INTERNATIONAL MEETING
MEDICAL TRAINING IMPLEMENTATION IN MENTAL HEALTH OF NON-SPECIALIST PHYSICIANS TO OVERCOME MENTAL HEALTH GAPS IN MEXICO

April 9 and 10, 2018

México City

International meeting

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Interuniversity cooperation project Universidad Autónoma de Madrid and Banco Santander in Latin America

April 9 and 10, 2018, Universidad Nacional Autónoma de México

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We also thank María Cabello for her collaboration in gathering information from the meeting held in Mexico City.

Introduction

The World Health Organization (WHO) has promoted the program (mhGAP) as a proposal for reducing the existing gap between people that suffer from mental and neurological disorders, and those that receiver treatment for said pathologies, in particular in low- or middle-income countries (LMICs).

Within the framework of the collaboration between the Universidad Autónoma de Madrid (UAM), the Universidad Nacional Autónoma de México (UNAM), and the Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz (INPRFM), formative mhGAP activities aimed at health professionals not specialized in mental health have been taking place for years.

This collaboration has led to encounters between mental health professionals and experts from different Latin-American countries for analyzing and planning the implementation of training for health professionals not specialized in mental health in the mhGAP program proposed by the WHO.

A first encounter centered on innovation in pre-graduate and post-graduate mental health education took place on December 2016 in Madrid, in which mental health representatives from 10 Latin-American and European countries participated. One of the consequences of the meeting was the implementation of an inter-university cooperation project between the UAM, the UNAM and the Peruvian university Cayetano Heredia (UPCH), with the aim of implementing medical training in mental health for doctors not specialized in mental health in Mexico and Peru.

This second international meeting takes place in Mexico City, with the objective of analyzing the situation of mental health training for non-specialists in mental health in Mexico, the challenges and needs of mental healthcare of the Mexican population, and proposing a roadmap for implementing mental health training in Mexico through the mhGAP program.

International Meeting

Medical training implementation in mental health of non-specialist physicians to overcome mental health gaps in Mexico

April 9 and 10, 2018

UNAM Department of Psychiatry

April 9

Opening ceremony

Dr. Silvia Ortiz. Chief of the UNAM Department of Psychiatry and Mental Health.

Dr. Ortiz welcomed all participants to the meeting, and introduced the professionals who presided over the opening ceremony: Dr. German Fajardo, director of the Faculty of Medicine of the Universidad Nacional Autónoma de México (UNAM); Dr. Medina Mora, director of the National Institute of Psychiatry Ramón de la Fuente Muñiz; Dr. Miguel Malo, representative of PAHO in Mexico; Dr. Pilar López, director of the Department of Psychiatry of the Universidad Autónoma de Madrid (UAM) and Dr. Germán Palafox, director of the Faculty of Psychology of the Universidad Nacional Autónoma de México (UNAM).

The goal of the meeting was to lead and carry out actions for training primary care physicians in Mexico to evaluate and treat mental disorders following the Mental Health Gap Action Program (mhGAP) proposed by the World Health Organization (WHO) to reduce the treatment gap. This idea arose as a result of the international meeting on Innovation in undergraduate and postgraduate medical training in mental health held at the Faculty of Medicine of the UAM in December 2016, attended by 12 academics from different Latin American countries to incorporate mental health training programs based on the mhGAP guide.

Dr. German Fajardo. Director of the Faculty of Medicine of the Universidad Nacional Autónoma de México (UNAM)

Dr. Fajardo welcomed all participants to the meeting. He affirmed that it was an honor for the Faculty of Medicine and for its founder Ramón de la Fuente, to whom Mexican medicine owes so much, to organize this meeting. He greeted Dr. Medina Mora, thanking her. He thanked the director of the Faculty of Psychology of the UNAM for his presence, and emphasized that it is a pleasure to share projects. He explained that the new Addiction Clinic of the Faculty of Medicine, opened in March 2018, is a great project of the Faculty, with the multidisciplinary participation of professionals from the Faculty of Medicine and the Faculty of Psychology. He also thanked the Universidad Autónoma de Madrid (UAM) and Dr. Pilar López for their presence, as well as Dr. Miguel Malo, representative of PAHO, whom he thanked for always being close to the country and the great challenges it faces, and specifically to mental health and its professionals. Finally, he thanked Dr. Silvia Ortiz for organizing this event and her involvement in the needs of the Faculty. In particular, he wanted to thank her for her support in attending to the victims of the earthquake suffered months ago, since he affirmed that she was very on top of what was happening, and knew how to quickly put the necessary activities into effect to assist the victims. He stated that on that day, this international meeting was opened in order to talk about mental health training, understood and attended from a multidisciplinary point of view. He said that many people have mental health conditions that require attention, and stated that professional specialists are not enough. Likewise, he also confirmed that of all the health priorities that the country has, it seems that mental health is relegated despite the disability that it entails, its prevalence, and the great impact in the country. He stated that the meeting to promote mental health was very timely for training doctors at both the postgraduate and undergraduate level, in particular for general practitioners who are usually not prepared to face these problems

Presentations

“State of mental health in Mexico”. Dr. Mª Elena Medina Mora.

She thanked Dr. Silvia Ortiz for the collaboration, and the UAM for the support received in recent years, specifically Dr. Pilar López and Dr. José Luis Ayuso. She said that they have worked with all of them to educate and train primary care doctors. She said that it is important to let people know why this WHO mhGAP program is important. The program allows us to give attention to make mental health count. She explained that mental health problems affect 30% of people at some time in their lives. Mental disorders have a high social cost and have an effect on the loss of productivity at work. She stated that people with serious mental illness die earlier from preventable diseases. Likewise, mental disorders account for a considerable proportion of the GDP. In Mexico, the burden attributable to mental illness is high, 22.9% of the days lived without health are due to mental disorders. She stated that mental illnesses have grown in importance. Violence and suicide have increased considerably. Mexico is a country that started with low levels of suicide but is currently one of the countries with the highest increase. Mexico does not have an annual prevalence of high mental disorders, however it has one of the largest care gaps in the world. This care gap is high in both men and women, being higher in men. 81% of people do not have the healthcare they require, and those receiving care are much delayed, and sometimes do not receive the right type of care. This delay in care affects more women in the first episode. The prevalence of mental problems is 11% in women and 6% in men. We also know that mental disorders have increased considerably in young people. A study with data collected in 2005 and 2013 on Mexican youth and adults pointed out that the new generations have considerably more mental illnesses than the young people of previous generations, and in general, young people also had more mental health problems than the adult population. The low socioeconomic level has a higher prevalence in mental disorders. On the other hand, there is a lot of comorbidity. Many physical illnesses are associated with depression and anxiety, such as diabetes and asthma. According to data collected in the global survey of mental health in Mexico, physical illness increases the risk of depression. On the contrary, when the person suffers anxiety there is greater risk of obesity. One of the main problems of comorbidity is that different diseases are treated in different centers. Therefore, we must think of an approach in which people receive joint care, in order to advance the treatment before reaching the level of specialized care. That is why

joint care from the first level becomes quite important. The probability of disability is greater when physical and mental illnesses occur. In fact, disability resulting from comorbidity is much greater than the sum of the disabilities when there are physical and mental illnesses separately. One of the main challenges is knowing why there is such a high attention gap in Mexico. For example, in the case of depression, only 6% of people receive adequate minimum attention. Mexico has a low prevalence of depression compared to other countries, but it is one of the highest in terms of the delay in receiving treatment. In addition, Mexico was one of the countries that sees more patients on the 3rd level of healthcare and that took the longest to attend to cases, approximately 11 years on average to attend for the first time. This presents a huge problem, because when patients reach the third level, they come with many losses and problems.

Another issue that needs to be addressed is return migration. People who have returned or who return to the country have a higher prevalence of mental disorders. Above all, the 2nd and 3rd generations in particular have many needs and diseases compared to people who have always lived in Mexico. This is due, among other things, to the fact that they face identity problems. These return migrants suffer more violence than the Mexican population and are victimized when they arrive in the country. Mental disorders greatly affect children whose parents are deported. The minors are citizens of the United States but they have a much higher prevalence of disorders, among other things because of uprooting and the constant threat that their parents will be deported.

