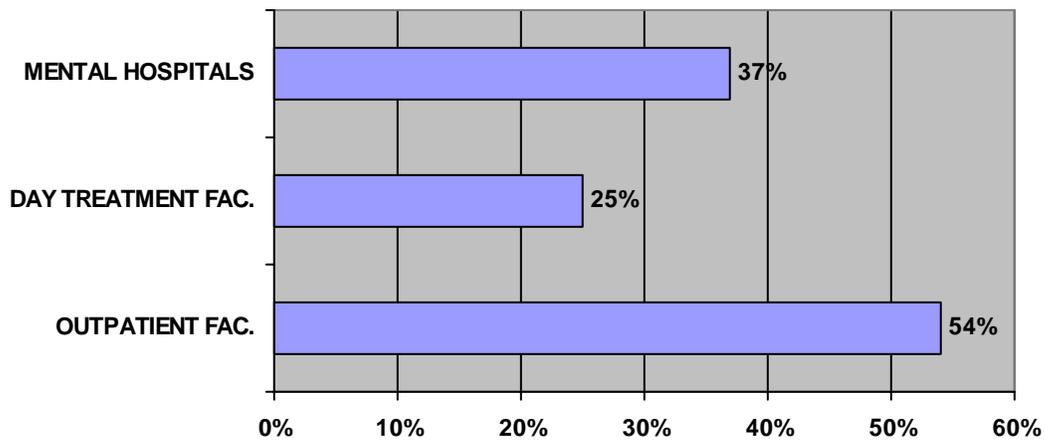
**Summary Charts**

**GRAPH 2.1 - BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES**



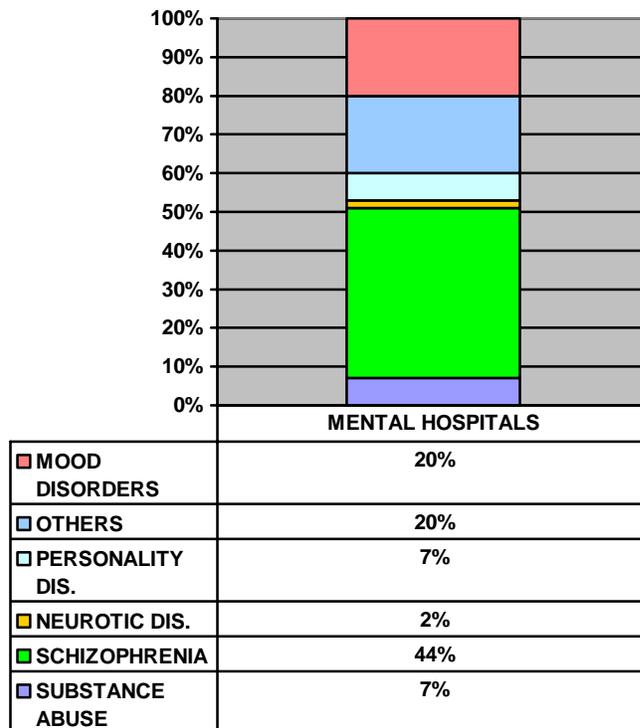
The majority of beds are provided by mental hospitals, followed by inpatient units.

**GRAPH 2.3 - PERCENTAGES OF FEMALE USERS TREATED IN MENTAL HEALTH FACILITIES**



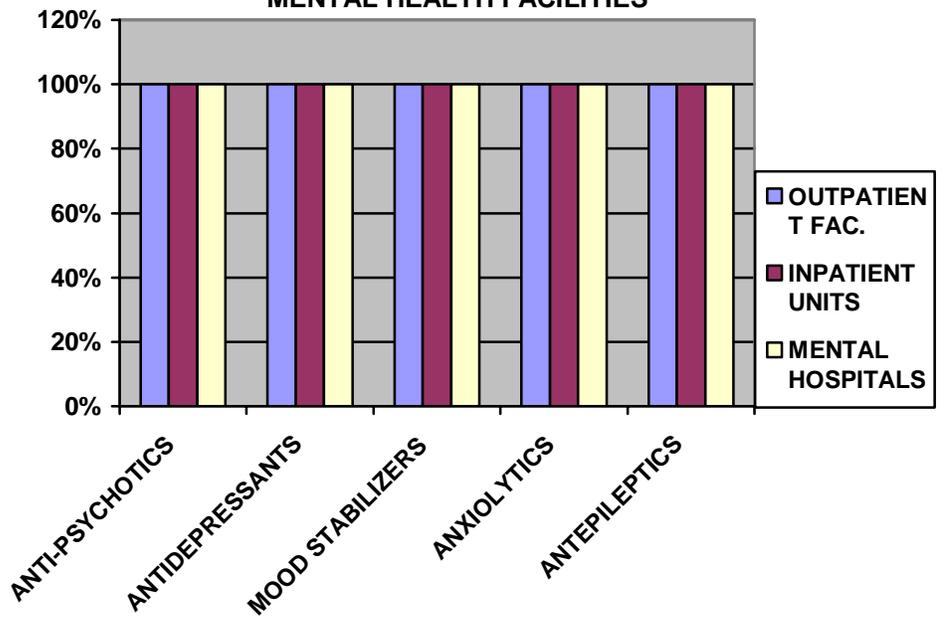
The proportion of female users is highest in outpatient units and residential facilities and lowest in day treatment facilities.

