# Mental health services in Nicaragua: Lessons for South Africa

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It is at present widely accepted among mental health workers and academics that South African psychology/psychiatry is in a state of crisis. In recent years we have seen the articulation of a challenge to the theory and practice of mental health from a large variety of sources, both inside and outside the country. It has been argued that mental health services are not only inadequate and inappropriate, but in many ways serve to legitimize and perpetuate the apartheid status quo in South Africa (for example: American Psychiatric Association, 1979; Dawes, 1985; Dawes, 1986; Dommisse, 1985; Dommisse, 1987; Hayes, 1987; Jewkes, 1984; Seedat, 1984; Vogelman, 1987a; Vogelman, 1987b). It has more recently been proposed that while the continuing critique of mental health services in South Africa is of obvious value, it is also necessary to examine alternative models of care (Vogelman, 1988a).

Arguments for a more appropriate mental health practice are popular in many circles, which has lead to the addressing of psychological concerns directly related to the apartheid regime and the repression inherent in the defence of this status quo. Organisations like OASSSA (Organisation for Appropriate Social Services in South Africa), detainees' counselling services and clinics, have been carrying out reparative work with victims of the system. Yet these attempts at an alternative have been largely responsive, dealing with the immediate psychological effects of apartheid and repression. There has been little focus on the future of mental health care in its wider context,

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although discussion within the paradigm of community psychology has been important in this respect (Lazarus, 1986; Vogelman, 1988b). Recently, Freeman (1988) has discussed mental health care in Zimbabwe and has pointed to some of the complexities involved in transforming services to meet the needs of a society in transition. Since radical mental health workers propagate social change as a precondition of mental health, it is evident that discussion about mental health care within the broader context of change in South Africa is overdue.

This paper arises out of research into an alternative mental health system - the Nicaraguan model. It aims to highlight aspects of the latter which we suggest are useful guidelines within the construction of appropriate, accessible and enlightened mental health services in South Africa, and hopes to build on a recent commentary on Nicaragua presented by Vogelman (1988c). It should be noted that the author has no personal experience with the Nicaraguan situation and that this paper relies on secondary sources.

**Background to Nicaragua's mental health system**

Nicaragua, like South Africa, has a history of oppression and exploitation of the majority of the population. It has emerged from the 45 year old Somoza dictatorship to construct a more equitable society with considerable achievements in the area of health, welfare and education since the Sandinista victory in 1979 (Melrose, 1985; Pickvance, 1987). There has been a particular focus on the provision of free, accessible and appropriate health services. Mental health has not been a priority, for obvious reasons in a Third World country, but it is clearly visible as a growing area of concern. Like the general health system, mental health services have been organised within a participatory democratic manner, challenging many of the classic problems of these services within both first and third world countries.

Before 1979, psychiatric and psychological services were scarcely accessible to the majority of Nicaraguans, but could only be obtained by a small elite grouping who were able to afford the private fees (Kroese, 1987). Those who were severely mentally ill were isolated in the psychiatric hospital in Managua. This hospital, the only one in the country, served as a "dumping ground" for those not considered worthy of rehabilitation (Personal communication - Varchevker). Substandard conditions existed with no attempt at therapeutic intervention. It has been claimed that psychologists during the Somoza regime served the interests of the status quo (Harris, 1987). For example, it is claimed that school psychologists would intervene with politically active students, treating them for behavioural problems. It is clear that despite the underdeveloped nature of mental health services in pre-revolutionary Nicaragua, there are many similarities to the more sophisticated South African system.

In post-revolutionary Nicaragua, the aim of the health system, including mental health, has been to provide free, accessible and decentralized services, with a focus on prevention rather than mere cure. Nicaragua has received advice and material support from a wide range of countries and groupings, but a major influence within the area of mental health is the "Mexico Group", now called the "Marie Langer Internationalist Group" (Kroese, 1987). As part of the reconstruction of Nicaragua the new government invited this group to work and teach in Nicaragua (Hooks, 1983). Since 1981, 2-3 members of the group, which is based in Mexico city, have been visiting Nicaragua every month for a period of 10 days (Hooks, 1983). They have been involved in the training of students, in research projects, in assessment of government projects and in teaching therapeutic techniques (Hooks, 1983; Pickvance, 1987). They have worked with the Faculty of Medicine and Psychology, with the Psychiatric Hospital and the Ministry of Health (Hooks, 1983). The team has a radical psychology tradition, drawing from psychoanalysis, systems theory and Marxism, with the assumption that psychological practice cannot be separated from political practice (Pickvance, 1987). Their stated goal has been the democraticization of mental health services (Pickvance, 1987).