People with depression lose on average 2.7 work days. This makes people with mental disorders also suffer consequences at the economic level. It has been estimated that a person with mental problems has a 33% reduction in their income compared to people without these problems. Only 27% of people with mental disorders have access to a job. Disorders are still more prevalent in adolescents who have to work and study. Another issue is that of the budget dedicated to mental health, approximately 75% is dedicated to hospital resources. The outpatient clinic of hospitals is taking charge of what had to be done in the first level. The result is that the third level is saturated, and only 6% receive an acceptable quality of treatment. For these reasons, integrating mental health into the first level of health system is essential. The World Bank has published that the most effective health programs (especially in low- and middle-income countries) consist of organizing the health system so that different pathologies are also covered at the first level. Evidence has shown that the first level of care is

very effective, possibly reducing 30% of the burden of diseases. With simple strategies and collaborative care models starting from the first level, by working together with the mental health team, the existing gap in treatment in mental health and the associated burden can effectively be reduced, since the physicians of the First level can identify candidates susceptible to receiving mental health care more easily. Therefore, among the challenges to be faced is finding knowledge of existing barriers to the integration and treatment of mental health at the first level, the need to modify policies, the identification of candidate patients to receive mental healthcare by general practitioners, and the training of general practitioners and the health team.

"Mental health requirements not covered in Mexico: First level". Dr. Shoshana Berenzon. Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz.

Dr. Berenzon has conducted a study on mental health infrastructure in Mexico regarding how first level mental healthcare is doing in the country. Dr. Berenzon reminds everyone that the proposal to address mental health in the first level is not new. Already in the 1970s, a model was proposed in which the first level became the central axis of healthcare, including mental health. At the Caracas convention in the 1990s, the strengthening of this level was also discussed, but the expected achievements were not achieved. There continues to be many difficulties and many barriers for the primary level of health to be a driver of mental health in low and middle income countries (LAMICs).

Among the main barriers to integrating mental health in the first level are:

-First level care is mainly focused on somatic symptoms.

-There exists a scarce collaboration between specialists and professionals of the first level.

-There is an overload of work in the first level of care.

-We must also remember that there is still a stigma towards mental disorders in the first level.

-Social security systems are limited.

In addition, there are limitations at the legislative level that impact on existing resources, which means that mental disorders are not adequately addressed. Currently, only 30% of health centers have resources for mental health care. Professionals do not receive systematic

training on mental health. Only 15% receive training on mental health issues, and these courses are generally limited, of short duration, and without much supervision. There are also problems in accessing basic psychotropic drugs.

With all these previous data, they considered carrying out a study to see the existing barriers and be able to improve the situation. First, they described how mental health in the Mexico public sector is structured at the legislative and administrative level. There are health centers coordinated by the Mexican government for those who do not have insurance, and provide free assistance. There are different types of centers (T1, T2 and, T3 depending on their resources, their size, and the amount of population they attend to). T1 centers only work at the prevention level. T3 centers are larger and include mental health. Only the most severe cases that cannot be attended to at the first level would be channeled to the hospital. However, this model has not paid off as much.

The study consisted of analyzing the barriers associated with mental healthcare in these centers. Doctors, social workers, and coordinators were interviewed. In a second phase of the study, a brief questionnaire was conducted to analyze the current situation of mental healthcare in health centers based on the perceptions and opinions of staff and users in Mexico City. An analysis structure was created, 6 levels were included to understand how mental healthcare was given in each of them.

- First level: Economic, political and social situations that impact on health services.
- Second level: Policies, laws and specific programs in health that promote care.
- Third: Direction and health coordination in Mexico City (organization, resources, administrative units).
- Fourth: Features and care resources. How are mental health services in the center as a whole (consultations, referral mechanisms).
- Fifth: Knowledge, attitudes and perceptions of staff.
- Sixth: Patients and the community in health centers.

First level: How political and economic social situations influenced care.

Health professionals	**Patients**
Inequality, scarcity of resources, and the way in which national priorities are defined impact on the quality of health services.	Only 35% receive the medication they need at the center.
In recent years, there has been a progressive lack of financing and an increase in users, which has led to services being reduced to a basic benefits package.	78% had to buy it for themselves, which impacts the patients' finances. In addition, these medications sometimes require time, and it is difficult to follow up.
The constant budget cuts directly affect the availability of personnel and medicine.	6.2% of patients have to move because their centers do not have them.
The most affected programs are those that are not considered a priority. Mental health is not a priority program.	2.8% do not receive medication.

Second level: Policies, laws and programs that promote care

Health professionals	**Patients**
Mental health is not a priority program.	They were only asked about alcohol problems.
The clinical records did not allow any type of mental disorder to be reflected.	

Third Level: Directions and health coordination in Mexico City

Health professionals	**Patients**
There is an absence of communication between professionals. There are no channels or formal ways to establish them.	Decrease in the quality of care.
There is an excess of bureaucracy where half of the consultation is given to fill out the form.	

Fourth Level: Features and care resources

Health professionals	Patients
It is complex because there are many patients and little time.	The service was perceived as good, but rotated a lot due to the mobility of the professionals.
The consultation time only gave them the opportunity to give assessments of physical problems.	50% did not know about the existence of modules for mental healthcare.
When the problems were evident or when the patient himself requested it, cases were always referred to the specialist. But this supposes a saturation in the third level. There is a long waiting list.	Relatives and the social network play an important role when it comes to going to health services.
There was no follow-up of what happened when patients were referred either.	
In many of the centers there was no privacy for dealing with personal matters.	

Fifth level: Staff knowledge and attitudes

Health professionals	Patients
Timely education is the main tool for acquiring training, and does not cover the "gaps" that follow since the regulated training	66% perceive that first level centers were not the appropriate ones for treating mental health problems.
The training courses are short courses, without continuity and are usually not evaluated.	Many perceive that if they have mental health problems they would go to another more specialized center.

There are few opportunities to put what you have learned into practice.	
They are sensitized about the importance of emotional discomforts, but some considered that the first level was not the ideal place to address this problem.	

Conclusions of the study:

1. It is necessary to give mental health a priority role not only at the level of laws and discourse, but also in terms of services.
2. The way the health system is structured, a biomedical model of care is now promoted more (in which the interventions that are given are mostly pharmacological)
3. The system allows for the care and prevention of mental health problems, but there is not much room left to see social problems that affect the mental health of the population.
4. We must have training proposals consistent with the features of the first level. Not temporary training solutions.
5. We must reorganize the organization of mental health training for professionals.
6. Greater coordination and planning is necessary so that the few resources allocated to the execution of mental health programs are optimized. The programs must have realistic expectations.
7. It is important that actions to mental health match up with the productivity and goals of health professionals.

“Mental health policies in Mexico”. Dr. Eduardo Madrigal de León. General Director of Psychiatric Care Services (SAP).

Most health personnel in Mexico identify and associate mental health problems with attending to patients with psychosis and not with all of the other problems. There are many training and implementation of mental health programs efforts, but these are not accompanied by adequate policies for this to have an impact and effect. There are professionals who have the knowledge to handle the disorders but cannot prescribe medications for structural reasons.

There has been an effort to increase the positions of psychiatric specialists, but there is a high temporality in the professionals. Popular insurance physicians (who usually cater to the neediest and most troubled of the population) usually have lower wages than other medical specialists. This causes them to leave the positions, and there is a high variability of professionals who care for patients in popular insurance over time.