**GRAPH 2.5 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS**



Data about diagnosis are available only for mental hospitals. The most prevalent diagnosis is schizophrenia, followed by mood disorders and others, such as epilepsy, mental retardation, organic mental disorders.

**GRAPH 2.7 - AVAILABILITY OF PSYCOTROPIC DRUGS IN MENTAL HEALTH FACILITIES**



At least one of each type of psychotropic medicines is available in all the facilities.

## **Domain 3: Mental health in primary health care**

### **Training in mental health care for primary care staff**

Two percent of the training for medical doctors is devoted to mental health, in comparison to 12% for nurses. There is no refresher training in mental health for doctors, nurses or non-doctor.

### **Mental health in primary health care**

All primary health care clinics are physician based. No physician-based primary health care clinic has assessment and treatment protocols for key mental health conditions available. Some (25-50%) physician-based primary health care clinics make on average at least one referral to a mental health professional. As for professional interaction between primary health care staff and other care providers, some (21-50%) primary care doctors have interacted with a mental health professional at least once in the last year. A few (1-20%) physician-based primary care facilities have had interaction with a complimentary/alternative/traditional practitioner.

### **Prescription in primary health care**

Primary health care doctors are allowed to prescribe but with restrictions (they can not prescribe all types of psychotropic medicines). Primary health care nurses and non-doctors are not allowed to prescribe psychotropic medications in any circumstance.

As for availability of psychotropic medicines some (21-50%) physician-based primary care clinics have at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available.

## **Domain 4: Human resources**

### **Number of human resources in mental health care**

The total number of human resources working in mental health facilities or private practice per 100,000 population is 26.66. The breakdown according to profession is as follows: 19.36 psychiatrists, 2.02 other medical doctors (not specialized in psychiatry), 0.69 nurses, 3.12 psychologists, 1.36 social workers and 0.11 occupational therapists.

Regarding human resources in the workplace, 160 psychiatrists work in outpatient facilities, 25 in community-based psychiatric inpatient units and 85 in mental hospitals. As for as nurses, 10 work in outpatient facilities, 17 in community-based psychiatric inpatient units and 29 in mental hospitals. With regards to psychologists, social workers and occupational therapists 148 work in outpatient facilities, 62 in community-based

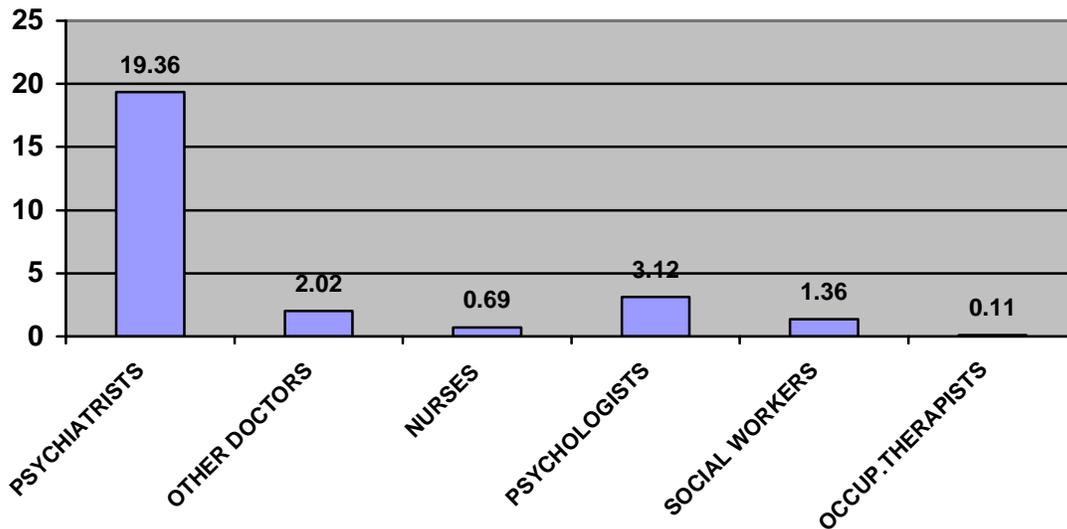
psychiatric inpatient units and 34 in mental hospitals. As for other health or mental health workers, 110 work in outpatient facilities and 211 in mental hospitals.

