WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
IN
COSTA RICA
WHO-AIMS

REPORT ON

MENTAL HEALTH SYSTEMS

IN COSTA RICA


COSTA RICA
2008

By the Ministry of Health of Costa Rica
Social Security Institution of Costa Rica
Panamerican Health Organization (PAHO/WHO)
WHO’s Department of Mental Health and Substance Abuse (MSD)
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The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was conceptualized and developed by the Mental Evidence Research Team (MER) of the Department of Mental Health and Substance Abuse (MSD), World Health Organization, Geneva, in collaboration with colleagues inside and outside of WHO.

For any further information please refer to WHO-AIMS (WHO, 2005) at the following Website: http://www.who.int/mental.health/datos_probatorios/WHO-AIMS/en/index.html

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Presentation

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) to collect essential information on the mental health system in the countries.

In 2007, Costa Rica used this instrument to collect information available from different sources related to its mental health system. The goal of this assessment is to improve the mental health system and provide a baseline for monitoring the change.

This document contains the Final Report, which highlights the country's main limitations and problems in the area of mental health, as well as the recent progress achieved in this area. Having a baseline with reliable and validated data will allow the country to continue to work to improve its mental health services.

It is important to point out that the country has an updated mental health policy, and a national mental health plan that address all the components in healthcare. One notable weakness is not having specific funding to achieve the goals of this policy and plan.

Additionally, the Social Security Institution of Costa Rica, which is legally bound to provide coverage to the entire Costa Rican population, has a health service network composed of first, second and third level of care. The first level of health care in mental health provides basic care. The second level provides healthcare services through external consultation and hospitalization in general hospitals. At the third level of care, mental hospitals, concentrated in the metropolitan area, provide specialized treatment. It is important to mention that most psychotropic medications are available in Costa Rica for the entire population.

Finally, we would like to recognize the team that developed and conducted this work, and especially to the authorities of the Social Security Institution of Costa Rica and of the Ministry of Health of Costa Rica for their support in this initiative. The assessment would not have been possible without the cooperation of the Regional Unit of Mental Health of PAHO/WHO and the Department of Mental Health and Substance Abuse of WHO. From now on, the most important thing is to transform this recently completed assessment into a tool for planning and implementing new actions. The PAHO/WHO country office in Costa Rica feels satisfaction for being able to contribute to this project in search of better health mental care for the Costa Rican population.

Dr. Carlos Samayoa  
PAHO/WHO Representative, Costa Rica
MENTAL HEALTH SYSTEMS IN COSTA RICA

Evaluation Results using WHO-AIMS

Geographical Division of Costa Rica

San José, Costa Rica
November, 2008
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 Costa Rica. The goal of collecting this information is to improve the mental health system and provide a baseline for monitoring the change. This will enable Costa Rica to develop information-based mental health plans with clear baseline 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.

An important strength in Costa Rica’s mental health system is the existence of an updated national mental health policy and plan that address all areas in health care. On the other hand, a notable weakness is the lack of specified funding to perform and achieve the goals of this policy and plan. Nonetheless, the country’s social security system provides health care, access to services, and medication from its official list of medicines (LOM). In addition, Costa Rica complies with human rights standards for people with mental disorders, and regular reviews of such compliance are conducted in mental health facilities throughout the country.

Costa Rica has a health service network that includes first, second, and third level of care. Primary care consists of first level of healthcare or basic mental health care since there is no specialized healthcare program in the community. Mental hospitals are concentrated in the metropolitan area, which makes access to services very difficult for the general rural population. A similar situation exists with community residential facilities. While the majority of mental health patients are treated in outpatient facilities, these facilities have the fewest resources available to integrate quality care.

It is worth highlighting that most psychotropic medications are available in Costa Rica for the entire population, as the law provides for complete coverage under its social security system. Only medical personnel are allowed to prescribe and refer patients. There are no established protocols available for most mental disorders; however, an adequate reference and counter-reference system exists at the first level of care to provide appropriate services.

Continuous refresher training, albeit irregular and sporadic, has been provided in some areas (e.g. child mental health, alcohol/drugs, and depression) to primary healthcare personnel, specialists, and other health workers. However, the lack of record-keeping as to the number and type of trained professional is a limitation in the system. Despite this continued training and education, overall, primary healthcare personnel receive little annual training on mental health.

The Social Security Institution of Costa Rica (CCSS - acronym in Spanish) has a specific information system for mental disorders that, at the moment, needs to be reformed to allow for a more qualitative analysis of the mental health information. Additionally, the collection of mental health information does not include international classifications of disorders, making data collection and decision-making processes difficult. Likewise, research on mental health in Costa Rica is scarce, and the research that is conducted is done primarily by universities.