As a general rule, there is an alignment between national programs and actions to improve mental healthcare. In other words, national programs do have elements to establish a mental health policy. Some of these national programs are: “México incluyente” (Inclusive Mexico) or “México próspero” (Prosperous Mexico). For example, in the sectoral health plan, the social and global integration of people with mental and behavioral disorders is present. In view of this variety of health programs, the Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz (INPRF) was asked to work on the creation of a single program that would include international recommendations. As a result, the PROSESA program was carried out. This program was carried out between 2013 and 2018, and aims to ensure effective access to quality health services. Within this program, strategy 2.4 highlights the need to strengthen comprehensive care and social reintegration of patients with mental and behavioral disorders, through the following courses of action

- Prioritize the implementation of community and family models of comprehensive care for patients with chronic mental disorders.
- Reinforce the diagnosis and comprehensive care of chronic mental disorders at all levels of care.
- Strengthen the care coverage of chronic mental disorders with a focus on family, community, and respect for human rights.

On the other hand, the WHO mental health action plan is based on the following principles:

- Universal coverage.
- Protection of human rights.
- Care based on people rather than disease
- Evidence-based practice.
- Care throughout the life cycle.
- Multi-sectoral approach.
- Empowerment of people with mental disorder and psychosocial disability.

The following are the current health plans that mention mental health and are aimed at overcoming the following problems:

- Illnesses should be treated in the same way as other illnesses.
- The concept of mental illness not only includes psychotic disorders and more serious disorders. This is a message addressed to professionals and non-health professionals.
- The healthcare system was built from services at the third level, with the consequent dispersion, distortion and inequity in access to mental health, and high cost.

1. **Specific Mental Health Plan** (Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz (INRPF) and Servicios de Atención Psiquiátrica (SAP, Psychiatric Care Services) that depend on the Secretary of Health. The objectives of the program were:
    - Strengthen and modernize psychiatric care services with a comprehensive and multidisciplinary community approach.
    - Formalize a specialized network of efficient psychiatric care between the INRPF and the SAP.
    - Carry out actions to prevent the priority mental disorders related to suicide and their risk factors.
    - Promote the training and education of researchers and specialists based on scientific evidence in accordance with priority diseases: mhGAP program.
    - Promote mental health research and the development of community care models.
2. **Program for comprehensive care of mental illnesses** (PAIEM)

The Program for comprehensive care of mental illnesses is developed by SAP and has the following objectives:

- Strengthening and modernizing existing specialized services.
- Development of the mental pathology care model in general and high specialty hospitals.
- Strengthening the first level of care.
- Deinstitutionalization of chronic patients who are in a state of neglect.
- Strengthening research as a vehicle for innovation and quality control.

Transversal objectives of the PAIEM:

- Research and implementation of community care models.
- Training of health teams in the mhGAP guide.
- Formalization of an efficient reference and countertransference system (referrals).
- Adequacy of popular insurance.

As an initial conclusion, we can therefore say that although it is defined that mental disorders must be integrated into the care, in practice mental disorders are not covered in the popular insurance.

3. **Strengthening of psychiatric hospitals and CECOSAM** (Community Mental Health Centers).

This line has the following objectives:

- Modernize services with innovative projects and reproducible care models (for example, guidelines have been created: Timely Attention to the First Psychotic Episode and Dual Pathology Care in the HPFBA).
- Training in specialized human resources: Given the data that 60% of people who had committed suicide had gone to a general hospital before their suicide. Guides have been established on how to act in the face of suicide.
- Homogeneity of resources and treatments. An operational guide has been prepared so that all of the states that decide to incorporate mental health modules into their services have the same resources and the same actions, so that each one does not do things differently.
- Promote basic, clinical, and operational research in hospitals.

4. **Reinforcement of the first level of care**

This line has as key action, both to expand the detection of mental disorders and to carry out the appropriate treatments of them. The challenge is enormous because of the scarcity of resources in this level of care in the country, as well as the great demand.

5. **Deinstitutionalization of chronic and abandoned patients (REINTEGRA Program)**

- We must change the concept. There are patients in situation of abandonment. Coverage of these patients should be reconceptualized, and we should evaluate if they have more social or medical problems, or both.
- The state must take care of those who are abandoned.
- The viable proposals consist of Transition Villas / Protected Residences.
- The measures should be useful for implementing a true model of rehabilitation and labor and community insertion in the medium and long term for recoverable patients.

6. **Strengthening of research projects**

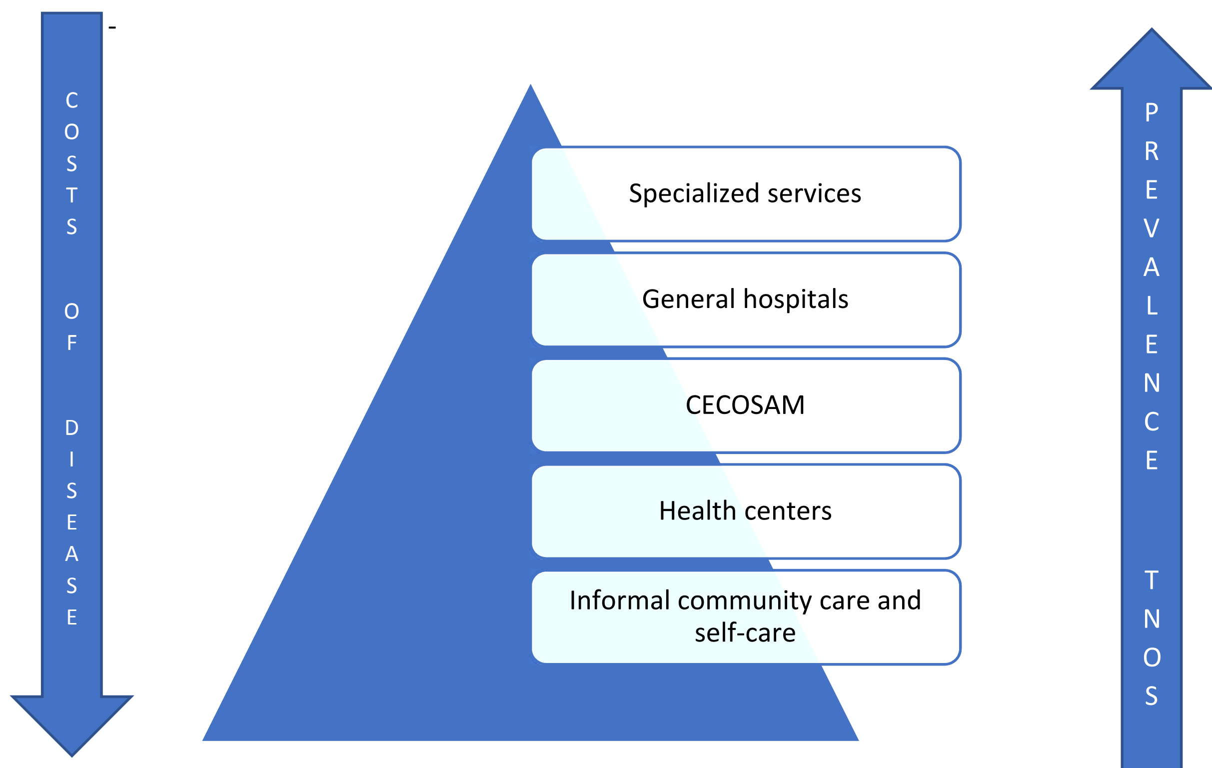
In the diagnostic assessment of the medical units assigned to the psychiatric care services (SAP) and identification of the care needs of the user population in the different care models, it was found that the effort of the training has little or not enough impact. There is an immersion in some topics but only briefly. Professionals do not feel safe and also only those who take interest receive them.

The REINTEGRA project is a pilot project of rehabilitation and labor reintegration of patients with serious mental disorders.

Telepsychiatry: Implementation of a telepsychiatry pilot unit in primary healthcare services for the early diagnosis and timely treatment of affective disorders in rural communities of Mexico.

