Family and Community Medicine as source of Mental Health Care

La Medicina Familiar y Comunitaria como fuente de cuidados de Salud Mental

Medicina Familiar e Comunitária como fonte de cuidados em Saúde Mental

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Abstract

During the Seventh Iberoamerican Summit of Family Medicine, Cali Colombia 2018, the Mental Health (MH) working group reflected on how Family Medicine (FM) can act to support people facing stressful situations in daily life as well as in conflicts (armed/unarmed), emergencies and natural disasters. Descriptive cross-sectional study, based on a survey of 42 questions to 99 Iberoamerican health professionals from 15 countries; 98 physicians and 1 psychologist. 8% residents of family medicine, 85% family physicians (FP), 4% general doctors, 2% psychiatrists and 1% internists. 47% of physicians perceive as good the ability of FP in the approach to MH. Concerning the MH problems observed, 30% where anxiety disorder, 27% depression, 17% insomnia, 10% alcoholism, 7% illicit drug abuse, 5% eating disorders and 4% post-traumatic stress disorder. Wich such results, recommendations for the Cali Declaration consider the necessary MH training for Family physicians, with cost-effective self-care strategies through strengthening community work. The teachers of FP must take actions tending to the self-care of their students, to facilitate the learning process and the preparation to practice the profession in such a complex environment as the Primary Care (PC) centers or in any place based on PC strategy.

Keywords: Family Practice; Mental Health; Emergencies; Disasters

Resumen

En la Séptima Cumbre Iberoamericana de Medicina Familiar, Cali – Colombia 2018, el grupo de trabajo Salud Mental (SM) reflexionó sobre como la Medicina Familiar (MF) puede actuar para apoyar a las personas que enfrentan situaciones de estrés frente a la vida diaria, conflictos (armados/no armados), emergencias y desastres naturales. Estudio descriptivo de corte transversal basado en una encuesta de 42 preguntas a 99 profesionales sanitarios iberoamericanos provenientes de 15 países, 98 médicos y 1 psicólogo, 8% residentes de MF, 85% especialistas en MF, 4% médicos generales, 2% psiquiatras y 1% internista. El 47% de los médicos percibe como buena la capacidad de los médicos de familia en el abordaje de la SM. En cuanto a los problemas de SM observados, 30% indica Trastorno de Ansiedad, 27% depresión, 17% insomnio, 10% alcoholismo, 7% adicción a drogas ilícitas, 5% trastornos alimentarios y 4% trastorno de estrés postraumático. En este contexto se realizaron las recomendaciones para la Carta de Cali que consideran la formación en SM necesaria para los Médicos Familiares, con estrategias de autocuidado costo efectivas, mediante el fortalecimiento del trabajo comunitario. El cuerpo docente de las residencias de MF debe hacerse cargo de acciones tendientes al autocuidado de los alumnos, propendiendo a facilitar el proceso de aprendizaje y la preparación para ejercer la profesión en un medio tan complejo como son los centros del primer nivel de atención o en cualquier contexto en el que se trabaje con la estrategia de Atención Primaria de Salud.

Palabras clave: Medicina Familiar y Comunitaria; Salud Mental; Emergencias; Desastres

Resumo

Na Sétima Cúpula Ibero-Americana de Medicina Familiar, Cali – Colombia 2018, o grupo de trabalho Saúde Mental (SM) refletiu sobre como a Medicina de Família (MF) pode atuar em para apoiar a saúde integral das pessoas que enfrentam situações de estresse na vida diaria, como conflitos armados/desarmados, emergências e desastres naturais. Estudo descritivo transversal com base em um levantamento de 42 perguntas a 99 profissionais de saúde ibero-americanos provenientes de 15 países; 98 médicos e 1 psicólogo. 8% de residentes de MF, 85% de especialistas em MF, 4% de clínicos gerais, 2% de psiquiatras e 1% de internistas. 47% dos médicos percebem como boa a capacidade dos médicos de família na abordagem da SM. Em relação aos problemas SM, 30% indicam Transtorno de Ansiedade, 27% de depressão, 17% de insônia, 10% de alcoolismo, 7% de dependência de drogas ilícitas, 5% de transtornos alimentares e 4% de transtorno de estresse pós-traumático. Neste contexto, foram feitas recomendações para a Carta de Cali que consideram o treinamento de SM necessário para médicos de família, com estratégias de autocuidado custo-efetivas através do fortalecimento do trabalho comunitário. O corpo docente das residências do MF deve se encarregar de ações que promovam o autocuidado dos alunos, visando facilitar o processo de aprendizagem e o preparo para a prática da profissão em um ambiente tão complexo como os centros de Atenção Primária à Saúde (APS) ou em qualquer contexto em que se trabalhe com a estratégia APS.