Several education campaigns have addressed a variety of mental health issues, like alcoholism, drugs and violence, and have targeted the general public.

Overall, mental health resources are insufficient, unevenly distributed, and concentrated in the third level of care: all of which impedes the creation, formation or sustainment of community-
based health units. Although mental hospitals receive the most resources compared to any other type of facility in any other level of care, mental hospitals provide care to the highest number of users.

Even though there is equal access to mental health services, there are geographical and cultural barriers for indigenous groups.

There are family and consumer associations present in Costa Rica, but they are not regulated by the state. Interaction between these associations and the CCSS’s health services are limited and not quantified. The government department responsible for mental health has formal links with various other government sectors via different commissions.

The ombudsman is the body responsible for ensuring the protection of human rights, including for people with mental illness, although monitoring and inspection are insufficient.
Introduction

The Republic of Costa Rica belongs to the Central American Isthmus and, within this context, has been recognized for its leadership on health indexes similar to those of developed countries, for its Social Security system, for its democracy, for being a country without armed forces, and for being a promoter of education and social policies throughout its history. Costa Rica has a republican government with democratic elections every four years, and is composed by four Powers: Executive, Legislative, Judicial, and Supreme Electoral Court. Its geographical area is 51,100 Km² and is administratively divided into 7 Provinces, 81 Cantons and 470 Districts. The population as of July 1, 2006 was 4,401,849 inhabitants, 2,238,327 of which are males (50.8%) and 2,163,522 are females (49.2%). Its official language is Spanish, and its religion is the Apostolic Roman Catholic, but it is a secular society. The most important indigenous groups are the following: Bribri with a population of 11,062, Brunca with a population of 3,936, Cabécar with 10,175 population, Chorotega with 995 population, Huetar with 1,691 population, Térraba with 1,425 population, Maleku with 1,115 population, and Guaymí with 2,729 population. The legal currency is the Colon. The climate is tropical with dry and rainy seasons. The country is considered a middle high income group country based on World Bank criteria. Thirty four percent of the population is under the age of 15 and 8% of the population is over the age of 60. Forty two percent of the population lives in rural areas and 58% in urban areas. Life expectancy at birth is 78.4 in general, 76.1 for males and 80.8 for females. The total literacy rate is 95.2: 95 for males and 95.5 for females.

With respect to basic house utility services, 96.7% have electricity, 89.5% have toilet connected to public sewerage system or septic tank, 89.3% consume water from an aqueduct and 97% are supplied with water from piping. The proportion of the health budget to Gross Domestic Product is 5%. The total number of hospital beds is 5,696, which represents a rate of 1.32 per 100,000 population. In terms of the organization of the healthcare system, there are three levels of care; the first level covers 97 health areas throughout the national territory, which are divided as population and management geographical units, characterized by a specific epidemiological profile. These areas consist of 812 sectors distributed throughout the entire country. Each sector has a basic health team (EBAIS – acronym in Spanish) composed by one general doctor, one nurse-auxiliary, one primary healthcare technician, one pharmacy technician and one medical records technician. The second and third levels of care consist of specialized services and better decision capacity (Health Areas, peripheral, regional, national and specialized hospitals). The number of doctors per 10,000 population is 20.8, for nurses it is 16.05, and for dentists it is 6.75. There are currently a total of 135 psychiatrists registered in the Board of Physicians and Surgeons.

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Costa Rica. The goal of collecting this information is to improve the mental health system and provide a baseline for monitoring the change. This will enable Costa Rica to develop information-based mental health plans with clear baseline 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.
METHOD AND PROCEDURES

**The Assessment Instrument for Mental Health Systems**

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was developed by the Evidence Research Team of the Department of Mental Health and Substance Abuse, World Health Organization, together with a team of consultants. The preparation of the instrument was based on the ten key recommendations that promote the development and improvement of services to mental healthcare, published in the World Health Report, 2001. For the purpose of WHO-AIMS, a mental health system is defined as all the activities whose primary purpose is to promote, restore or maintain mental health and includes all organizations and resources geared towards achieving these objectives. This instrument was used to assess the ten key components and identify the main weaknesses in Costa Rica's mental health system. This baseline information will inform efforts to redirect the country's mental health policies and plan, and subsequently, help monitor their progress. WHO-AIMS consists of 6 interdependent, conceptually related and even overlapped domains, with 28 paragraphs and 154 items.