The new horizons are:

- Use of information and communication technologies (ICT)
    - Bring therapeutic tools to the user
    - Psychoeducational programs
    - Training and long-distance education for general practitioners (mhGAP)
    - Remote monitoring and continuity of patient treatment
- Legislation
    - Offer standardized models in all States
    - Unique database and portability of the clinical record
    - Universal coverage for the mentally ill
    - Universal treatment for the main mental illnesses
- Perspective of Public Health in mental health
    - Focus on prevention
    - Early diagnosis and timely treatment
    - Impact on rehabilitation
    - Care to diseases according to the costs of the services and the frequency of disorders



Conclusions:

- The problems of Mental Health in Mexico should be considered as matters of Public Health.
- Mental health care services must be included in the general healthcare system.
- Mental health programs must build the pyramidal base of attention stratified by levels, as it done for other illnesses.
- The network of comprehensive care services for mental illness should be extended to the communities.
- We must strengthen leadership in mental health and promote the participation of other sectors.
- We must generate a culture of respect for human rights and combat stigma.
- We must increase multidisciplinarity and promote a profound transformation of institutions and the roles of mental health professionals.
- In the face of structural, budgetary, and bureaucratic challenges, we must develop a long-term strategic vision, imbued with will and optimism.

"State of mental health training for doctors in Mexico". Dr. Silvia Ortiz, Head of the Department of Psychiatry and Mental Health, UNAM

In Mexico there are a total of 4393 psychiatrists, who are mostly concentrated in large cities, leaving some areas of the country very neglected.

In relation to the mental health training of physicians, there are no common regulations that regulate the undergraduate training content nor the training of specialist professionals. In addition, there are no continuous training programs in the first level of care.

We have carried out a study to analyze the number of hours and subjects dedicated to mental health within the curricular plans of Medicine in undergraduate studies, and the number of subjects in postgraduate studies. We included 73 institutions with medical degrees accredited by the Mexican Council for the accreditation of Medical Education (COMAEM), and for the postgraduate program the specialties in the Single Plan of Medical Specializations (PUEM) were included, totaling 78 curricular plans.

We found that in most universities, the number of hours dedicated to mental health training ranges between 2.6-3.9% of the total number of hours throughout the curricular plans. At the UNAM, 3.9% of the hours of the curriculum are devoted to subjects related to mental health.

Regarding postgraduate courses of the PUEM, of the 78 specialties that were reviewed, mental health related issues were included in 28 of them. Some examples are:

Psychiatric specialties	Internal Medicine	Medical Oncology	Neurophysiology	Clinical neurophysiology	Emergency medicine
Neurology	Pediatric clinical medicine	Pediatric oncology	Pediatrics	Radiooncology	Child and adolescent psychiatry
Child psychiatry course	Obstetrics	Family Medicine	Work Medicine	Pediatric emergency	Endocrinology

Conclusions:

- At the undergraduate level, increasing the number of hours devoted to mental health training in Medicine degree is necessary.
- At the level of continuing education, more mental health courses should be developed. The INPRFM does continuous training courses, but at the UNAM they are not covered.
- Including the mhGAP guide for mental health training in medical training is recommended.
- Implementing the monitoring and impact of the training of the doctors at the first level of care is necessary.
- The implementation of mental health services in the first level of care removes some burden from services of the second and third levels of care.
- Inform the population that professionals and primary services are trained to deal with mental health problems, as well as psychologists
- First aid interventions, psychology therapies by psychologists, and social workers must all be in the same center, so that the strategies are successful after framing them in the patient's cultural context.

- Increase collaboration with psychology. The faculty of psychology has its care centers, and it is necessary that by attending patients, efforts are coordinated between faculties and professionals. They should also make agreements between the faculties of Medicine and Psychology for the training of first level doctors and for psychologists to implement psychological interventions.

"Mental health needs for training primary care doctors. Lessons from the first level ICD-11 studies". Rebeca Robes, Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz.

The World Health Organization is strongly committed to mental healthcare in the first level, since it is the gateway to the health system and is a cost-effective approach. This reduces waiting lists in the detection and treatment of mental disorders. Within the development of the new version of the manual of classification of diseases ICD (ICD-11), the new version of the ICD (ICD-11) was intended to be a true effective tool for the first level.

The creation process of a new version of the ICD was based on the development of tools based on evidence of clinical utility. The study aims to improve clinical applicability. Therefore, it was not only a question of improving the classification in terms of classification, but also of helping the clinician to understand the patient and design their treatments so that there is a reduction in the care gap and the burden of mental disorders.

This review process was carried out by workgroups of experts on mental health issues from around the world. Making an ICD-11 that was useful in the first level of attention was the intention from the start. The previous ICD-10 of primary care was a reduced revision of the specialized ICD.

It is important that the ICD-11 is used and is useful in the first level because when there is a comorbidity, both illnesses improve if they are treated in the first level of care.

To this end, field studies were developed, a part of them being developed directly in Spanish with population from Mexico and Spain. The practices of the clinicians were reviewed by checking if the proposed categories really had a utility. This was done separately for both the specialized and the first level classifications. This particular study was conducted in Latin America: Mexico and Brazil; and in other countries: Hong Kong and Pakistan.

For the selection of disorders, the WHO mhGAP guide for managing mental disorders in the first level of care was taken as a reference. This way, mental disorders that have a greater burden and / or higher prevalence in the first level (in this case, depression and anxiety) were chosen. Furthermore, there are many people who have physical symptoms without a medical explanation, and these problems are very frequent seen in the first level (Body Stress Syndrome).

Conclusions regarding the mhGAP:

- The mhGAP guide was useful because it helps knowing what to do and what not to do.
- The mhGAP only names psychological interventions but does not cover how to do them.
- Therefore, apart from the doctor, we train psychologists to apply the psychological interventions suggested by the mhGAP. The doctors had not implemented the mhGAP before because the psychologists had not been trained yet.
- Training psychologists of the health centers to establish psychological techniques is necessary. A manual of psychological intervention was created.
- There was a psychiatrist who also supervised the process closely in order to make the reference in case patients require it.
- It was discovered that doctors at the first level were willing to evaluate mental disorders if they had that possibility of supervision.
- When depression was treated, not only did depressive symptom decrease, but so did anxious and physical symptoms.

"Promotion of PAHO in the implementation of mhGAP in the Americas". Dr Miguel Malo. Advisor for Chronic Diseases of PAHO / WHO in Mexico.

In Latin America, the first mhGAP guide pilot training project was carried out in 2011 in Panama. Since then, PAHO has given training in different modalities, both in some modules of the mhGAP guide, and in all of the complete material, both on-site and remotely.

One of the most noteworthy courses was one for professionals from the health team and community health workers who work on the US-Mexico border.

It is important that formal education systems, both undergraduate and postgraduate ones, incorporate mhGAP. To this end, it is important that the mhGAP reaches the agendas of the ministries of health. At the moment it is not a priority, but making health managers aware of its importance is vital.

Since the launch of the mhGAP program, the importance of evaluating the effectiveness of mhGAP has been stressed. In the Changed project, the mhGAP was valued by professionals as useful or very useful for the evaluation and management of mental disorders.

One of the critical points after training in the mhGAP is the availability of medications and the guarantee of supervision.

PAHO is using a "virtual mental health clinic" for supervising professionals who have been trained with the mhGAP. Through this platform, case supervision is offered by specialists for 6 months.

Lessons learned from mhGAP:

-it is a useful tool
-the commitment of the national health authority is important
-the availability of medications has to be guaranteed
-establishing supervision systems is crucial (the role of specialists)
- incorporating the mhGAP in the curricula of the regulated training programs is important
-establishing an evaluation and monitoring system from the very beginning is important
-incorporating nursing and social work is a necessary challenge

Regarding the training of professionals with the mhGAP in Mexico, greater homogenization and greater communication are needed from all the training processes that are under way. Some states are more prepared while others have only received isolated training. MhGAP is incorporated into the National Plan of Mental Health but its actual application in all states has been very dispersed.

Suggestions for Mexico:

1. Continue with a training plan prioritizing some states, for example, the states that are on the border with the US, such as Michoacán or Chiapas.
2. Continue training professionals. A network of universities has lately been set up to train professionals in emergency medical health care (EMC), it is a diploma course. It proposes the university as the training nucleus of the professionals to carry out multiprofessional training.
3. Train other professionals who are not from the health sector, such as those who are in contact with migrants on the border between Mexico and the United States.
4. Train medical students in the mhGAP during social service.
5. Incorporate the mhGAP in the regulated training of the following professionals.