In terms of staffing in mental health facilities, there are 0.04 psychiatrists per bed in community-based psychiatric inpatient units, in comparison to 0.07 psychiatrists per bed in mental hospitals. As for nurses, there are 0.03 nurses per bed in community-based psychiatric inpatient units, in comparison to 0.02 nurses per bed in mental hospitals. Finally, for other mental health care staff (e.g., psychologists, social workers, occupational therapists, and other health or mental health workers), there are 0.11 per bed for community-based psychiatric inpatient units, and 0.20 per bed in mental hospitals.

The distribution of human resources between urban and rural areas is unfair: the ratio of psychiatrists working in mental health in or near the largest city to the rest of the country is 1.47 and the ratio of nurses is 1.42. It was estimated that approximately 90% of the psychiatrists live in the capital, Montevideo.

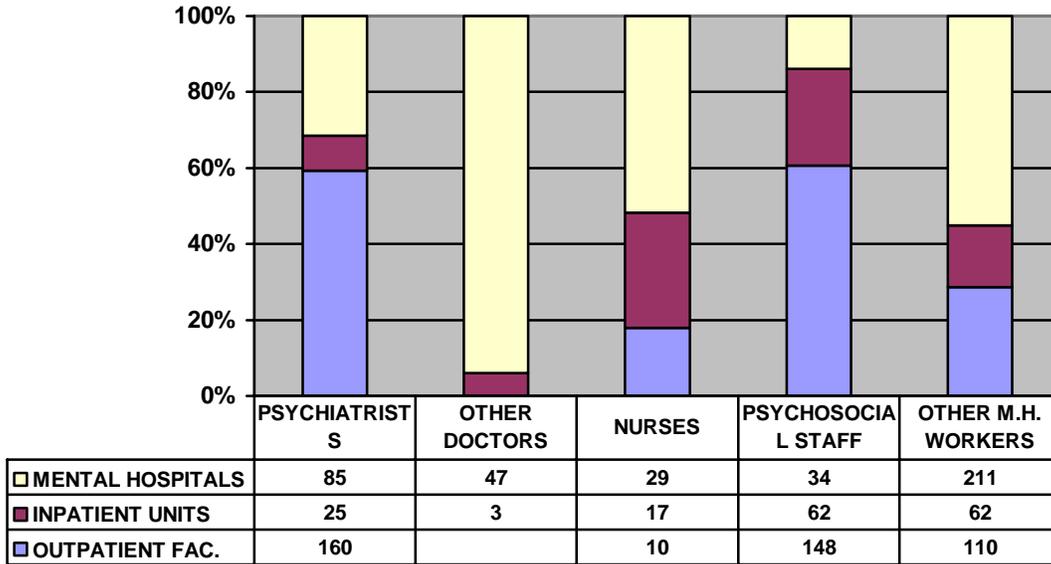
Graph: 4.1 Human resources in mental health

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



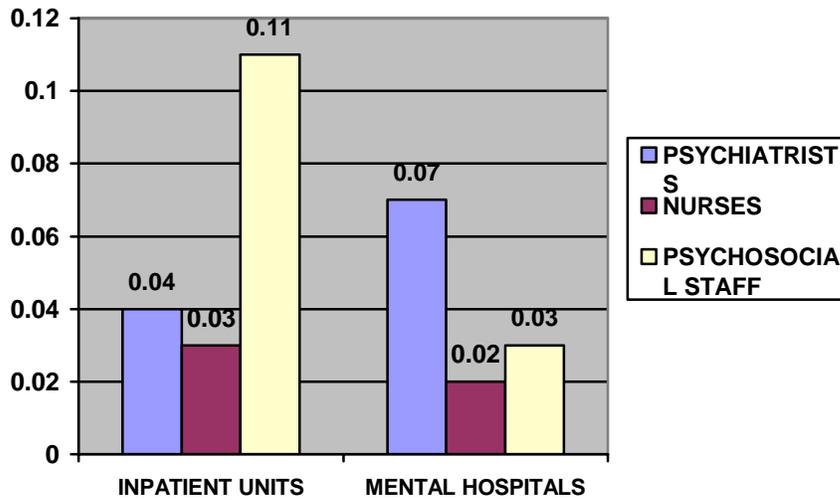
Graph 4.2: staff working in mental health facilities