**Data collection**

In March 2007, the process was initiated with a visit from the Minister of Health to express her support for the evaluation, and to state its purpose and importance to the country. As the next step, a meeting was held at the Ministry of Health where the instrument was introduced and discussed with potential candidates who would conduct the study, the national coordinator for mental health, and two consultants from WHO.

The consultant responsible for collecting and organizing WHO-AIMS-based information was allowed three months to complete the work. A three-month extension was granted due to personal reasons, difficulties in scheduling and conducting interviews with key informants, and difficulties collecting information that was not systematically recorded via databases. Multiple work meetings to discuss the progress were held with the national consultant under contract, the mental health coordinator of the Ministry of Health, and the mental health consultant for the PAHO/WHO country office. Furthermore, in September 2007, a meeting was held in Costa Rica with the PAHO/WHO Subregional Consultant in Mental Health for Central America, Hispanic Caribbean and Mexico, and with the national team to discuss, validate, and thereby ensure the quality of the data. The WHO-AIMS team at WHO Geneva headquarters also reviewed the report, made clarifications and recommendations, and gave their approval for developing the final report. The information is based on the year 2006, and represents services within the public sector, as the information from the private sector could not be collected.

Report findings will be presented and discussed at a national workshop with representatives of institutions that address mental health in the country, in order to identify priorities and establish an action plan that includes short-term and medium-term objectives and goals.

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Domain 1: Policy and Legislative Framework

Policy, plans and programs

In 2006, Costa Rica revised its national mental health policy, which includes the following elements: development of community mental health services, organization of mental hospitals, development of a mental health component in primary healthcare, human resources, participation of consumers and families, advocacy, defense, promotion and protection of human rights of users, equity of access to mental health services among different groups, funding, quality improvement and an evaluation system. To make this policy operational, a national mental health plan was developed, which was recently revised and reformulated for the 2004-2010 period. This plan has the following elements: development of mental health services, organization of large mental hospitals, modification of mental hospitals to provide better integral care of a mental health component in primary healthcare, financial resources, participation of users, advocacy, defense and promotion, protection of human rights of users, equity of access to mental health services among different groups, quality improvement and an evaluation system. However, it does not have information on funding of such components. Some of the goals included in the plan have been reached in recent years, especially mental health care for children-youth. Currently, there is no mental health contingency plan per se for emergencies and disasters, although there have been a few non-systematic efforts in this area (e.g., by EDAN - Evaluación de Daños y Necesidades), which have involved assessments of the needs and damages in some communities affected by natural disasters.

The Social Security Institution of Costa Rica, as the primary provider of health services in the country, has an official list of essential medications (LOM). This official list includes antipsychotic, anxiolytic, antidepressant, mood stabilizers, and antiepileptic medicines.

The last legislation on mental health was enacted in 1999, and includes the following components: access to less restrictive care, rights of users, families and other citizens in mental health services, competence issues, capability and guardianship for people with mental disorders, voluntary and involuntary treatment, accreditation of professionals and services (facilities or units), law enforcement, and other issues of the legal system for people with mental disorders. In addition, this legislation includes mechanisms for overseeing admission practices and involuntary treatment, and mechanisms for implementing the provisions of mental health legislation. A General Health bill is currently in Legislative Assembly, which includes several chapters on mental health to guarantee equity, quality and timely access to community mental healthcare.

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Financing of mental health services

Three percent of the government’s health budget is directed toward mental health (see graph 1.1), through the Social Security Institution of Costa Rica. Mental hospitals receive 67% of all mental health expenditures (see graph 1.2). The majority (80%) of the population has free access to essential psychotropic medicines. For those who pay for their medicines, the average cost of antipsychotic medication is 1,229 Colons, or 25% of the minimum wage. In contrast, the cost of antidepressant medication is 215 Colons, which represents 4% of the minimum wage of a Costa Rican worker. The federally established minimum wage is 4,956 Colons. All mental disorders and all mental health problems of public interest are covered by social security schemes.

Graph 1.1 Mental Health Expenditure by the Social Security Institution of Costa Rica

Graph 1.2 Mental Health Expenditures
**Human rights policies**

The Ombudsman Office serves as the national human rights review body, and has the authority to: 1) Monitor or inspect mental health facilities or units on a regular basis, 2) Oversee involuntary admissions and discharge procedures, 3) Oversee claims investigation processes, and 4) Impose sanctions (for example, removal of accreditation, impose fines or close those facilities that repeatedly violate human rights).