Proposals to continue training in Mexico:

1. Make an inventory of first level professionals that are already trained in the mhGAP guide.
2. Improve coordination with the Ministry of Health.
3. Establish an articulating core of national training, so that some states can be prioritized for training, networks of supervisors and trainers can be established, and a monitoring and evaluation system can be proposed. We do not have a systematic experience of the impact of mhGAP in many states. There is only some knowledge on the border. In Chiapas there is a proposal for monitoring and evaluation.
4. Training actions in social service and undergraduate studies.

"Formative experiences with the mhGAP in Peru". Dr. Silvana Sarabia. Cayetano Heredia University (Peru).

In Peru there are 962 registered psychiatry specialists (they represent 1.5% of all doctors). There is an unbalanced distribution of specialists, most of them are in Lima, while more peripheral or rural areas hardly have any specialists.

There is a system of captive slots that guarantees that residents who are being trained reside and work in their place of origin, but go to Lima to receive training and supervision through telemedicine. This is a competency-based training program. At present, in the Psychiatry training programs in Peru there are 61 free slots and 16 captive slots.

Regarding mental health training at the undergraduate level, students perform simulation practices in their 4th year.

Courses of the psychiatry and mental health section at the University:

	Psychological medicine	Introduction to the clinic	Psychiatric clinic	Psychiatry externship	Internship
Formative year	3	4	5	6	7
Duration	3 weeks	3 simulation practices	5 weeks	4 weeks	
Main subjects	Interview: Doctor-patient relationship	Mental examination: Psychiatric syndromes	Psychiatric disorders: mood, psychosis, personality, and addictions	Psychiatry (1 month)	Medicine (3 months) Gynecology and obstetrics (3 months) Surgery (3 months) Pediatrics (3 months)

It has been proposed that during the externship (in 6th grade), one of the rotations be completely on Psychiatry. The rotations during the internship (7th) depend entirely on the ministry, but the university has the power over the marginal rural service.

After 7 years of studies, medical students have to complete one year of marginal rural service. A survey was conducted with these students on the mental disorders that they most often attended, and they responded that they were depression, anxiety, psychosis, and alcoholism. They were also asked about the topics in which they would have liked to receive more training and answered that alcoholism and family violence.

A reform in mental health training is underway. Many hours were spent in disorders that do not present very often. Now it focuses on the most frequent mental disorders and less extensive training is given on disorders that are not so frequent.

At the postgraduate level, emphasizing that there is a decree law that requires 3 credits of the last year of the residence be dedicated to mental health training is necessary. In Peru, 1 credit is equivalent to 16 theoretical hours and 32 practical hours. This training is regulated by law, since in Peru everyone has the right to mental healthcare, and therefore incorporating mental health in the training of health professionals is mandatory. The way in which they are giving this training in mental health is through an online course called "Learning about mental health". This training has to take place in all residences of all specialties (n = 42) and in all subspecialties (n = 31).

As a result of this law, a study was made on the effectiveness of this course on mental health problems and satisfaction. The course was held from March 15 to May 14, 2017, and involved 245 third-year residents, including 12 psychiatric residents. We wanted to know if the course was useful for identifying mental disorders and how to intervene with the family. The modules that were addressed during the course were: communication, stress, stigma, self-care of the doctor, violence, depression, anxiety, suicide risk, alcoholism, psychosis, and bipolar disorder. The structure of the course was the following:

- Pre-test evaluation on mental health
- 12-30 minutes online classes (30 minute classes were very long)
- 3 videos about the mhGAP. Questions were asked about the video and a feedback to the question was included later.
- Readings on the subjects. For example, in the depression module, readings on the differential diagnosis with bipolar disorder, evaluation of depression, lifestyles and depression, etc. were proposed.

- Final exam. It was found that those who took the course improved significantly.

Course satisfaction results:

-The course was useful for identifying mental health problems and for communicating with patients who have mental disorders.

-They improved their attitude towards mental health.

-They liked the methodology used and the duration of the course.

-There were no notable problems in the use of the virtual classroom.

-The most useful modules for them were depression, self-care, and communication. The least useful was alcoholism.

-Among the negative aspects, they emphasized that the course was given very late.

Conclusions:

So far the mandatory course on mental health has been implemented in the third year of residency, and it has been shown that it is not the right time, it should be done before.

Developing a homogenous competency curriculum throughout the country in mental health for physicians is important.

"Formative experiences with the mhGAP in Mexico". Dr. Pilar López García. Universidad Autónoma de Madrid.

For several years, a collaboration has been taking place between the Department of Psychiatry of UAM, the Department of Psychiatry and Mental Health of UNAM and INPRFM. In particular, through the *Chair in Psychiatry and Health* between UAM and UNAM with the sponsorship of Banco Santander, efforts have been made to favor innovation and the promotion of teaching and research activities in the area of Psychiatry and Health Sciences.

There is a gap in the treatment of mental disorders that is greater in low and middle income countries (LMIC). In most LMIC countries, 85% of people with major depressive disorder do not have access to adequate mental health services.

To reduce the gap in the treatment of mental disorders in LMIC countries, the WHO launched the mental health Gap Action Program (mhGAP) in 2008. Among the objectives of this program

was to strengthen the commitment of governments, international organizations, and other agents to increase the distribution of human and economic resources for the treatment of mental disorders, with particular emphasis on the integration of mental health care in primary care settings. In 2016, version 2.0 of the mhGAP-IG was launched.

In the context of the sponsorship Chair between UAM and UNAM, training courses for health professionals in Mexico began. The first of them took place in 2014, and was carried out by professionals from the Department of Psychiatry of the UAM, with the support of INPRFM. 22 health professionals were trained in Mexico City. Two months later, the course was held again in Guadalajara (Jalisco), training 60 health professionals, mostly primary care physicians. In 2015, professionals from the UAM moved to Mexico City for a new edition of the training course in the mhGAP guide, this time the training took place at UNAM, and 22 professionals attended, mostly ISSSTE doctors. In 2016, another training course was held at UNAM, coordinated by professionals from the Department of Psychiatry of UAM, in which 19 professionals participated. In total, 123 health professionals have been trained through the mhGAP training courses coordinated by UAM in Mexico.

The courses had of a 5-week online section, prior to the face-to-face section of the course. In each of the 5 weeks, a training module was addressed. In the first week there was an introduction to the management of mental health disorders in non-specialized care, in the 2nd week it was about the mhGAP guide, in the 3rd week it was about the depression module, in the 4th week it was about the suicide module, and in the 5th week it was about the psychosis module. The face-to-face course lasted 4 days and was about the mhGAP guide, depression, suicide, and psychosis. Once the course was finished, the participants were followed up for 3 weeks, in which they had online tutorials with the trainers and performed a report that consisted of selecting a clinical case of their clinical practice that had to do with any of the modules that were addressed, and propose evaluation and management according to the contents learned during the course.

A survey was carried out with the 60 professionals who took the course in Guadalajara Jalisco. All of them increased their knowledge in the modules of the course, being this change significant in the field of mhGAP and suicide. An adapted version of the questionnaire was applied based on the Prochaska and DiClemente model that evaluates the phases of precontemplation, contemplation, and action, in order to study the willingness to change the usual care to patients, incorporating the identification and management of depression and of the risk of suicide after the received training. The majority reported being in the precontemplative and contemplative phase (62.3%), however at the end of the course the majority were in the action phase (63.9%).

The results of the study showed that training in the detection and management of mental disorders through the mhGAP guide increases the willingness to change in these professionals, by increasing motivation and training for the treatment of mental disorders.

Dr. Rebeca Robles. Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz.

Dr. Robles emphasizes that the training course coordinated by UAM works to motivate professionals and helps eliminate stigma. Work continues on the follow-up evaluation on the increase of knowledge and motivation to change. The analysis of all the data is currently being worked on.

Dr. Claudia Fouilloux Morales. UNAM.

They have conducted a training course in the humanitarian intervention guide for mental and substance use disorders of the WHO. This course has been a collaboration between the PAHO, Psychology Faculty and the Department of Psychiatry of UNAM.

