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**MENTAL HEALTH**

The need for mental health care in the Region, both now and in the near future, requires creative and scientifically-based intervention programs, as well as political will and social consensus for their promotion. The distribution of these needs is not random; the more adverse the living conditions, the greater the needs. Hence, investment in programs and services for the preservation and recovery of mental health at every age will increase the populations that attain sustainable human development. Response to these needs is possible thanks to the significant advances made in knowledge about the brain, in psychology and sociology, and in the development of prevention models and technologies at all levels of care.

This document examines the bases for action, the objective of the program, and its principal components, as well as the functional approaches to technical cooperation. The document discusses two initiatives in particular: (1) the initiative to restructure psychiatric care, which promotes the improvement of psychiatric services and their transfer to the community, thereby facilitating their integration into primary health care and the development of programs to reduce the prevalence of depression, epilepsies, and psychoses; and (2) the initiative to promote mental health and the psychosocial development of children.

At its 120th Session, the Executive Committee adopted a resolution for consideration by the XL Directing Council (CE120.R20, Annex) aimed at: (1) supporting promotion and prevention activities in mental health through the formulation of national mental health plans articulated with health and human development plans; (2) ensuring the inclusion of mental health services in the care provided by all health services; (3) supporting the restructuring of psychiatric care; (4) implementing community programs to reduce the prevalence of untreated neuropsychiatric disorders of the type described above and their psychosocial impact; (5) fostering activities to promote mental health and the psychosocial development of children; (6) strengthening the managerial capacity of the divisions/departments of mental health (or in their absence, establishing them); and (7) fostering the development of technical personnel to serve as leaders in mental health.

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## EXECUTIVE SUMMARY

The objective of the Program on Mental Health of the Division of Health Promotion and Protection, which was examined by the Subcommittee on Planning and Programming in April 1995 and by the Executive Committee in June 1996, is to provide technical cooperation to the countries in activities related to mental health and psychiatric care. The Program has three components: (1) the promotion of mental health and primary prevention of psychiatric disorders; (2) the control of psychiatric disorders; and (3) interventions on the psychosocial aspects of health and human development.

The Program's technical cooperation priorities and strategies arise from a regional situation analysis and the interpretation and implementation of the policies of PAHO's Governing Bodies. The analysis reveals that, notwithstanding the definition of health adopted by the Member States and the intrinsic importance of mental health, this area generally receives inadequate support from the governments and is undervalued by society, in spite of the overwhelming current and future needs. By way of illustration, in 1990 five out of the world's 10 leading causes of disability were psychiatric in nature; by the end of the century some 88 million adults in Latin America and the Caribbean will have experienced some form of emotional disorder; and more than 11 million will suffer from affective disorders by the year 2010. It should also be noted that children are not exempt from the need for mental health care; in Latin America and the Caribbean, an estimated 17 million boys and girls between the ages of 4 and 16 suffer from psychiatric disorders that warrant intervention. Health for All by the year 2000 will thus be an elusive goal unless the current state of mental health programs and services is improved through technical creativity and firm political will.

The analysis also reveals that the orientation of the services available to meet these needs is frequently inappropriate and that the number of such services is inadequate and the quality deficient. In order to respond to this situation the Initiative for the Restructuring of Psychiatric Care was launched, with support from PAHO/WHO Collaborating Centers and regional and international agencies. The implementation of the Initiative relies on a number of strategic approaches: the transfer of services and knowledge to the community, the expansion of treatment alternatives for patients and their families, the preservation of human rights, the provision of more humane care, the update of mental health legislation, and the inclusion of patients and family members in the management process. The reorientation of the services makes it possible to conduct community programs to control three neuropsychiatric disorders—depression, epilepsies, and psychoses—which, due to their magnitude and the disability that they produce, place a heavy burden on the populations of the Region. The

existence of technical and scientific resources is making it possible to offer a feasible response.

In addition to the previous component, the Program has begun to foster activities to promote the mental health and psychosocial development of children. This has been done under the umbrella of a regional interagency plan of action that has two chief components: the promotion of early childhood development and the reduction of violence against children.

The experience accrued thus far indicates that the Program can be further strengthened through a number of activities. The countries may consider the following lines of action: adopting policies and formulating mental health plans and programs that are intimately articulated with those of health and human development; undertaking the necessary activities to ensure that mental health care is included in the health services provided; strengthening the mental health divisions/departments in the ministries of health taking more decisive action to restructure psychiatric care in terms of services, training, and legislation; the control of affective disorders, epilepsies, and psychoses; broader support for promotion of mental health and the psychosocial development of children as part of an integrated intersectoral model of action; and enlarging the cadres of professional experts who lead the mental health programs through fellowships and other pertinent measures.

During the discussion of this item at the 120th Session of the Executive Committee, the Member States agreed on the need to strengthen mental health activities and improve psychiatric services in order to overcome the current deficiencies. It should be noted that the proposed resolution that is being submitted to the XL Directing Council includes an item urging the Member States to incorporate mental health care into the health services provided. This reflects the prevailing consensus in the Executive Committee about the importance of making mental health care duly accessible and giving it parity with health care in general.