All mental hospitals have at least one review/inspection per year of human rights protection of patients, while 0% of psychiatric units in general hospitals and residential facilities have such a review.

In terms of training on the protection of patients’ human rights, no accurate data is available on the percentage of staff in mental hospitals and in psychiatric units within general hospitals and in residential facilities trained in the year of the assessment.

**Domain 2: Mental Health Services**

**Organization of mental health services**

Within the Ministry of Health’s Health Promotion Unit, a psychiatrist oversees mental health at the national level. This professional has the temporary support of a national commission that is currently inactive due to restructuring of the institution. This commission provides advice to the government on mental health policies and legislation, service planning and coordination, monitoring, and quality assessment of mental health services in coordination with other Directorates of the Ministry of Health.

Mental health services, provided by the Social Security Institution of Costa Rica (CCSS), are organized in terms of catchment areas.

**Mental Health Outpatient Facilities**

There are 38 mental health outpatient facilities available in the country, of which 8% (3) are for children and adolescents only. These outpatient facilities treat 1,916 users per 100,000 general population. Of all users treated in mental health outpatient facilities, 62% are females (52,298) and 22% are children or adolescents (18,771 adolescents, 15 years of age or less). The users treated in outpatient facilities are primarily diagnosed with: mood disorders (36%; F30-F39) and neurotic disorders, stress-related disorders and psychosomatic disorders (26%; F40-F48).

The average number of contacts per user is 4.32. Only 3% of outpatient facilities provide follow-up care in the community, while the total number of mobile mental health teams is unknown. In terms of available treatments, most outpatient facilities (51% to 80%) offer psychosocial treatment/interventions. All mental health outpatient facilities had at least one psychotropic medication of each therapeutic class (antipsychotic, antidepressant, mood stabilizers, anxiolytic and antiepileptic) available in the facility or a near-by pharmacy all year round.

It is necessary to clarify several special situations in this regard. The Calderon Guardia Hospital suffered a fire in the year 2005, which caused major damage to its structure, and thus affected...
its service delivery, including psychiatric services. Consequently, damages resulting from the fire also affected its hospitalization capacity, forcing it to hospitalize only female patients. On another case, the Mexico Hospital and San Juan de Dios Hospital do not have specific psychiatric beds, but have the possibility of hospitalizing patients in Internal Medicine beds and other services; this is why statistics on hospital discharges do not reflect psychiatric hospitalizations. Other regional and peripheral hospitals also face a similar situation, except for the regional Limon Hospital, which does have exclusive psychiatric beds.

**Day treatment facilities**

There are 2 day treatment facilities (day hospital) available in the country, both located in the capital city. None are for children and adolescents only. These facilities treat 3,68 users per 100,000 population. Of all users treated in day treatment facilities, 38% are females. On average, users spend 9.57 days in this type of facility.

**Psychiatric Units in general hospitals**

There are 26 psychiatric units in general hospitals in the country, with a rate of 2 beds per 100,000 population. There are no data available on the number of beds reserved for children and adolescents only.

Forty seven percent of admissions to psychiatric units in general hospitals are females and 6% are children/adolescents. The diagnoses of admissions to psychiatric units in general hospitals are primarily from the following diagnostic groups: 17% represented by mental and behavioral disorders due to the use of psychoactive substances (F10-F19) and 38% represented by mood disorders (F30-F39). The average stay was 8 days per patient discharged. All or almost all patients (81% - 100%) in psychiatric inpatient units within general hospitals received one or more psychosocial interventions in the past year, while 69% of these units had at least one psychotropic medication of each therapeutic class (antipsychotic, antidepressant, mood stabilizers, anxiolytic and antiepileptic) available in the facility.

**Community residential facilities**

There are 35 community residential facilities available in the country, with a rate of 3.9 beds per 100,000 population. Ten percent of these beds in community residential facilities are reserved for children and adolescents only. Forty eight percent of users treated in community residential facilities are females and 26% are children. The number of users in these facilities was 199 and the average number of days spent was 322.81 days.

**Mental Hospitals**

There are 2 mental hospitals in the country, located in the central area of the capital city, with 22 beds per 100,000 population. Both of these facilities are organizationally integrated with mental health outpatient facilities. Two percent of these beds are reserved for children and adolescents. The number of beds has decreased by 6% in the last five years. The patients admitted in the mental hospitals belong primarily to the following diagnostic groups: schizophrenia, psychotypical and delirious disorders (28%; F20-F29) and mood disorders [affective] (37%; F30-F39). The number of patients treated in general hospitals is 5,547 with a rate of 126.01 per 100,000 population. The average stay of patients is 47 days. Fifty eight percent of patients spent
less than a year, 14% between 1 and 4 years, 9% between 5 and 10 years, and 19% more than 10 years in mental hospitals.