The trainers who taught the course had been previously trained through the training activities on the mhGAP guide carried out by PAHO or through the ones carried out by UAM.

The objective was to carry out a course to train medical interns of the social service that work in the ISSSTE. However, there were barriers to implement it. Of the 30 doctors initially invited, there were doctors who did not participate because they could not make the course

compatible with their healthcare services. Those who agreed to participate (n = 24) had all their mornings occupied with healthcare services, so she programmed it during the afternoon. Finally only half of them went to the course, which consisted of 20 hours for 4 days. The course was taught by two psychiatrists who had been previously trained, and by four psychologists. The following modules were taught: addictions, intellectual disability, acute stress and post-traumatic stress, grief, and dementia.

Lessons learned and course evaluation:

- The place where the training was conducted was adequate, but resources are required to carry it out.
- A small number of professionals were reached, as there were losses. Some students suggested that the course be open to more students. The course should be given to all interns. Online training could be the solution.
- Professionals who participated in the course felt that the duration was short. They suggested that it be distributed among more days. They would have liked some subjects to have been dealt with more deeply. There was no time for the psychological part of the attention.
- The mhGAP guide was a useful tool for clinical practice, but they would have liked to have the algorithms of the modules that were treated that were not available.
- The presentation styles that were most effective were role plays and clinical cases. They believed that they lacked practice time.
- Regarding the question of whether they felt safe to provide services based on the mhGAP guide in clinical practice, the majority answered yes, there were only 3 people who did not feel so safe.
- It was suggested that the best time to do this course among interns was at the beginning of the internship in order to control the impact.
- The participation of psychologists and psychiatrists was liked very much.

Abril 10

“Challenges of mhGAP opportunities in Mexico” Dr. Javier Mendoza. UNAM.

Dr. Mendoza recently participated in the Panama meeting organized by PAHO in which version 2 of the mhGAP was presented. The meeting discussed the need to promote efforts so that the results of training can reach more people.

There is still a gap in mental healthcare due to the lack of professionals, the little investment in mental health, the fact that mhGAP is not a priority program for the ministries of health, and the fact that there are identifiable barriers to the application of mhGAP in the first level.

The audience is asked to state what barriers they consider to exist for the application of mhGAP:

- Not being able to prescribe the medications recommended by the guide.
- Structural difficulties in the workplace, other professionals of the center not collaborating in the implementation of this initiative.
- The examples that were used during the training did not represent the cultural features of the country.
- Following the algorithm proposed by the mhGAP guide in everyday clinical practice was complicated.
- Work overload.
- Some doctors thought that some of the medications proposed by the mhGAP guide were not the most suitable.
- The psychological therapies proposed by the mhGAP guide are based on the cognitive-behavioral paradigm, and it is difficult to implement them because Psychology university training in most universities still has an important psychodynamic approach. For some psychologists, mhGAP has a clear biomedical orientation.

Some of the improvements of version 2 of the mhGAP

- Evidence to build recommendations has been improved and made easier for the public to understand.
- The algorithm is visually easier to follow since it is represented in vertically.
- The psychosis module has been renewed and some drugs have been added.
- Alcohol disorders are included within substance disorders, not separately like in version 1.
- The need for knowledge and skills of psychiatrists and specialists as trainers and educators is reiterated.
- The need to train not only doctors but also other professionals: nurses, health workers, and other non-specialized personnel according to the needs of the community is reiterated.
- First module "General principles of care"
    - The general principles of care are maintained: communication, respect and dignity, and fighting against stigma
    - The need for physical health assessment is maintained.
- Evaluation of mental disorders and treatment
    - Maintenance of psychosocial interventions. Some professionals cannot prescribe but they can perform these interventions.
    - Pharmacological interventions have been changed.
    - Derivation: Emergency intervention modules
- Preparation of training manuals for adults:
    - Through experience. Keep in mind that many of those who are trained are people who are already in contact with the patient. Training is more practical and based on competencies. Effective use of feedback.
    - Facilitate learning: Give trainers the feeling of re-experience; that way, professionals felt more respected and valued
    - Relate concepts to experiences
    - Reinforcement as a useful form of learning
    - Learning based on the acquisition of competencies. Develop skills rather than develop themes.

Existing Challenges / Opportunities for the mhGAP:

- Making an evaluation of the implementation in order to know the results after training is necessary.
- Standardizing monitoring and supervision is important. Time should be given in the agenda to do the monitoring. Adapting this monitoring is also necessary.
- Carrying out an evaluation of competences and feedback of the practices is necessary.
- The need to refresh the knowledge given in the training is also highlighted. That would make follow-up easier (perceived utility).
- The competencies that should be favored must be homogenized.
- Having all of the instruments to do the training, since in some courses, the evaluation instruments have not been accessible.
- Access to the training materials is not global. The version 2 manual is still only in English. Psychological intervention manuals are not yet in Spanish either.
- An evaluation of how the training of the mhGAP version 1 guide has been carried out before the release of version 2 should have been carried out. However, how version 1 worked to make version 2 has not been systematically evaluated. An assessment of the mhGAP's impact on the health system (i.e. if mhGAP has decreased long-term illnesses) should have been made earlier.
- Everyone should use the same tools to train.
- Other evaluation instruments that reflect beyond the knowledge are needed, as well as other variables of quality of care and compliance with the guide, for example, studying the number of referrals after the training.
- Adaptation has been given a lot of freedom, which creates a lot of heterogeneity in training. The WHO has lately proposed training guides.
- The paper material of the guides is very expensive. Mobile applications can be an opportunity for universal access.
- Creating groups of trainers that might be necessary in order communicate and report the experiences with generic and homogeneous indicators for use in studies.
- Creating a page where experiences are shared is proposed.
- Obtain financing is necessary.

Dr. Pilar López affirms that there is currently an operations manual (pending translation into Spanish) that is very interesting and relevant for implementation by country.

We would like to remind everyone that this manual suggests that to implement this (and any) program, performing a series of steps is necessary:

Phase I. Plan preparation. It is necessary to stablish an mgGAP operations team and to conduct a situation analysis:

- To know the situation of the different states
- To know the priority actions that have been established.
- To know the health context: number of professionals.
- To identify needs and resources at district and facility levels
- To establish objectives (determine priorities, evaluate options, and establish objectives)

Phase II. Preparation. Adapt the program to reality. Specify in advance how to train professionals, and see how supervision is going to be done.

Phase III. Provision of services. It is important to raise awareness among the general public, health managers, and professionals, and encourage dialogues between them. Importance of monitoring the results.

Summary of the previous day: barriers, uncovered needs, and opportunities. Dr. Pilar López, UAM.

To summarize, the following aspects can be highlighted:

POSITIVE ASPECTS

- The training of non-specialist professionals through the mhGAP mental disorders assessment and management guide is an opportunity for advocating the importance of mental health before the ministries of health.
- The mhGAP has highlighted the need for multidisciplinary work. Collaboration between specialists (psychologists and psychiatrists) and first level professionals is necessary.
- Academics, regardless of political support, can promote training initiatives for first level doctors.