Palavras-chave: Medicina de Família e Comunidade; Saúde Mental; Emergências; Desastres

Introduction

The Seventh Iberoamerican Summit of Family Medicine, Cali Colombia 2018, through the group that had as its motto "Family and Community Medicine as a source of Mental Health care", gave us the opportunity to reflect on how family medicine can and should act in relation to the problem of Mental Health (MH), seeking concrete contributions according to the central theme of the summit: "Family Medicine and Public Policies in territories of equity and peace".

In the executive summary on Suicide Prevention of the World Health Organization (WHO) of 2014, it is stated that more than 800,000 people commit suicide per year and that for every person who commits suicide there would be at least 20 other people who have attempted suicide. It is also the second cause of death among people aged 15 to 29 years.[1] There would then be 16 million people each year at risk of death due to suicide attempts because of Mental Health conditions in the world. On the other hand, the main risk factor against suicide is a previous suicide attempt, so these 16 million people potentially have a higher risk of death than the common population.

The causes are multiple and related to crises that determine a decrease in the ability to cope with the stresses of life, both those of everyday life (financial problems, broken relationships, chronic pain and

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illness, etc.), and those of more complex situations: emergencies and natural disasters[1] (floods, earthquakes, tsunamis, etc.), as well as anthropogenic disasters[2] (political and/or armed conflicts, fires, etc.).

The term *tsunami of mental health*[3] has even been coined, in the context of the development of children and adolescents who are victims of serious physical or sexual violence, who initiate criminal careers around the age of 13 depending on the countries and that progressively increase the consumption of drugs and alcohol. A latent threat to the future of our nations.

Because of the life style and situations created or not by the human being, a context in which a significant number of people are potentially unable to face the difficulties of daily life and determine a greater inability to face the inherent difficulties to emergencies and disasters is taking place, particularly anthropic disasters, in which the human being is the direct cause; and especially, those determined by political conflicts, armed or unarmed.

While all the above information may seem apocalyptic, the 2013 WHO report: "Rebuilding Better" ["Volver a construir mejor"][4] raises the paradox that emergencies are an opportunity to rebuild better the system of attention in MH, no matter how weak the system was before the emergency or its seriousness. It is pointed out that emergencies and disasters, natural or anthropic, can give rise to situations where MH requires special consideration due to three common problems:

- increase in the rates of MH problems,
- the weakness of MH infrastructure and
- the difficulties that are generated in the coordination of the entities that provide services in the MH area.

In these situations, the prevalence of depression and post-traumatic stress disorders increases substantially. There is also an increase in the vulnerability and needs of people who already had serious mental disorders such as schizophrenia, bipolar disorder, anxiety and alcohol and drug dependence.

As a result of emergencies and disasters, the service infrastructure in MH can be weakened. There is a greater need for services and the health workers themselves can be victims of the emergency, in many cases they need to take care of their own families or friends before fulfilling their professional duties. This can lead to a shortage of qualified health workers.

In major emergencies with sudden starts, chaotic situations can be created by the appearance of multiple support agencies. Faced with this great initial impulse of organizations of all kinds, governmental and non-governmental, special emphasis must be placed on the coordination of the supply of services. The fundamental role of humanitarian aid is to strengthen public structures, thus managing to coordinate actions and the long-term sustainability of the functional structure of health services.[5] The importance of long-term sustainability lies not only in achieving a better state of general health, but also greater education, greater productivity and better interpersonal relationships, and therefore a better quality of life. This action not only benefits the MH of the people, but also the general functioning of the affected country and the resilience of the society that is capable of recovering from an emergency situation. Actions in the framework of early recovery provide the basis for a long-term mentality.

Attention in MH should focus on services that are accessible to the community. In the aforementioned WHO report, it is argued that the decentralization of MH systems towards community-based care systems is a fundamental strategy, especially to deal with situations of emergencies and disasters. It is necessary for early recovery that the guidelines of the agencies generate standards based on consensus between the health services and the community. The community must become a strategic actor. It is important to emphasize that the greatest investment must be made in people, community and health workers, rather than in infrastructure.

It is necessary to strengthen and expand attention in community-based services on Mental Health. The action of long-term psychiatric hospital centers should be redefined, even considering reducing their size. No level of service, from primary to secondary and tertiary, can meet all mental health needs, it is necessary to find the right combination among all of them. Self-care, informal care of the community and primary care in MH are the basis of the pyramidal care model. It is at this level where most of them should be coordinated. For those who require more intensive services at some point in their life, the secondary level should provide ambulatory care and short stay hospitalization. The secondary level is understood as community mental health centers and general hospitals. Only a very small portion of people with severe MH problems need long-term hospitalizations, considering a tertiary level, but without considering structuring psychiatric hospitals permanently. The goal is always to achieve ambulatory care and control. At all levels, the model emphasizes that people with MH problems must participate in self-management of their conditions.[5]

In this general context, a report of 2017 by the Organization for Economic Cooperation and Development (OECD) on MH[5] states that it is necessary to promote and invest in the introduction of programs that promote good mental health and the prevention of mental illness. Establishing actions that prevent depression and anxiety brings economic benefits to families, while certain interventions in the workplace can reduce the cost of low productivity by more than a third. There is, however, an unequal government commitment between the promotion of mental health and other pathologies in health systems, with a tendency to lean towards the latter, such as, for example, the strong focus on the promotion of cardiovascular pathologies.