All or almost all patients (81-100%) received one or more psychosocial interventions in the last year. Both mental hospitals had at least one psychotropic medication of each therapeutic class (antipsychotic, antidepressant, mood stabilizers, anxiolytic and antiepileptic).

**Forensic and other residential facilities**

There is one forensic unit with psychiatrists, but it does not hospitalize people with mental disorders. Persons treated in this unit who require hospitalization are referred to the National Mental Hospital.

The number of beds in other residential facilities, such as homes for persons with mental retardation, disintoxication inpatient facilities, homes for the destitute, etc. is unknown.

**Human rights and equity**

Involuntary admissions to psychiatric units in general hospitals and mental hospitals are unknown. Between approximately 11 and 20% of patients were restrained or secluded at least once within the last year in psychiatric units within general hospitals, in comparison to 20% or more of patients in mental hospitals.

More than 80% of psychiatric 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 (e.g., linguistic, ethnic or religious minorities) is a moderate issue.

**Summary Charts**

The majority of psychiatric beds (79%) are found in mental hospitals, followed by community residential units (14%) and psychiatric units in general hospitals (7%) (see graph 2.1). The number of beds in other residential facilities is unknown.
The majority of users are treated in outpatient facilities (1,916 per 100,000 population). Mental hospitals have an average of 126 users per 100,000 population, while psychiatric units within general hospitals average 53.3 per 100,000 population; day treatment facilities have 3.68 per 100,000 population, and residential facilities have 4.52 per 100,000 population, see Graph 2.2.

On average, females make up close to 50% of the user population in all mental health facilities in the country. The proportion of these female users is highest in outpatient facilities (62%) and in mental hospitals (56%), and lowest in day treatment facilities (38%), see graph 2.3.
The percentage of children and/or adolescents varies significantly from facility to facility. The proportion of children users is highest in residential facilities (26%) and lowest in mental hospitals (2%) (see graph 2.4).

The distribution of diagnoses varies across facilities: neurotic disorders in outpatient facilities are 26% and affective disorders in psychiatric units in general hospitals are 36%. In general hospitals, schizophrenia diagnoses represent 28% and affective disorders 37%, (see graph 2.5).
The longest length of stay for users is in community residential facilities (322.81), followed by mental hospitals, and then psychiatric units in general hospitals (graph 2.6).

Psychotropic medicines are available in all mental hospitals, in all outpatient facilities, and in 69% of psychiatric units in general hospitals (graph 2.7).
The ratio between outpatient/day care contacts and days spent in inpatient facilities (mental hospitals, residential facilities and units of general hospitals) is an indicator of the extent of community care. In this country the ratio is 1:1 (see graph 2.8).

Graph 2.7 - Availability of psychotropic drugs in Mental Health facilities

Graph 2.8 - Inpatient Care versus Outpatient Care

Domain 3: Mental Health in Primary Health Care

Training in mental health care for primary care staff

Three percent of the training for medical doctors is devoted to mental health, in comparison to 9% for nurses; the percentage of non-doctor/non-nurse primary health care workers is unknown. In terms of refresher training, 3% of primary health care doctors have received at least two days of refresher training in mental health, while the number of nurses and of non-doctor/non-nurse primary health care workers who have received such training is unknown. There is training for
non-doctor/non-nurse workers but there are no adequate records to determine the type of professional who is receiving such training (graph 3.1).

**Graph 3.1 - % of Primary Health Care professionals with at least two days of refresher training in Mental Health in the last year**

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>1%</th>
<th>2%</th>
<th>3%</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHC Doctors</td>
<td>3%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Mental health in primary health care**

All the primary health care centers in the country have a doctor and most of these centers (51 – 80%) have assessment and treatment protocols for key mental health conditions available, which are administered by doctors. Most primary health care centers (80-100%) make an average of at least one referral per month to a mental health professional.

As for professional interaction between primary health care staff and other health care providers, the majority of primary care doctors (51 – 80%) have interacted with a mental health professional at least once in the last year. However, no doctor interacted with a complimentary/alternative/traditional practitioner during the year of the assessment.

**Prescription in primary health care**

In Costa Rica, doctors are the only health professionals allowed to prescribe psychotropic medicines. Primary health care doctors are allowed to prescribe but with restrictions. All or almost all primary health care facilities (81 – 100%) have at least one psychotropic medication of each therapeutic class (antipsychotic, antidepressant, mood stabilizers, anxiolytic and antiepileptic).