**The Mental Health System in Nicaragua**

We have construed the structures dealing with mental health within three different categories; at the tertiary level is the psychiatric hospital and psychiatric wards in general regional hospitals; at the community level are psycho-social centres (CAPS), children's centres, and psychological services within the school and work-place; and at the popular level are support structures, which are not normally termed mental health services but obviously function as such, like the brigadistas (see below) and mass organisations (in particular AMNLAE, the women's organisation. These various levels of mental health services span the continuum of curative to preventative intervention. They also illustrate the incorporation of both professional and non-professional mental health care workers.

1. Hospitalization

There is still only one psychiatric hospital in Managua which is described as lacking facilities and under-staffed, but still a vast improvement on pre-Sandinista days (Hooks, 1983). There is strong de-emphasis on institutionalization with admission to the psychiatric hospital being a last resort (Hooks, 1983). In an attempt to challenge the social isolation of mental illness, patients will firstly be placed in general hospitals and will be admitted to the psychiatric hospital only under strict diagnostic criteria. These include emotional or organic psychosis, severe epilepsy and severe alcoholism (Hooks, 1983). Within the psychiatric hospital a ward has been set up for acute cases where intervention is carried out as soon as possible so as to return the patient back to society (Hooks, 1983). The Mexico group has tried to infuse the psychiatric hospital with a critical awareness of the implications of psychiatric

labelling as well as a skepticism of the traditional medical model (Hooks, 1983). More recently, the Italian model of Basaglia, which totally rejects institutionalization of psychiatric patients, has begun to have an influence at the psychiatric hospital (Pickvance, 1987). Electro-shock therapy is not present in Nicaraguan psychiatry at all and there is a cautious approach to the use of drugs (partly because of ideological reasons, but also because of the U.S. embargo on medical supplies to Nicaragua) (Kroese, 1987).

2. Community Mental Health Services

The primary unit for clinical psychology/psychiatry at the community level is the psycho-social centre (CAPS) of which there were about 17 throughout the country by 1986 (Personal communication - Varchevker). In that these are decentralised they go some way towards making mental health services more accessible to all members of the community. These centres function as day centres. Admission groups occur on certain days, so that a new client will attend an introductory group session in which diagnosis will take place (Personal communication - Varchevker). If necessary referral will follow, for example to a neurologist. Otherwise the new clients will then meet in a group for about twelve meetings. Short-term psychodynamic group work follows. The staff of a CAP is usually made up of four psychologists, a social worker and a psychiatrist (who may be a visiting one). The staff usually spend some time on research, self-education, training of other health workers and staff meetings. It is clear that a great deal of self-reflection and evaluation of their work takes place. The team members also travel to healthposts in villages close to the CAPS. During these visits they will train and supervise brigadistas, hold clinics, make home visits and collect statistical information. Following the emphasis on group work and the understanding of psychological problems in social context, most of the therapeutic intervention happens in a group setting with individual therapy being a rarity (Kroese, 1987).

Another level of psychological intervention within the community setting are centres for children, including residential and day centres. The emphasis on multi-disciplinary work within the entire health system is evident within these projects. An example of a residential centre for children is the I.N.S.S.B.I. (Social Security and Welfare Ministry) centre for "Protection and Prevention" in Managua (Kroese, 1987). This is for children who have been abused, abandoned or who have special needs (mental, physical or sensory handicaps). There are four psychologists employed in the centre, which houses about 100 children, who assess the children, develop individual programs and advise residential staff and teachers (Kroese, 1987). There are also 23 therapeutic day-centres in Managua to cater for children between 6-15 years from deprived backgrounds. Again a multi-disciplinary team of teachers, psychologists, social workers and art therapists is evident. The centres also attempt to organise parents' groups in order to advise them on child

management and family problems (Kroese, 1987).

Mental health work is also visible within the general health structure. Through the Mexico Group, doctors, nurses and other medical staff have been trained with psychological skills and knowledge. They have been involved in initiating a "Work and Study Programme" which incorporates a focus on mental health (Hooks, 1983), through a praxis-based approach to training (i.e. students spend time in the community attempting to integrate theory with practice). Thus there is a strong emphasis within the general health system on the emotional aspects of physical health. Another example of this is the involvement of psychologists in rehabilitation work with the large numbers of physically disabled war survivors (Kroese, 1987; Britten & Stenfert-kroese, 1988). Psychologists are found within a multi-disciplinary team at the Aldo Chevarria Rehabilitation hospital, the only rehabilitation hospital in Nicaragua. They undertake group assessments, run psychotherapy groups, provide individual psychotherapy and give psychosexual counselling. They are also involved in the Equipo Mobil (Mobile team) which serves the whole country and functions to reintegrate the patient back into his/her community. Home visits are made to the family and support work is carried out with them as well (Kroese, 1987; Britten & Kroese, 1988). It is evident that victims of the ongoing military defence against the contras are treated with sensitivity to their psychological needs. A war victim with psychological problems will receive priority at the CAPS and other mental health services (Kroese, 1987).