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



Graph 4.3: ratio human resources/beds in inpatients units and mental hospitals

**GRAPH 4.3 - RATIO HUMAN RESOURCES/BEDS**



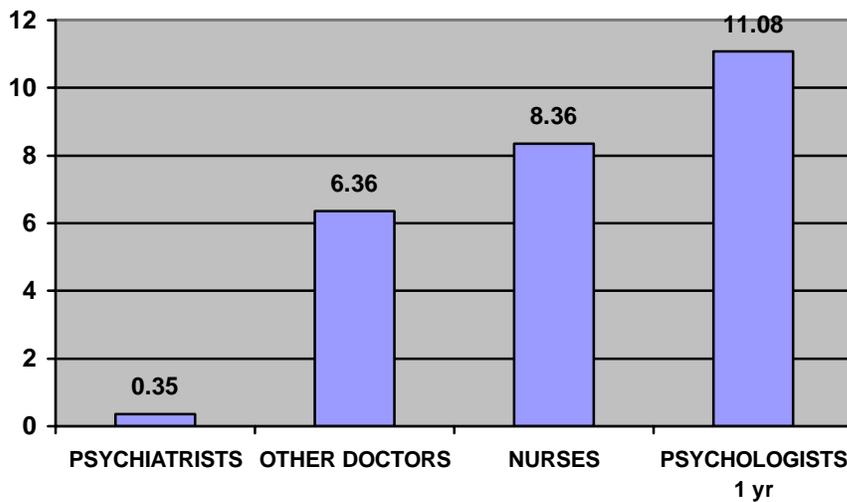
### **Training professionals in mental health**

The number of professionals graduated last year in academic and educational institutions per 100,000 is as follows: 12 psychiatrists (0.35 per 100,000 population), 220 other medical doctors (not specialized in psychiatry, 6.36 per 100,000 population), 289 nurses (8.36 per 100,000 population), 383 psychologists with at least 1 year training in mental health care (11.08 per 100,000 population). A few (1-20%) psychiatrists have emigrated to other countries within five years of the completion of their training.

With regards to refresher training, the only information available is that 13% of psychiatrists received a training of at least two days on the rationale use of psychotropic drugs in the last year.

Graph 4.4: Professionals graduated in mental health

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



### **Consumer and family associations**

There are no users/consumers association in the country and 7 family associations. All of the family associations have been involved in community and individual assistance activities. These associations have been involved in the formulation or implementation of mental health policies, plans, or legislation in the past two years. A few mental health facilities have interacted with family associations in the last year.

In addition to family associations, there are two non-governmental organizations in the country involved in individual assistance activities such as counselling, housing, or support groups.

## **Domain 5: Public education and links with other sectors**

### **Public education and awareness campaigns on mental health**

There is no coordinating body to oversee public education and awareness campaigns on mental health and mental disorders. Government agencies have promoted and coordinated public education and awareness campaigns on the topic of legal (alcohol and tobacco) and illegal drugs in the last five years.

### **Legislative and financial provisions for persons with mental disorders**

The following legislative and financial provisions exist to protect and provide support for users: provisions concerning a legal obligation in the public sector to hire a certain percentages of employees who are disabled and provisions concerning protection from discrimination at work. However, only the second provision is enforced. At the present time, there is no legislative or financial support for priority in state housing for people with severe mental disorders.

### **Public Education and relationship with other sectors**

In addition to legislative and financial support, there are formal collaborations with the departments/agencies responsible for primary health care/community care, child and adolescent health, substance abuse, education, welfare and the elderly.

In terms of support for child and adolescent health, it was estimated that 25% of secondary schools have either a part-time, or full-time mental health professional, and a few (1-20%) primary and secondary schools have school-based activities to promote mental health and prevent mental disorders.