The Official List of Medicines (LOM) of the CCSS specifies what type of medicines can be prescribed without restriction by primary health care doctors. In those cases in which the patient has been examined by a specialist, medication can be continued with the indicated prescription.
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 is 19,39 per 100,000 population. The breakdown according to professionals is as follows: 135 psychiatrists, 19 other medical doctors (not specialized in psychiatry), 182 nurses, 83 psychologists, 76 social workers, 63 occupational therapists, and 297 other health or mental health workers (graph 4.1).

<table>
<thead>
<tr>
<th>Category</th>
<th>Count per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>3.02</td>
</tr>
<tr>
<td>Other Doctors</td>
<td>0.43</td>
</tr>
<tr>
<td>Nurses</td>
<td>4.13</td>
</tr>
<tr>
<td>Psychol</td>
<td>1.88</td>
</tr>
<tr>
<td>Social Workers</td>
<td>1.72</td>
</tr>
<tr>
<td>Occup. Therapists</td>
<td>1.43</td>
</tr>
<tr>
<td>Other</td>
<td>6.74</td>
</tr>
</tbody>
</table>

Seven percent of psychiatrists work only for government administered mental health facilities, 2% work only for nongovernmental organizations (NGOs), for profit mental health facilities and private practice, while 90% work for both the sectors. In terms of psychologists, the percentage who works in different institutions is unknown. With regard to the workplace, 60 psychiatrists work in outpatient facilities, 49 in psychiatric units of mental hospitals, and 26 in mental hospitals. The number of other medical doctors, not specialized in psychiatry, who work in outpatient facilities and psychiatric units of general hospitals, is unknown. Fifteen non-specialized medical doctors work in mental hospitals. With regard to nurses, 46 work in outpatient facilities, 22 in psychiatric units of mental hospitals, and 114 in mental hospitals. As for psychologists, social workers and occupational therapists, 83 work in outpatient facilities and mental hospitals, while 26 work in psychiatric inpatient units within general hospitals. As for other mental health care staff, 43 work in psychiatric units in general hospitals, and 254 in mental hospitals, whereas the number working in outpatient facilities is unknown (graph 4.2).
In terms of staffing in mental health facilities, there are 0.56 psychiatrists per bed in psychiatric inpatient units within general hospitals, compared to 0.03 psychiatrists per bed in mental hospitals. As for nurses, there are 0.25 nurses per bed in psychiatric inpatient units within general hospitals, in comparison to 0.16 nurses per bed in mental hospitals. For other mental health care staff, there are 0.30 psychologists and occupational therapists and 0.49 of other health care staff per bed in psychiatric inpatient units in general hospitals. Finally, there are 0.09 psychologists and occupational therapists and 0.35 of other health care staff per bed in mental hospitals. See graph 4.3.
The distribution of human resources between urban and rural areas is unfair: the ratio between psychiatrists who work in or near the largest city and the overall country is 1.54 and for nurses is 2.61.

**Training professionals in mental health**

The number of professionals graduated last year in academic and educational institutions is as follows: 5 psychiatrists, 699 medical doctors and 357 nurses. The number of psychologists, occupational therapists, and social workers with at least 1 year training in mental health is unknown; and the number of other health or mental health professionals with such training is also unknown (including auxiliary staff, medical assistants, professional and paraprofessional psychosocial counselors). A small number (20%) of psychiatrists emigrate to other countries within 5 years of the completion of their training.

![Graph 4.4 - Professionals graduated in the last year (rate per 100,000 population)](image)

At the national level, the Center for Strategic Development and Information on Health and Social Security (CENDEISSSS) is the body responsible for health training. Even though there is substantial health training, there is no updated information on the type or number of professionals who receive mental health training per year.

The graph 3.1 shows the percentage of mental health care staff with at least two days of refresher training in the rational use of drugs, psychosocial interventions, and child/adolescent mental health issues.

**Consumer and family associations**

There are 50 members of consumer associations and 113 members of family associations. The government does not provide economic support for consumer associations or for family
associations. Both consumer and family associations have been involved in the formulation or implementation of mental health policies, plans or legislation in the past two years. Some mental health facilities (21 - 50%) have interacted with some user and family associations. In addition to consumer and family associations, there are 6 nongovernmental organizations in the country involved in individual assistance activities such as counseling, housing or support groups. Information on all nongovernmental organizations and associations is not centralized, and in some cases these institutions are not registered in the civil registry, thus making it difficult to know how many actually exist in the country.