NEGATIVE ASPECTS

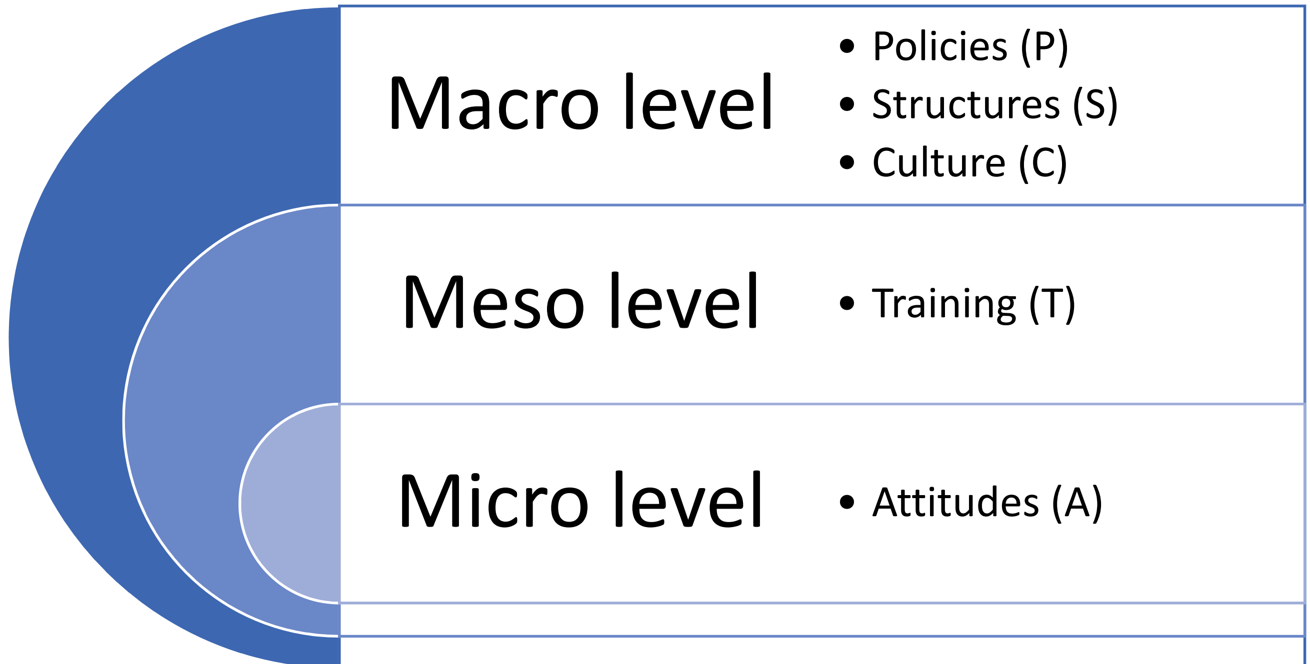
- Mental problems are not a priority despite being prevalent conditions, with an increase in cases in the adult population and also in children, and with the associated high disability. Despite the great burden of the disorders, there is a lack of awareness among health policy managers on the importance of mental health for an adequate allocation of resources.
- There are economic barriers and structural challenges when integrating mental health in primary care.

Discussion on how to implement the training of non-specialist doctors through the mhGAP program in Mexico.

Working groups are organized to identify barriers, opportunities, and tactical proposals to implement the training in the mhGAP program in Mexico. Three working groups are formed and each one incorporates professionals from different institutions (UAM, UNAM Psychiatry, UNAM Psychology, Family Medicine UNAM, INPRFM, SAP).

Workgroup sharing of knowledge

There are several action levels and different types of elements to consider



Barriers

<table>
<tr><th>Type of barrier</th><th colspan="2">Barrier</th></tr>
<tr><td rowspan="5">Training</td><td colspan="2">Lack of training in both undergraduate and postgraduate levels (health professionals)</td></tr>
<tr><td colspan="2">Fragmentation of the curricula (both in undergraduate and postgraduate courses)</td></tr>
<tr><td colspan="2">Biomedical model in medical training (both in undergraduate and postgraduate courses)</td></tr>
<tr><td colspan="2">Resistance to change, by teachers and professionals</td></tr>
<tr><td colspan="2">Lack of systematization of the management of mental health disorders</td></tr>
<tr><td rowspan="12">Structural</td><td colspan="2">Lack of derivation mechanisms</td></tr>
<tr><td colspan="2">Fragmentation of the health system</td></tr>
<tr><td colspan="2">Overload of professionals</td></tr>
<tr><td colspan="2">Lack of a national health model</td></tr>
<tr><td colspan="2">Lack of planning by the authorities</td></tr>
<tr><td colspan="2">Lack of institutional coordination</td></tr>
<tr><td colspan="2">Instability in health policies produced by political changes</td></tr>
<tr><td colspan="2">Little availability of medications</td></tr>
<tr><td colspan="2">Lack of interdisciplinary work</td></tr>
<tr><td colspan="2">Few specialists in rural areas</td></tr>
<tr><td rowspan="2">Policies</td><td>Lack of prioritization of mental health in the Ministry's health agenda</td></tr>
<tr><td>Lack of incentives for professionals and centers. For example, it is not taken into account for accreditation</td></tr>
<tr><td>Evaluative</td><td colspan="2">Lack of means to evaluate the impact</td></tr>
<tr><td rowspan="2">Cultural</td><td colspan="2">Stigma</td></tr>
<tr><td colspan="2">Beliefs about mental health</td></tr>
<tr><td>Application</td><td colspan="2">Lack of coordination between the WHO and the trainers (structured training, materials used for training, resources for evaluation, etc.)</td></tr>
</table>

Opportunities

Interinstitutional Network (SAP, INPRFM, UNAM)
Telepsychiatry
Interns (training in the mhGAP)
Teacher training
Impact evaluation through the tools currently available
mhGAP as a practical tool
Supervision: there are materials for supervision that are being implemented (specifically, the Faculty of Psychology is currently carrying out an implementation)
Combination of online / face-to-face methodology
Incorporation of mhGAP into the curriculum of the Medicine curriculum
Multidisciplinary work
Support from the WHO (neutral entity at the political level)
Implication of the university as a unifying element that has the possibility of accessing interns in the training period to train teachers.
Rethinking and reforming training programs in family medicine
Make a test run in a state, in a group of health centers. In which doctors, nurses, psychologists, and social workers are all trained

Recommendations and roadmap

The university is proposed as the coordinating body for the training initiatives. Carry out training a test run of professionals in the following levels is proposed:

Action	Responsible
Training plan for interns	Dr. Claudia Fouilloux (department of Psychiatry UNAM) in August 2018 and Dr. Abel Delgado (coordinator of social service at UNAM): at the beginning of the internship (January-February 2019)
Training plan for family doctors	Dr. Isaías (Family Medicine subdivision)
Training plan in family medicine units (FMU)	Dr. Octavio (Family Medicine subdivision)
Training plan in health centers	Dr. Mazón (director of the Family Medicine subdivision)
Teacher training plan	Dr. Patricia Vidal (clinical teaching UNAM)

Annexes

Annex 1. Meeting agenda.

International meeting

Medical training implementation in mental health of non-specialist physicians to overcome mental health gaps in Mexico

9 y 10 de Abril 2018

Location: UNAM Department of Psychiatry

AGENDA

Monday, April 9

8:45 Welcome. Introduction of the participants. Goals of the meeting *Dr. Germán Fajardo, Director of the Faculty of Medicine, UNAM* *Dr. Miguel Malo, Advisor for chronic diseases, PAHO/WHO* *Dr. Silvia Ortiz, Head of the Department of Psychiatry and Mental Health, UNAM* *Dr. María Elena Medina Mora, Director Instituto Nacional Psiquiatría Ramón de la Fuente Muñiz* *Dr. Pilar López, Director of the Department of Psychiatry, Faculty of Medicine, UAM*
9:30 State of mental health in México *Dr. Mª Elena Medina Mora, Directora INPRFM*
10:00 Mental health requirements not covered in Mexico *Dr. Shoshana Berenzon, Investigator INPRFM*
10:30 Mental health policies in Mexico *Dr. Eduardo Madrigal de León, Head of the Servicios de Atención Psiquiátrica SAP, Comisión Coordinadora de Institutos nacionales de Salud y Hospitales de Alta especialidad*
11:00-11:15 Coffee break
11:15 State of mental health training for doctors in Mexico *Dr. Silvia Ortiz, Head of the Department of Psychiatry and Mental Health, UNAM*
11:45 Mental health needs for training primary care doctors *Dr. Rebeca Robles, investigator INPRFM*