Psychological services are also present within community institutions, like schools, factories and rural productivity centres. Industrial psychology with a very different flavour to its First World Western counterpart, is a growing area (Harris, 1987). At the work place, psychologists are involved in the selection and promotion of personnel, as well as the provision of clinics dealing with stress and other mental health problems (Harris, 1987). In rural productivity centres, the Ministry of Agrarian Reform has been employing psychologists to work with rural peasants (Harris, 1987). The rural economy has been reorganised into co-operatives, but the ideological framework necessary for successful functioning has been lacking. Psychologists are part of a multi-disciplinary team of agronomists and others, in training farmers for co-operative farming (Harris, 1987).

3. Popular Mental Health

Popular mental health structures which perform a largely preventative function and are primarily carried out by lay people are evident within Nicaragua. In this respect popularization of mental health knowledge and skills as well as de-professionalization is occurring. The major vehicle for this level of mental health is the brigadista (voluntary health worker based in all communities at local level). Brigadistas have been extremely valuable within the general health system and have been largely responsible for projects like

mass immunisations (Melrose, 1985). More recently brigadistas have been trained in para-psychological skills and knowledge, like relaxation exercises, setting up of self-help groups and the problem of "frozen grief" (the somatization of unresolved bereavement) (Kroese, 1987; Personal communication - Varchevker). The Mexico group has been involved in the programmes for the trainers of brigadistas, with input on family therapy, crisis intervention, theories about the development of the personality and problems that may arise, etc. (Personal communication - Varchevker). Brigadistas view themselves as "multipliers" of knowledge who should pass on their skills and knowledge to those that they work with. The ideology of "multipliers", that is the spreading of knowledge, is an important part of the popularization of medical and psychological knowledge and services to demystify the traditional elitism attached to these bodies of practice.

Emotional support at the mass level is evident within the national women's organisation (AMNLAE) and it's projects (Personal communication - Hunt). The most important project in this respect is the support groups with mothers and companeros (comrades) of soldiers at the front or those who have been killed. AMNLAE has also set up offices for "the protection of the family" whose main work is to support, emotionally and practically, women who have been abandoned by the fathers of their children (Personal communication - Hunt). They have also set up a legal office for women in Managua which deals with domestic violence, rape and incest (Personal communication - Hunt). Although these projects are not identified as mental health services, in that they are dealing with problems which have psychological sequelae, they naturally provide emotional support as part of the service they provide.

The Nicaraguan Association of Psychologists (ANIPS) organises popular programmes on mental health on TV and radio, which makes knowledge accessible to a wider audience (Harris, 1987).

**Conclusions**

This paper has presented the model of Nicaraguan mental health services as they have developed since 1979 when the Saninistas came to power. We do not consider this to be a fully comprehensive picture given the dynamic nature of the country and limitations in collecting resources.

There may be some skepticism arising out of the fact that the Nicaraguan model is very young and unsophisticated. In contrast there are many aspects of the South African system which are very sophisticated and developed. The Nicaraguan model is one which is putting into practice principles of participatory democratic mental health which is the goal of mental health workers throughout the world. Some of the most inspiring aspects of the Nicaraguan model are exactly those which South Africa lacks: a free, accessible, decentralised service; participation of the community within their

own service; popularization and demystification of psychological knowledge; de-professionalization and the widespread use of lay people; avoidance as far as possible of isolation of psychiatric patients from the rest of the community; the emphasis on prevention rather than cure; the understanding of psychological problems within the social context; and the emphasis on group intervention rather than the individualisation of the problem.

We are by no means claiming that Nicaragua has put into effective practice all that they are striving for. This would be impossible in the short space of time and the advancements that have been made are constantly undermined by the Contra aggression. Nonetheless the Nic araguan goals and proposed structures for a more appropriate and equitable mental health service provide a useful site upon which to begin our own journey of reconstruction of South African mental health services. If nothing else the Nicaraguan model facilitates inspired thought about the possibilities of a better alternative.

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