The OECD document makes several recommendations for the governments of the countries, including:
- Implement integrated mental health programs, application tools and labor policy;
- Prioritize the mental wellbeing of citizens of all ages. For some countries this may demand activities throughout the life of the individual and for others it will involve promoting efforts focused on particular groups such as the elderly or unemployed. It can be done through a phased approach to the action, using new opportunities, such as, for example, on-line computer systems.
- Develop and support a permanently updated and comprehensive strategy to promote MH throughout life. Based on the best evidence of the effectiveness of interventions focused on the local context.

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- Monitor and evaluate in a permanent way the effectiveness of the implemented actions, in such a way that it allows calculating estimates of the economic return of the investment in promotion and prevention activities. This can improve the understanding of the cost/effectiveness of the investments aimed at improving the MH of the people, favoring that other actors, external to the health care provision sector, visualize better the economic return of this investment, encouraging them to invest and participate in the realization of promotion and prevention activities.
- Establish networks of intersectoral collaboration, recognizing their importance beyond the health care systems and the MH, involving in the promotion and prevention in MH to other interested sectors including social assistance, education systems and workplaces.

The report of the Pan American Health Organization (PAHO 2013) on MH systems in Latin America and the Caribbean[6] reflects the importance of covering mental and neurological disorders from the field of Primary Health Care (PHC), since they represent almost a quarter of the total disease burden in Latin America and the Caribbean. "An efficient mental health system is vital both to be able to offer an appropriate response and reduce that burden that translates into morbidity, mortality and disability, and to close the high gap of sick people who are not receiving any type of treatment".[7]

The evaluation of the attention systems in MH is developed from the relevance of its restructuring. The report recognizes that in South America, Central America, Mexico and the Latin Caribbean, undergraduate training in medicine and nursing, as well as training in the work environment in APS, related to the dedication and workload with respect to mental health, are generally low, with in-service training being slightly better in South America.

The formation and training in PHC services are at least unsatisfactory, they do not allow an adequate response to the MH problem. They are insufficient to improve the ability to solve the demand for attention due to psychosocial and MH problems. The integration of MH into PHC services is usually limited. This considerably restricts the capacity of the PHC to fulfill the functions in relation to the MH and the level of resolutivity entrusted to it in the context of a community model of mental health.

According to this report, the availability of evaluation and treatment protocols is very different, from almost nonexistent to not necessarily available or known according to the region. In addition, the limited interaction and limited integration, sometimes due to lack of information, of the PHC professionals with specialized MH professionals and with agents of the alternative care system (complementary integrative medicine).

Regarding the therapeutic plan to be established to people who consult in PHC for problems of MH, as the document states, it is evident that access to psychotropic drugs is a necessary condition for fulfilling the function of attending them appropriately. In this context, it is reported that medications are partially available, in many cases.

In terms of human resources, the data show their scarcity and the unequal distribution in the countries, with a marked variability among the sub regions.

It is important to mention the factors that limit access to mental health, among others:

- the distribution between the private and public system of professionals trained in MH, often at the expense of the public system, where the majority of the population is concentrated,
- the imbalance in the distribution of trained personnel in MH with a trend towards greater numbers in psychiatric hospitals, with the exception of South America, where a trend is beginning to exist for more trained personnel in intermediate ambulatory care centers, but without a comparable trend in PHC yet,
- an unequal distribution of available psychotropic drugs, and
- an unequal geographical distribution of trained personnel, in which the majority is concentrated in the cities and especially in the capitals of the countries of the region.

Another fundamental aspect in the development of strategies for the intervention in MH pathologies is the role of civil society - community, user and family associations. Although the WHO document on the region states that for the moment it is very limited and even non-existent (it does not participate in the discussion or decision-making regarding the provision of mental health services), other documents reviewed in this analysis highlight the importance of community participation, especially in emergency situations and disasters. Maybe then we need to develop devices that allow the participation of users in habitual contexts, since in situations of emergencies and disasters, the community acquires a spontaneous and vital role.