12:15 Promotion of PAHO in the implementation of mhGAP in the Americas *Ponente: Dr. Miguel Malo, Advisor for chronic diseases PAHO/WHO*
12:45 Formative experiences with the mhGAP in Peru *Dr. Silvana Sarabia, Associate Professor Department of Psychiatry, Faculty of Medicine, Universidad Peruana Cayetano Heredia*
13:15 Formative experiences with the mhGAP in Mexico *Dr. Pilar López, Department of Psychiatry, UAM; Dr. María Cabello, Department of Psychiatry, UAM; Dr. Rebeca García-Robles INPRFM; Dr. Claudia Fouilloux, , Department of Psychiatry and Mental Health, UNAM*
13:45 Summary session and end of the day

Tuesday, April 10

9:00 Challenges of mhGAP opportunities in Mexico *Dr. Javier Mendoza, Department of Psychiatry and Mental Health UNAM*
9:30 Summary of the previous day: barriers, uncovered needs, and opportunities
10:00 How to implement the training of non-specialist doctors through the mhGAP program in Mexico *Group discussion*
11:45-12:00 Coffee break
12:00 Sharing of knowledge
13:00 Recommendations and roadmap.
13:30 Conclusions and end of meeting

Annex 2. List of participants

International meeting

Medical training implementation in mental health of non-specialist physicians to overcome mental health gaps in Mexico

April 9 and 10, 2018

Location: UNAM Department of Psychiatry

LIST OF PARTICIPANTS

SPEAKERS

1. **Dr. Shoshana Berenzon**, investigator in Medical Sciences of the Instituto Nacional de Psiquiatría Ramón de la Fuente, Mexico City.

2. **Dr. María Cabello Salmerón**, Researcher and honorary professor, Department of Psychiatry, Faculty of Medicine, Universidad Autónoma de Madrid, WHO collaborating center for research and teaching, Madrid, Spain.

3. **Dr. Germán Fajardo,** Director of the Faculty of Medicine, Universidad Nacional Autónoma de México, Mexico City.

4. **Dra Claudia Fouilloux Morales,** Undergraduate Coordinator, Psychological Medicine and Communication, Department of Psychiatry and Mental Health, Faculty of Medicine, UNAM, Mexico City.

5. **Dr. Pilar López García,** Director of the Department of Psychiatry, Faculty of Medicine, Universidad Autónoma de Madrid. Director, Centro , WHO collaborating center for research and teaching, Madrid, Spain.

6. **Dr. Eduardo Madrigal de León**, Head of the Servicios de Atención Psiquiátrica SAP, Comisión Coordinadora de Institutos nacionales de Salud y Hospitales de Alta especialidad, Mexico City.

7. **Dr. Miguel Malo**, Advisor for chronic diseases of PAHO/WHO, Mexico City.

8. **Dr. Mª Elena Medina Mora**, Director Instituto Nacional de Psiquiatría Ramón de la Fuente, Mexico City.

9. **Dr. José Javier Mendoza**, research coordinator, Department of Psychiatry and Mental Health, Faculty of Medicine, UNAM, Mexico City.

10. **Dr. Silvia Ortiz León**, Head of the Department of Psychiatry and Mental Health, Faculty of Medicine, Universidad Nacional Autónoma de México, Ciudad Universitaria, Avenida Universidad 3000, 04510, Mexico City.

11. **Dr. Rebeca Robles Garcia**, Researcher in Medical Sciences of the Instituto Nacional de Psiquiatría Ramón de la Fuente, Mexico City.

12. **Dr. Silvana Sarabia Arce,** Associate Professor in the Department of Psychiatry and Mental Health, Alberto Hurtado Faculty of Medicine, Universidad Peruana Cayetano Heredia, Avenida Honorio Delgado, 430, 15102, Lima, Perú.

INVITED OBSERVERS

1. **Dr. Dení Alvarez Icaza**, Instituto Nacional de Psiquiatría Ramón de la Fuente, Mexico City.

2. **Dr. Margarita Cabrera Bravo**, Coordinator of Basic Sciences of the Faculty of Medicine, UNAM, Mexico City.

3. **Dr. Teresita Corona,** Instituto Nacional de Neurología y Neurocirugía Manuel Velasco Suárez, Vicepresident of the Academia Nacional de Medicina, Mexico City.

4. **Dr. María Gabriela Cortés Meda.** Assistant psychiatrist of the Dirección General de Servicios de Atención Psiquiátrica. Mexico City.

5. **Dr. Abel Delgado Fernández**, Social Service Coordinator of the Faculty of Medicine, UNAM, Mexico City.

6. **Dr. Irene Durante Montiel**, General Secretary of the Faculty of Medicine, UNAM, Mexico City.

7. **Dr. José Halabe Cherem**, Head of the Postgraduate Studies Division of the Faculty of Medicine, UNAM, Mexico City.

8. **Dr. Gerhard Heinze,** Head of the Medical Specializations Postgraduate Subdivision, Faculty of Medicine, UNAM, Mexico City.

9. **Dr. Alberto Lifshitz Guinzberg**, Secretary of Education, Clinic, Internship, and Social Service, Faculty of Medicine, UNAM, Mexico City.

10. **Dr. Juan José Mazón Ramírez**, Head of the Family Medicine Subdivision, Faculty of Medicine, UNAM, Mexico City.

11. **Dr. Silvia Morales Chaine,** Full professor at the Faculty of Psychology, UNAM, Mexico City.

12. **Mtra. Guillermina Natera Rey,** Director of Epidemiological and Psychosocial Research, Faculty of Medicine, UNAM, Mexico City**.**

13. **Dr. German Palafox,** Director of the Faculty of Psychology, UNAM, Mexico City,

14. **Dr. Ileana Petra Micu**, Undergraduate Teaching Coordinator, Department of Psychiatry and Mental Health, Faculty of Medicine, UNAM, Mexico City.

15. **Dr. Gabriel Sotelo Monroy.** Management Director of Psychiatric Care Services, Mexico City.

Annex 3. Workgroups

Group1	
Pilar López García	Director of the Department of Psychiatry. UAM
Octavio Noel Pons Alvarez	Family Medicine Subdivision. UNAM
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Ileana María Petra Mico	Department of Psychiatry and Mental Health UNAM
Shoshana Berenzon	Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz
Tania Gordillo Moreno	Faculty of Psychology. UNAM
Joaquín Ricardo Gutiérrez Soriano	Department of Psychiatry and Mental Health UNAM
Claudia Fouilloux Morales	Department of Psychiatry and Mental Health UNAM
Patricia Vidal Licona	Department of Clinical Teaching, Internship and Social Service, UNAM Faculty of Medicine
Gabriel Sotelo Monroy	Management Director. Psychiatric Care Services, Secretary of Health
Group 2	
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Isaías Hernández Torres	Teaching coordinator. Subdivision of Family Medicine. Faculty of Medicine UNAM
Silvia Aracely Tafoya Ramos	Faculty of Medicine UNAM
Rebeca Robles García	Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz
Silvana Sarabia	Faculty of Medicine, Universidad peruana Cayetano Heredia (Peru)
Eduardo Madrigal de León	Management Director. Psychiatric Care Services, Secretary of Health
Ana Carolina Rodríguez Machain	Department of Psychiatry and Mental Health UNAM
Alberto Lifshitz	Department of Clinical Teaching, Internship and Social Service, UNAM Faculty of Medicine
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Juan José Mazón	Head of the Family Medicine Subdivision, Faculty of Medicine, UNAM
María Cabello Salmerón	Department of Psychiatry. UAM
Javier Mendoza	Department of Psychiatry and Mental Health UNAM

Silvia Morales	Faculty of Psychology. UNAM
María Gabriela Cortés Meda.	Assistant psychiatrist of the Dirección General de Servicios de Atención Psiquiátrica, Department of Health
Guillermina Natera Rey.	Director of Epidemiological and Psychosocial Research, Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz
Aurora Leonila Jaimes Medrano	Department of Psychiatry and Mental Health UNAM

Opening of the session. Intervention of Dr. Germán Fajardo. At the presidential table from left to right, Dr. Silvia Ortiz, Dr. Miguel Malo, Dr. Mª Elena Medina Mora, Dr. Pilar López, and Dr. Germán Palafox.

Some of the speakers at the meeting.

Discussion and working groups during the meeting.

Participants at the meeting.