Domain 5: Public Education and Links to other Sectors

Public education and awareness campaigns on mental health

There is a coordinating body in the country that oversees public education and awareness campaigns on mental health and mental disorders in different institutions and organizations, including: government institutions (e.g. Ministry of Health, Social Security Institution of Costa Rica), nongovernmental organizations, professional groups, private foundations, and international agencies. These campaigns have targeted the following groups: general population, children, adolescents, women, trauma survivors, other vulnerable groups or minorities. However, there are no data on campaigns targeting ethnic groups. Additionally, there have been public education and awareness campaigns targeting professional groups, including: healthcare providers, teachers, social service personnel, leaders and politicians, and other professional groups related to the health sector, but it is unknown if they have been involved in the complimentary/alternative/traditional sector.

Legislative and financial provisions for persons with mental disorders

Legislative and financial provisions on employment and work discrimination exist to protect and provide support to users; these provisions are contained in Law 7600. Thanks to this law and to the coordination of the mental hospital with the National Council of Rehabilitation and Special Education that governs the area of disability, we have been able to fight against work discrimination, as well as deinstitutionalizing a significant number of patients with chronic mental disorders.

Links with other sectors

In addition to legislative support, there are formal collaborations with the departments / agencies responsible for Mental Health Care, HIV/AIDS, reproductive health, child and adolescent health, substance abuse, child protection, education, employment and housing, social assistance, judicial system, and the elderly.

In terms of support for child and adolescent health, 4% of primary and secondary schools have either a part-time or full-time mental health professional, while many primary and secondary schools (51%-80%) have school-based activities to promote mental health and prevent mental disorders.

In the criminal justice system, the percentage of prisoners with psychosis and mental retardation is less than 2%. Regarding mental health activities in the criminal justice system, most prisons (51%-80%) have at least one prisoner per month in treatment contact with a mental health
professional. As for training, some police officers (21%-50%) and some judges (21%-50%) have participated in educational activities on mental health in the last five years. In terms of financial support for users, 20% of mental health facilities have access to programs outside the mental health facility that provide outside employment for users with severe mental disorders. Finally, the percentage of people who receive social welfare benefits due to mental disability is unknown.

**Domain 6: Monitoring and Research**

A formally defined list of 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. The Ministry of Health received data from 100% of mental hospitals, psychiatric inpatient units within general hospitals, and mental health outpatient facilities. Based on these data, a report was published which included comments on the data. In terms of research, 20% of all health publications in the country were on mental health. The research focused on epidemiological studies in community samples, epidemiological studies in clinical samples, and biological and genetic studies.

<table>
<thead>
<tr>
<th>Table 6.1 - Percentage of mental health facilities collecting and compiling data by type of information</th>
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<tbody>
<tr>
<td>Nº of beds</td>
</tr>
<tr>
<td>Nº of inpatient admissions / users treated in outpatient facilities</td>
</tr>
<tr>
<td>Nº of days spent/user contacts in outpatient facilities</td>
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<tr>
<td>Nº of involuntary admissions</td>
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<td>Nº of users restrained</td>
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<tr>
<td>Diagnoses</td>
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Strengths and Weaknesses of the Mental Health System of Costa Rica

**Strengths:**

- Costa Rica is among the 80% of countries with a National Mental Health Policy and Plan in effect. 45% of public institutions have considered the mental health issue and have included it in bi-weekly institutional plans.

- The existence of a national mental health program for children, coordinated by the Costa Rican Social Security Entity (CCSS) has allowed the intersectorial coordination and mobilization of national and international resources in order to address mental health determinants since the early stages of life.

- An extended outpatient service network and short internship in general hospitals is available throughout the regions of the country.

- By law, Social Security covers the entire Costa Rican population including mental health care, thus covering all first and second line medicines and psychosocial interventions. The assessment showed that 80% of facilities, including primary health care facilities had all five essential categories of medicines available (antidepressants, anxiolytics, antipsychotics, antiepileptics and mood stabilizers).

- From the legal perspective, equal access to mental health care services is ensured for every person throughout the life cycle, which represents an investment of 3% in health expenditure by the Costa Rican Social Security Entity.

**Weaknesses:**

- The National Mental Health Plan lacks financing leading to a limited implementation and thus a lower impact. Sensitization and empowerment of regional and local teams of the Ministry of Health is still very weak.

- One of the weaknesses is the sustainability of the children’s national mental health program, since this process requires permanent participation of the leading technical multidisciplinary group with the political support of CCSS's authorities.