Faced with the spontaneous and vital role of civil society, there is a need to generate easy-to-implement strategies for the management of MH problems and diseases, both in daily life and in situations of emergencies and disasters. This is how strategies such as the "Program of Action to overcome the Gaps in MH: mhGAP" (for its acronym in English: mental health Gap Action Program) are developed. This program was launched in 2008 by the WHO as a way to face the great challenge of developing low-cost strategies, accessible to the population, especially from low to middle-income countries, and particularly in situations of humanitarian emergencies. This is how different guides and programs that are easy to implement and accessible to people without formal training or with very specific recommendations of the required training emerge.

There are therefore clinical guidelines for health professionals that allow rapid and effective support in humanitarian situations. One of them is the Humanitarian Intervention Guide mhGAP (GIH - mhGAP).[8] It is a basic clinical guide on mental, neurological and substance use disorders addressed to health workers: general practitioners, nurses, midwives and clinical assistants, as well as doctors with specialties outside psychiatry or neurology, who work in non-specialized services, particularly for low and middle-income countries. It contains advice for directors of clinical services regarding general principles of care applicable to humanitarian emergencies, highlighting the importance of multisectoral support.

It raises the following general principles of care for people with mental, neurological and substance use disorders in humanitarian emergencies:

1. **Principle of communication**: Direct, concise, respectful confidential communication is pondered, with active listening, including for the patient, and, if necessary, with trained interpreters.

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2. **Principle of evaluation**: Importance is given to the full identification of the mental, neurological or substance use disorder and to the interpretation that the patient gives to their health problem. There must be an interrogation that includes family background, person background, strategies used to solve the problem and the social support. It is advised to ask questions about suicide in a sensitive way.

3. **Principle for handling**: The training and understanding of the management that the patient will have on the part of the caregivers.

4. **Principle of stress reduction and strengthening of social support:** Fundamental is the reduction of stress that the patient or their caregivers may present. The use of the IASC Guide on Mental Health and Psychosocial Support in Humanitarian Emergencies and Catastrophes is recommended, as well as relaxation exercises with breathing techniques.

5. **Principle of protection of human rights**: Protect the rights of people with mental or neurological conditions and integrate them into the community.

6. **Principle of attention to the general welfare**: Help affected people to access, without danger, the services they need to survive, with a dignified life and ensure general physical health.

It addresses the symptoms and signs of acute and post-traumatic stress, grief, major depression, psychosis, epilepsy, alcohol addiction and other emotional disorders; mentioning the important points for the evaluation of the clinical picture; and specifies a basic management plan that includes pharmacological and psychosocial interventions.

There are also short counseling programs aimed at problems, easy to implement by health professionals not specialized in MH. This is the case of the Problem Management Program "Plus" - Help, for adults affected by anxiety in communities exposed to adversity, within the mhGAP program already described; program known by the acronym PM+.[9]

The PM+ strategy requires professionals to have basic help skills, with a focus on communication and building a relationship with the people they will serve. Family Physicians, especially those trained in the approach focused on the patient and on communication skills, are specially prepared for this. On the other hand, PM+ helps to improve the skills to treat patients who have had to face complex life situations.

The interventions or behavioral strategies considered are:

1. **STRESS MANAGEMENT**: Slow breathing strategy is used, the most appropriate in most situations that produce anxiety and stress. It can be combined with localized relaxation methods when the situation is perceived as more complex. This behavioral intervention is introduced from the beginning in the PM + and should be practiced at the end of each session.

2. **MANAGEMENT OF PROBLEMS**: in situations in which people face practical problems (unemployment, family conflicts, etc.). The professional and the user will work together to consider possible solutions to the problem that most concerns the person. They can jointly propose solutions to solve the problem and generate a strategy to carry out the solutions.

3. **GET STARTED, KEEP ACTIVE**: the goal is to recover and maintain the level of activity, which has an immediate impact on the mood, since people with depression often stop doing their usual activities.

4. **STRENGTHENING OF SOCIAL SUPPORT**: individuals with emotional problems can isolate themselves from their personal and organizational support networks. If people have a good social support network and use it regularly, it may be the case that all that is necessary is to encourage them to continue doing so. In the case of people who do not have them, it may take longer to analyze how they can improve their social support networks and they should be helped to develop a plan for them to receive more social support.

5. **KEEPING GOOD AND LOOKING TO THE FUTURE**: in the same way that people who recover from wounds or physical illnesses do, people with mental illness or problems suffer "ups" and "downs" of their emotions during recovery. It is important at the end of the sessions to clarify that practicing the strategies after the completion of counseling is essential to stay well. In the event that a problematic situation that causes distress reappears, it is likely that the person will be able to respond using these strategies.

General objective

Analyze the role of the family doctor in mental health in Ibero-America in order to support the integral health of people suffering from disorders as a result of facing situations of conflict (armed or unarmed), emergencies and natural disasters, as well as those present in daily life.