Regarding mental health activities in the criminal justice system, almost all (81-100%) prisons have at least one prisoner per month in treatment contact with a mental health professional. As for training police officers, judges, lawyers a few (1-20%) have participated in educational activities on mental health in the last five years.

In terms of financial support for users, a few (1-20%) mental health facilities have access to programs outside the mental health facility that provide outside employment for users with severe mental disorders.

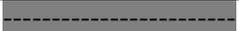
## **Domain 6: Monitoring and research**

A formally defined list of individual data items that ought to be collected by all mental health facilities exists, but it is not currently used by all facilities. As it is shown in table 6.1, the extent of data collection is variable among mental health facilities.

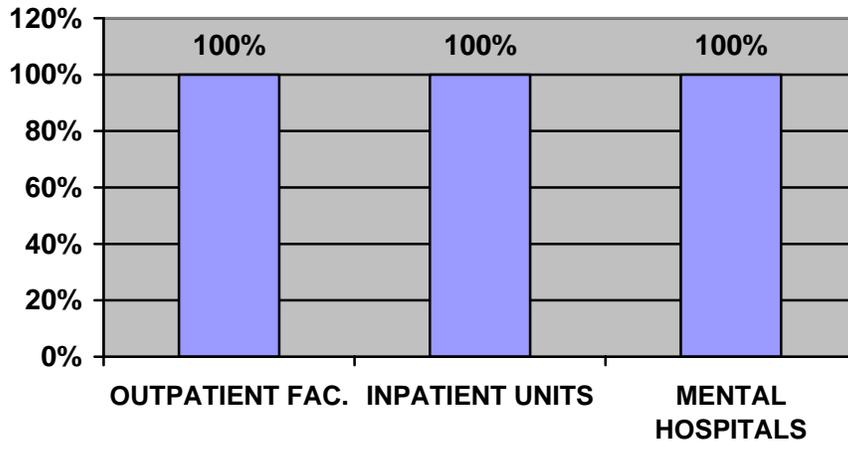
The government health department received data from all the mental health facilities. However, no report was published on the data transmitted to the government health department the last year

Few professionals are involved in mental health research. The research that has been conducted as focused on the following topics: epidemiological studies in community samples, non-epidemiological clinical/questionnaires assessments of mental disorders, biology and genetics, policy, programmes, financing/economics, psychosocial interventions/psychotherapeutic interventions, pharmacological, surgical and electroconvulsive interventions.

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

	<b>MENTAL HOSPITALS</b>	<b>INPATIENT UNITS</b>	<b>OUTPATIENT FACILITIES</b>
<b>N° of beds</b>	100%	UN	
<b>N° inpatient admissions/users treated in outpatient facilities</b>	100%	UN	100%
<b>N° of days spent/user contacts in outpatient facilities</b>	50%	UN	100%
<b>N° of involuntary admissions</b>	UN	UN	
<b>N° of users restrained</b>	UN	UN	
<b>Diagnoses</b>	50%	UN	100%

**GRAPH 6.1 - PERCENTAGES OF MENTAL HEALTH FACILITIES TRANSMITTING DATA TO HEALTH DEPARTMENT**



Uruguay has mental health legislation and a mental health policy and plan, but the legislation is from 1936 and the mental health policy and plan were last revised in 1986. There is no disaster/emergency preparedness plan for mental health. A national human rights review body exists, but there were no inspections either in mental hospitals or in community-based psychiatric inpatient units during the last year. Most of the mental health financial resources are in the mental hospitals.

The mental health system in Uruguay includes all types of mental health facilities (35 outpatient facilities, 31 day treatment facilities, 25 community based facilities, 2 mental hospitals and 8 other residential facilities). During the last ten years the government has reduced the numbers of beds in mental hospitals and promoted the building of community based psychiatric inpatient units. However, most of the psychiatric beds are still in the mental hospitals. The aim of the mental health authority is to reduce inpatient care, to improve mental health training for primary care, and to improve outpatient mental health care. Another concern is that few facilities are devoted to children and adolescents. Fortunately, psychotropic medicines are available in all facilities and all mental disorders are covered in social insurance schemes.

Uruguay has a high number of psychiatrists working in mental health facilities (19.36 per 100,000 population). However, there are few nurses and occupational therapists working in mental health facilities. Refresher training is scarce for most professional groups and the distribution of human resources between urban and rural areas is disproportionate to the population.