- Health care services are mainly of pharmacological nature and within facilities. Insufficient human resources formed or trained to provide preventive, timely and quality care.

- Of the 3% of the national health budget on mental health in CCSS, 67% is directed towards the two mental hospitals while the remaining 33% towards other health services and prevention activities.
Although medicines in health services are widely available, no updated protocols exist for all four clinical cases and only doctors are authorized to prescribe psychotropic medication.

Although the Costa Rican health system has had an extended primary health care development, this has not been the case in mental health, where it is limited to isolated training in certain syndromes to general doctors.

Planning and execution of mental health investigation are in the early stage of development, with a large gap in the epidemiological profile of mental disorders among the national population.

No information and surveillance system on mental health is present to support timely decision making. Information is dispersed, not quantified and not systematically reported.

New Steps in Planning Mental Health Actions

The WHO-AIMS evaluation report will be presented and submitted to the authorities of the Ministry of Health and the Social Security Entity to inform them about the methodology used and results. It will also show that the 2004 – 2010 National Mental Health Plan has not been satisfactorily executed by those responsible institutions mentioned in the plan and they will be required to take on their commitment.

The WHO-AIMS evaluation report will also be printed and distributed to the different actors involved in the National Mental Health Plan.

Recommendations for action

Policies, plans and legislative framework

The national mental health plan needs to be updated and reoriented, setting short and medium term actions and concrete goals. Current mental health care institutions should be reformed into community models, including mental health in primary care and mental health promotion. More participation, including funding, should be required from the health sector’s institutions, as well as advocacy initiatives for having their own funding to provide sustainability.

To create urgently a national commission at high political and technical levels for the follow-up, surveillance and evaluation of mental health policies and plans.

Contracting human resources formed in mental health and training them for the execution of mental health policies and plans both at central and regional and local levels.
• To develop a national plan for the provision of mental health care to people affected by natural disasters in coordination with universities, CCSS, Costa Rican Red Cross, local governments, National Emergencies Commission, Children’s National Patronage and others.

**Mental Health Services**

• To take the existing inpatient units in general hospitals and transform them into real health care units, with trained interdisciplinary teams to provide integrated and quality care both internally and externally, with the participation of users and psychiatric patients’ family members, community leaders, private sector and other existing resources in the community.

• A reform plan of existing mental care services needs to be executed to decentralize all type of resources and strengthen or create community mental health units. Also, a plan of incentives should be considered to encourage current service workers to their transfer to first and second care levels.

• To decentralize external consultation and specialized human resources in mental hospitals towards community services.

• To create interdisciplinary and intersectorial teams in the CCSS’s health areas, to train them in risk management and group processes for mental health care in emergencies and natural disasters.

• Primary care intervention protocols and standards should be updated.

**Budget**

• To increase mental health budget directed towards CCSS and the Ministry of Health for contracting new personnel, provide training and creating or strengthening community services for an integral mental health care.

**Investigation**

• To promote the execution of national investigations on risk behaviors and protective factors of mental health.

• To promote, together with other Central American countries, investigations on determinant factors of social violence and their relations with mental health.

**Information System**

• The Ministry of Health should promote, coordinate and conduct the design and execution of a national interinstitutional information system on mental health and key indicators for the evaluation of processes, results and impact in mental health.
**Links with other sectors**

- To establish agreements with the Ministry of Public Education and the Children’s National Patronage for the development of mental health programs for teachers and students in educational centers.

- To establish political links and provide technical support to organizations in the civil society that work in mental health issues, and include them in the formulation of national and local mental health policies and plans.

- To improve effective coordination channels and joint planning in strategic areas with the Institute of Alcoholism and Drug Dependency – IAFA (acronym in Spanish) for conducting prevention activities.
BIBLIOGRAPHY


The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Costa Rica. The goal of collecting this information is to improve the mental health system and provide a baseline for monitoring the change. This will enable Costa Rica 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.

Costa Rica used this instrument in the year 2007, collecting available information from different sources in order to evaluate the conditions of the mental health system. Available information was collected from different sources to ensure reliability.

The work was conducted under the direction of the Ministry of Health of Costa Rica, with the support of the Social Security Institution of Costa Rica, PAHO/WHO Representation in the country, the Regional Unit of Mental Health of PAHO/WHO and the Department of Mental Health and Substance Abuse of the World Health Organization who provided their technical support and collaboration during the entire process.

This document is the Final Report of the assessment, which outlines the country’s main limitations and problems in its mental health care system. The report also outlines the country's progress in this area and its potential to reform mental health services.