Specific objectives

1. Identify the role of the family doctor in the detection and treatment of the prevailing disorders of Mental Health, as well as the ability to support the detection of disorders in the population affected by armed and unarmed conflicts and emergency situations and natural disasters, in Ibero-America.

2. Know the role of the Family Doctor in the early detection of mental health disorders in all life situations and especially post-traumatic stress in post-conflict population and emergencies and disasters.

3. Analyze the availability of family doctors and human resources in general in the countries of Ibero-America for the approach of the mental health problem in the population in charge.

4. Recognize the participation capacity of Family Doctors in the development of strategies to address problems that arise in armed and non-armed conflicts, emergencies and natural disasters.

5. Identify the strengths of the integral care model, centered on the person, his family and the community, as a permanent form of early detection and management of mental health problems in the usual clinical practice of Family Doctors.

6. Identify the skills available to the Family Doctor for the prevention of mental health problems, according to the individual and family life cycle.

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Method

Descriptive cross-sectional study, which collects the opinion of different health professionals in Ibero-America about their own and others' abilities to address mental health problems.

For the collection of information, a survey was designed based on the objectives of the study, which consisted of 42 questions, 12 general identification (country, city of residence, age, gender, profession, etc.), 21 closed questions and 9 open questions, directed to know the opinion, attitudes or experiences, in relation to mental health.

For the validation of the instrument, a pilot test was carried out allowing the correction of the main authors of the work. The survey link was sent via email to members of the Ibero-American Confederation of Family Medicine, and they were asked to spread it among their contacts. It was established as an inclusion criterion that all the respondents were health professionals graduated or in postgraduate training, excluding students in undergraduate training.

There were 100 responses to the survey, of which 99 met the inclusion criteria and 1 did not comply because it was 1 undergraduate student of medicine. The remaining 99 were answered by Physicians with or without specialty and 1 Psychologist.

When analyzing the answers of the 99 surveys in 8 of them, 2 questions were suppressed when errors were detected in the selection of the proposed alternatives or in the **interpretation** of the open questions. In those questions the analysis was based on 91 surveys. The final analysis was based on 99 surveys, except for items 16 and 17, where 91 responses were obtained.

Bibliographic review

A bibliographic review of the topic of Mental Health (MH) in situations of emergencies and disasters, natural and anthropic, and in contexts of daily life was carried out, with active search oriented to articles that provide global information of MH (Regions, Sub regions) and Orient towards the management of MH problems.

The selection criterion of the bibliography was fundamentally due to the search of the last 10 years of reports of health organizations and contributions of the same authors in relation to their countries of origin.

The bibliographic review was carried out through the distribution of different texts in interest groups. 18 documents were distributed among the 12 interested in participate, so they could prepare a summary of the documents that had been assigned to them. 9 abstracts of the distributed documents of 7 participants were obtained.

Summit Plenary presentation

The topic of Mental Health in Ibero-America and the needs of approach were presented in plenary at the Summit, as a way of introducing the theme for group work.

Group work

During the Summit event, we carried out a working group to establish recommendations on the issue of Mental Health for the Cali Letter. Initially, it was made a presentation on the Mental Health theme. Then the participants were distributed in small groups (5 to 6 people maximum) with key questions regarding the objectives of this study. Specifically, they were asked to propose three recommendations for the Cali Letter. At the end, all the recommendations were registered, grouping them according to quality and action in the area of Mental Health, to finalize with three recommendations based on the recommendations.

Results of the Survey

From the 99 surveys admitted in the study, it appears that the respondents came from 15 (75%) countries that make up the Ibero-American Confederation of Family Medicine (CIMF), registering an abstention in the filling of the instrument in 5 (25%) countries of the region (Cuba, El Salvador, Nicaragua, Portugal and the Dominican Republic). Participation by country was unequal (Graph 1), determining a bias that should be considered in future studies.
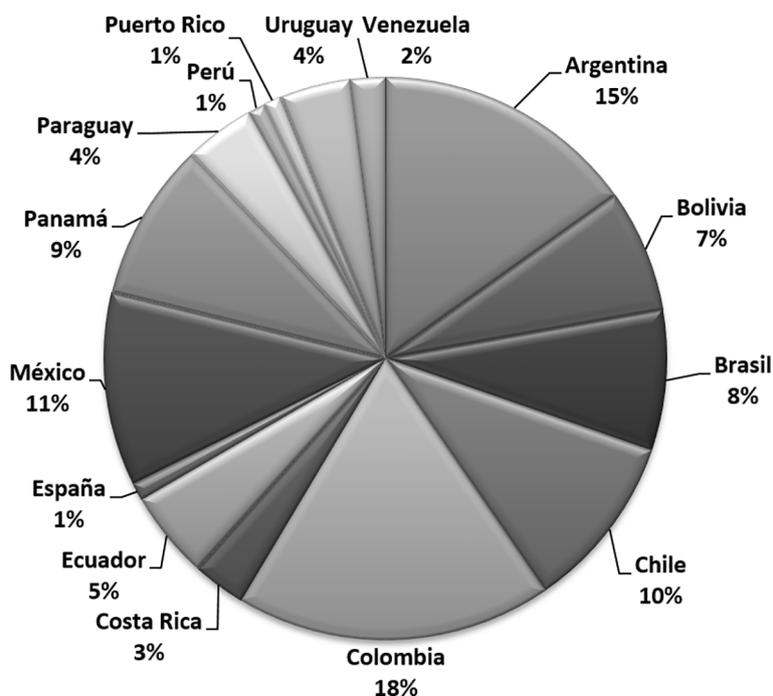

