BUILDING MENTAL HEALTH CARE INTO LATIN AMERICAN PRIMARY CARE

Geisel researchers are leading an international team creating a sustainable mental health care model in Colombia

by Susan Green

Colombia's high rate of depression and alcoholism is exacerbated by more than 50 years of endemic violence. Though depression is among the top causes of misery and disability globally, health-care systems including those in low- and middle-income countries have not been responsive to the prevalence of mental health disorders among their populations. Inadequate insurance coverage, an insufficient number of psychiatrists, and a dearth of primary care providers trained to recognize symptoms are among the factors contributing to this treatment gap.

Psychiatrists Carlos Gómez-Restrepo and Miguel Uribe are intimately familiar with these issues. Long dedicated to easing the high burden of mental illness, they are leaders in the transformative work being done around mental health care in Colombia and are now part of a new partnership between Geisel School of Medicine and Pontificia Universidad Javeriana. The 31-member interdisciplinary team is working toward creating, implementing, and evaluating a sustainable mental health care model, which leverages science-based mobile interventions into Latin America's health-care systems.

A five-year initiative, the Latin American Mental Health Project is funded by a grant from the National Institute of Mental Heath (NIMH), part of the National Institutes of Health, to Dartmouth's Center for Technology and Behavioral Health (CTBH).

"This is an ambitious project with a lot of partners and a broad array of stakeholders, including researchers, governmental organizations, patient advocacy organizations, insurance company payers, and non-governmental and multilateral organizations in both the United States and Latin America," says Lisa Marsch, PhD, director of CTBH and the project's principal investigator.

Marsch is a leading researcher in using digital technology for therapeutic purposes and has demonstrated that technology-based interventions can produce comparable positive therapeutic outcomes to face-to-face interaction with a therapist.

"Focused on reducing the treatment gap for depression and alcohol abuse in Colombia, the ultimate goal of this pilot project is to implement a novel mental health care model and evaluate its sustainability along with training primary care clinicians to offer resources to patients," Marsch explains. "But expanding access to mental health care in a way that can be rapidly scaled to a population level is a global challenge."

Many low- and middle-income countries are dealing with widespread constraints in mental health care delivery. Leonardo Cubillos, MD, MPH, a resident in psychiatry and senior policy advisor at Dartmouth, is well versed in the machinations of health-care systems in his homeland of Colombia and in other countries. Drawing on years of experience with the World Bank where he focused on health insurance and human rights in India, Africa, and Latin America, he says, "One of the most important values of this research from the international public health perspective lies in using the scientific method to adapt and test an innovative approach—mobile technologies—to potentially overcome supply constraints."

Sharing science-based methods and information contributes to the capacity building component of this initiative, which teaches other early-stage investigators how to develop science-based programs in their own countries and how to work with policy makers to implement those programs.

Studies of effective mental health interventions abound, but they lack recommendations on how to best implement interventions in low- and middle-income countries. Geisel researchers are well versed in therapeutic interventions and they have collective expertise in implementing evidence-based practices into treatment systems.

"Here at Dartmouth we have been building out support in the primary care system to identify and then address addiction and mental health in both the adult and child clinic. We are in the process of defining that care more systematically and building it out among the Dartmouth-Hitchcock Medical Center community groups," says William Torrey, MD, a professor of psychiatry at Geisel. "If we can figure out how to address this effectively in a primary care system in Colombia using mobile technologies, it can translate into affecting a lot of people's lives—that's exciting and interesting."

Uribe and Gómez-Restrepo, co-principal investigator, are optimistic about imbedding technology into the model of primary care. Both agree appropriate treatment through technology needs to be done in a way that is efficient and makes sense for the patient, especially those living in remote, difficult to reach areas. In addition to accessibility, treatment needs to be low cost—a high cost would burden patients and be difficult to implement.

Along with access, stigma, and the insufficient insurance coverage, primary care physicians in Latin America lack training to recognize mental health disorders, Gómez-Restrepo says. Patients are equally uninformed about mental health issues and may not recognize they need help. Training physicians to recognize symptoms of depression and alcohol use is an important part of the pilot as well as educating the public.

"If you screen for depression within the primary care setting, you will likely find a lot of cases—perhaps up to 20 percent of people who visit a physician may have some level of depression," Uribe says. "And you have to be sure you are going to be able to either treat or offer some help to the people you are diagnosing. Otherwise it does not make sense to screen for this then not be able to offer an effective treatment."

Though there are programs and treatments available to those who suffer from severe mental health disorders, most services for those with less severe disorders are fragmented and reflect a long-standing weakness in the Colombia health system. Psychiatry is mostly practiced in mental hospitals, not in ambulatory settings or by solo practitioners, meaning patients with schizophrenia receive care while those with moderate mental health issues, such as depression, are on their own. To a great extent, this reality is a common feature across health systems of many other low- and middle-income countries.

BUILDING MENTAL HEALTH CARE INTO LATIN AMERICAN PRIMARY CARE

Efforts to reform and strengthen primary care in Latin America have redoubled in recent years. Job turnover among primary care providers is high, so training and maintaining the motivation of the workforce to treat mental health issues is a big hurdle requiring significant behavioral change—the same is true for the lingering cultural stigma around mental health issues.

With a summer 2017 implementation rollout looming, everyone involved in the Latin American Mental Health Project gathered for their first face-to-face meeting in Bogotá last September.

While in Bogotá, the delegation toured the pilot study site where Gómez-Restrepo and Uribe introduced the researchers to the clinic's physicians and delved further into the workings of the Colombian health-care system. "Being there was very useful. Seeing the environment, meeting the people, and getting to know each other better makes us more productive and efficient," Torrey says.

Gómez-Restrepo's team is leading the effort to better understand the landscape of primary care and how mental health care can be embedded into their systems during this early, developmental phase of the project. He has already begun training physicians and other providers affiliated with the pilot site to screen for depression and will continue expanding that training to a large array of providers in primary care in Chile and Peru as well.

An important part of leveraging mobile interventions to deliver a scalable, science-based solution requires an understanding of what is already being done and what people have access to so the team can refine the implementation model.

To that end, interviews, focus groups, and a large-scale survey is underway with community members, patients, primary care physicians, and administrators across three diverse regions in Colombia—Bogotá, Lerida, and Duitama—to gauge people's access to and use of mobile technology and the Internet. Colombian researchers will gather data to create a snapshot of access and use in both urban and rural areas and whether or not people want their primary care physician to be involved with treating depression or alcohol use.

> "This project is a true collaboration between the teams from Dartmouth and Colombia, and is being adapted to both local and cultural norms prior to implementation."

"This project is a true collaboration between the teams from Dartmouth and Colombia, and is being adapted to both local and cultural norms prior to implementation," Uribe says. "That the model will be workable for other sites in the region is something that is very exciting."

Once the pilot is in place, researchers will begin a multi-level analysis evaluating the clinical outcome of patients' depression and problematic drinking to the organizational impact of this model of care—and the cost impact by working with insurance company payers to see how it affects their expenditures.

"I love this project," Marsch says. "This is exciting work and a process of discovery because we are all learning together. We have such a great team and they are so committed to the collective effort."

For Uribe, this is a unique opportunity to place mental health on the national agenda, "In Colombia, with the peace process launched, we are in a post-conflict era that will yield a lot of investments and international collaborations—good mental health is an important part of any post-conflict society."

SUSAN GREEN IS A SENIOR WRITER FOR *DARTMOUTH MEDICINE.*

Latin American Mental Health Project team members gathered in Bogata for their first meeting last fall. LIsa Marsch is front row center.