Graph 1. Representation (%) of the countries in the responses to the survey (n=83).

In the distribution by sex, 58.6% is women and 41.4% is men. According to the profession, 99% declared to be physicians and 1% psychologist.

93% of the physicians indicated that they were linked to Family Medicine (family doctor), with 8% of residents, 85% of specialists in family doctor fulfilling full residency. 4% of general practitioners, 2% psychiatrist and 1% of internal medicine. From the family doctors, the majority (83%) work as a primary health care doctor (understood in the context of this research as the first level of care), while 8% answered

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that they were monitors of family doctor residents. It is necessary to emphasize that the question was oriented to the main work carried out by family physicians, which is why it cannot be inferred, if those who practice in primary health care also perform resident tutoring tasks (Graph 2).
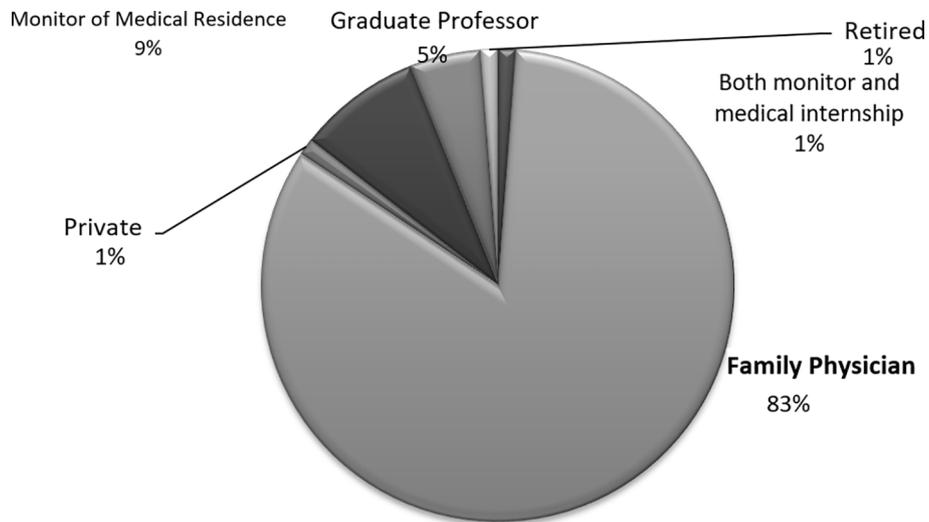
Graph 2. Distribution (%) of Family Physicians who answered the survey according to the work (n=83).

From the family doctors with university postgraduate training, discarding those countries in which only 1 person responded, it is worth noting that the majority of family doctors that responded from Argentina (64%), Bolivia (71%) and Brazil (83%), felt that the ability of the family doctors to address MH problems is Regular. On the other hand, family doctors in Mexico responded 45.5% Regular and 45.5% Good, with 9% Poor. The family doctors of countries such as Chile (100%), Colombia (86%), Costa Rica (100%), Ecuador (80%), Panama (88%), Paraguay (67%), Uruguay (75%) and Venezuela (100%) declare that the capacity of the family doctor in their country is Good and Very good (Graph 3).
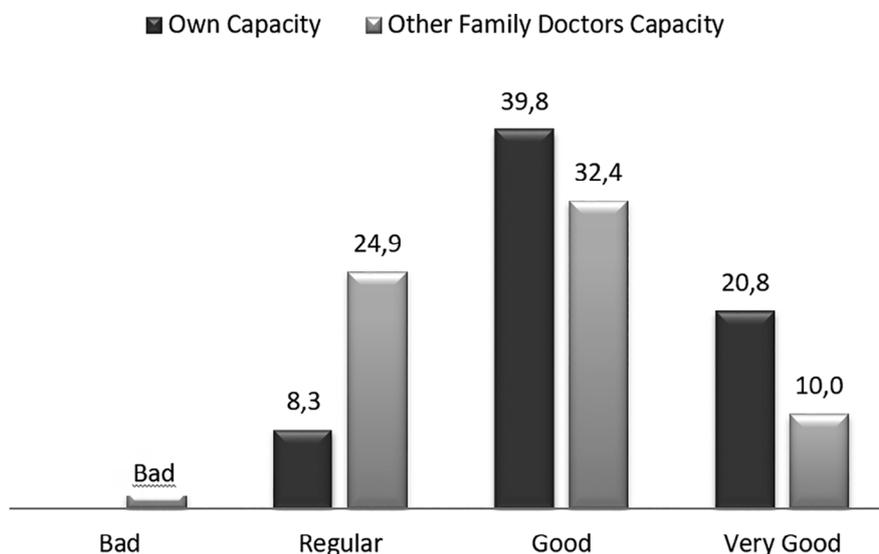
Graph 3. Graph 3. Comparison (%) between the perception of Family Physicians regarding their own capacity in handling Mental Health problems and the capacity of the other family doctor (n = 83).
Source: Survey of the Group.

When talking about one's ability to deal with Mental Health problems, a better perception of themselves is observed. Thus there are cases such as, for example, the family doctor of Argentina perceive that 27% of their colleagues in family doctor have a good and very good capacity, and that they themselves have 64% between good and very good capacity. Likewise, in Brazil, the self-perception of quality varies from 17% to 100%, while in Mexico it fluctuates from 45% to 82% and Uruguay varies from 75% to 100%. This change could suggest that they are more strict with respect to other family doctors than of themselves, or that there is a bias due to greater interest regarding the MH problem when responding to the survey and that they know themselves with greater capabilities than their colleagues. A percentage comparison between the perception of the family doctor about their capacity and that of their colleagues can be verified in Graph 3.

On the other hand, the only psychologist who answers the survey is from Argentina and states that the capacity and interest of the family doctor in the MH problem is regular, which coincides with the perception of the doctors in Argentina, who mostly (64.3%) consider it to be fair or bad. Only 35.7% consider it as good or very good. The interest follows a similar trend, respondents declare that the interest of the family doctor in their country is mostly regular (78.6%).

The number of general physicians (GP) without specialty that responded to the survey was very small (2 from Chile, 1 from Panama and 1 from Colombia). However, it is already analyzed that it could guide a tendency on the perception they have of the family doctor. The GP of Colombia, Panama and one in Chile, indicated that the capacity of the family doctor was good in MH's problems, the other in Chile considered it to be regular, and at the same time also indicated how to regulate its own capacity. The others rated their own capacity as very good without being family doctor, as opposed to their perception that the capacity of the family doctor is good. He emphasizes that they give as justification of this difference their own interest in the subject of MH and, therefore, their interest in training. On the other hand, one of them states that the capacity of the family doctors is due to the type of integral attention they provide.

Regarding the interest in the subject of MH, the GPs report it as good and very good in 100%, but they cannot always develop it due to the time limitations of the consultations.

The other specialists surveyed, 2 psychiatrists and 1 internist (IP), considered that the ability of family doctors to detect MH problems is good. Regarding the interest of the family doctor in the detection and approach of mental health problems they say that it is good and very good. The IP emphasizes that it is because of the knowledge that family doctors have of how MH disorders affect physical health. In relation to the question about the approach of people who have MH problems at the primary level of attention, the three choose the answer: "I think that family doctors are professionals of great relevance because the concepts and tools of this specialty can bring new perspectives and possibilities of intervention in mental disorders". However, when the review is extended to all physicians, the dispersion of the answers and the response to several possibilities at the same time, even opposed, makes it difficult to observe a pattern in the rest of the doctors.

Regarding the frequency of MH problems observed, from the valid answers of the doctors, 30% indicate the Anxiety Disorder as the most frequent, followed by depression with 27%, insomnia 17%, alcoholism 10%, addiction to illicit drugs 7%, eating disorders 5% and post-traumatic stress disorder (PTSD) 4%.

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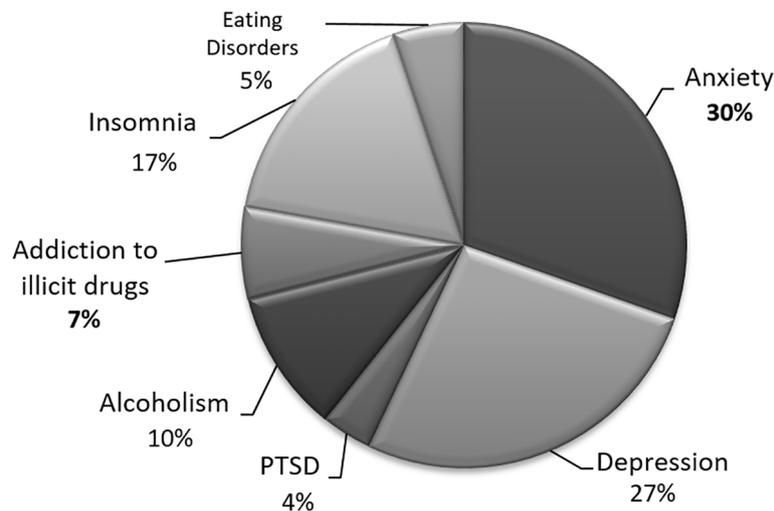
Graph 4. Frequency of mental health problems according to the perception of respondents in Latin America. March 2018 (n 99).

In relation to the question about what other pathologies could be included as frequent, in the respondents of several countries, Schizophrenia appears in 12%. This could reflect that family doctors are also playing a role in addressing chronic MH disorders, as they do for example in chronic cardiovascular diseases. Some even justify it in the context of chronicity, including also as a follow-up control to Bipolar Disorder, Attention Deficit Disorder and others.

One of the family doctors reminds us that smoking as any addiction is a MH problem. The fact that we did not include it in the list reflects the normalization of its use, even among us doctors.

In the same context 5.5% remind us that violence in relationships in general and family abuse are not uncommon.

Regarding the role of the family doctor in armed conflicts, 31% stated that they have specific skills and a special bond with the population, 21% say that they have adequate skills to be part of the team, 17% that there is a need for greater training and 2% state that they have no role.

Regarding the role of the family doctor in natural disasters there is a very similar distribution to that of armed conflicts: 41% say that the family doctor has specific competences and bonds with the population, 30% that have adequate skills to be part of the team, 24% that is necessary more training, 4% that is not their role and 1% do not know.

Regarding the Strengths that the family doctor has to act in these situations, they are expressed: *integrality, longitudinality and family focus, in the context of the continuity of the attention, the closeness with the community - physical and affective - and the adequate formation,* although it is suggested that more is always needed.

Regarding the Barriers, there is a clear ignorance of the participation in public policies. 60% do not know or believe that the family doctor do not participate in definitions of public policies regarding Mental Health of people. 65% do not know or do not believe that we participate in the development of training strategies and protocols to address mental health problems.

Results of the Working Group

During the working group process several concerns were generated regarding the mental health of the health teams. Likewise, there was a marked concern for the MH of the residents of Family Medicine, emphasizing that during their training, family doctor tutors should provide the necessary tools for future Family Physicians to develop the self-care skills, and also, allow them to implement and strengthen the attention of MH in the centers in which they work.

On the other hand, the group said that the mental health of the service providers should be guaranteed, including the family doctor, guaranteeing a space of emotional discharge and decent wages.

It was also considered a priority for the family doctors to participate in the creation of team intervention protocols, specifying the scope and limit of each intervention. To this end, MH training should be strengthened, to work on prevention in MH and to make an early diagnosis when necessary. Structuring also training in community interventions in MH, to develop the strategy of community-based rehabilitation and strengthening of support networks.

The importance of developing specific competences according to the epidemiological profile of each country was also highlighted. The idea is to guiding the work of the family doctor to generate the highest impact on the health of the population.

Conclusion

Considering the high prevalence and incidence of the problem of MH and the influence they have on the development of people, families and communities, the family doctor must incorporate into our daily work, in the comprehensive look, questions aimed at knowing situations in the emotional area. In each service, whatever the reason for it, we should ask about the mental health area, not just "How are you, how are you doing?". We must ask specifically about the mood, emotional problems in the last time. We must always remember that people do not consult because of mental problems. Not only because of the stigma that still persists in the world regarding this type of problem, but because of the own condition of the mental health problem.

Then, this is the ***challenge***, which is at the same time an ***opportunity:*** to make Family Medicine visible as a specialty that can and should address the problem of Mental Health due to its formation and its proximity to the population in its territories.

In this context, the following recommendations are made to be included in the Cali Letter:

1. Incorporate and/or strengthen, as the case may be, the training in mental and community health necessary for care spaces in which family doctors operate, without considering life situations as pathological, with the development of self-care strategies of the people, sustainable both in time and in the financial capacity of the countries of Ibero-America; in order to develop the ability to face stressful situations of daily life, which allow developing strengths for emergencies and disasters.

2. Strengthen and empower community work so that it is the empowered community itself that establishes support networks in mental health problems and is prepared together to face situations

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of daily life and allows it to develop immediate actions in situations of emergencies and disasters, natural or not.

3. Prioritize cost-effective self-care strategies oriented to personal and family development tools, including health teams, and teachers, tutors of Family Medicine. In such a way that virtuous relations oriented to a cordial and constructive treatment are established. The faculty of the residences of family doctor must take charge of actions tending to the self-care of the students, tending to facilitate the learning process and the preparation to practice the profession in such a complex environment as the Primary Health Care centers or in any context with the PHC strategy.

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