The fundamental purposes of the Pan American Health Organization . . . shall be to promote and coordinate efforts of the countries of the Western Hemisphere to combat disease, lengthen life and promote the physical and *mental* health of the people (*Constitution of the Pan American Health Organization, Chap. 1, Art. 1*).

Health is a state of complete physical, *mental*, and social well-being, and not merely the absence of disease or infirmity (*Constitution of the World Health Organization*).

## **1. Introduction: The Bases for Action**

The technical cooperation provided by the Program on Mental Health of the Pan American Health Organization is based on the analysis of current factors operating in the countries of the Region: conceptual (e.g., the definition of health), operational (e.g., epidemiological), or mixed (e.g., health and human development policies, state of the services). It also recognizes that it is the Program's responsibility to interpret in its field the policies and program priorities established by the Governing Bodies, as expressed in mandates at the global (1) and regional levels (2,3).

### **1.1 Definition of Mental Health and Mental Life**

Mental health is an integral component of the definition of health adopted by the Member States. However, societies and governments are still a long way from granting its due importance. Indeed, it has been repeatedly pointed out that mental life does not occupy the place it deserves on society's scale of values, despite the fact that it is what makes human beings human. This is expressed in numerous ways, e.g., in the absence of national mental health policies and in the limited resources assigned to national programs.

### **1.2 Integral Nature of Health**

Health and disease are of an integral nature. Significant discoveries in the biological component of medicine have blurred our vision on the role of behavior in health, whether in its promotion (e.g., the development of healthy lifestyles), preservation (e.g., the reduction of toxic agents in the physical environment), or recovery (e.g., adherence to a course of treatment). Noteworthy, in 1990 behavior was a critical factor in at least 4 of the 10 leading causes of death in the developing countries and in 6 in the developed countries (4). Behavior, however, is a factor that is frequently glossed over in health policies and health activities at both the individual and collective level.

### **1.3 *Development and Mental Health***

Society has begun to recognize the intimate link between human development and health in general. This interdependence is equally true where mental health is concerned, especially for populations living in adverse situations. Indeed, the more these populations succeed in preserving or recovering their mental health, the better they can negotiate successful solutions to their problems or, at the very least, avoid behaviors that generate new obstacles (e.g., alcoholism or violence). Economic and social development in the Americas has wrought many changes. One of these is related to the changes in habitat faced by large population groups as a result of migration from rural to urban settings, causing people to suffer discontinuities and losses (e.g., loss of social supports, loss of values) and has affected the mechanisms for personal and collective adaptation. All this has translated into a variety of mental disorders and psychosocial problems such as violence, substance abuse, and demoralization.

### **1.4 *Mental Health Care Needs***

The epidemiology of psychiatric disorders and psychosocial problems in the Region indicates that the magnitude of the situation is overwhelming. In the United States of America, the ECA (Epidemiologic Catchment Area) study, which included several urban and one rural population (N=19,640), reported a lifetime prevalence of 32% and an active case rate for the previous year of 20% (1991) (5). In Canada, a study conducted in Edmonton using a similar method yielded a lifetime prevalence rate of 33.8% (1988) (6). A multicenter research study in Brazil (1993) reported prevalence rates ranging from 19% to 34% for a series of psychiatric disorders requiring treatment (7). In Chile, the lifetime prevalence rate calculated in a study was 33.7% (1993) (8). It should be noted that these rates covered selected disorders only. Children are no less immune to psychiatric disorders. A study done in Puerto Rico reported a prevalence rate of 16% for moderate and severe psychiatric disorders (9). Projection of this rate to the population of Latin America and the Caribbean would yield 17 million children between the ages of 4 and 16 currently suffering from disorders that warrant intervention (10). With regard to epilepsies, the prevalence rates reported for Latin America range from 1.3% to 5.7% in the general population (13). The prevalence rates (per year) for affective disorders is around 4.1%, and for schizophrenic psychoses (in both Latin America and the Caribbean), 1.1%. The prevalence rates for alcoholism and substance abuse are equally high and are being addressed by the corresponding PAHO program.

As for the impact of mental illnesses on the populations of Latin America and the Caribbean, the World Bank has estimated that 8.0% of the disability-adjusted life years lost are attributable to them, a greater proportion than for cancer (5.2%), or cardiovascular diseases (2.6%) (11). It has also been estimated that five of the leading

10 causes of disability worldwide (1990) are psychiatric in nature, with depression ranking first (4). The economic burden is also heavy. To illustrate, in the United States the yearly cost of depression has been estimated at \$43 billion (1990) (12).

It should be recalled that the distribution of mental illness in the population is not random; there is an inverse relationship between socioeconomic level and the aggregate rate of mental disorders. The needs are also greater in the higher-risk groups, such as indigenous populations (14) and the victims of war, persecution, and displacement.

### **1.5 *Future Needs***

Mental health care needs in the countries will increase even further toward the beginning of the century due to the projected demographic changes, which will result in a greater number of people entering the ages at risk for psychiatric disorders. No less than 88 million people will suffer from some sort of mental or emotional disorder in Latin America and the Caribbean in the year 2000 (15); the proportional increase will be greater than the increase in the general population. Estimates indicate that by the year 2010 Latin America and the Caribbean will have more than two million people with schizophrenic disorders and more than 17 million with affective disorders.

Health for all will elude societies and governments unless creative mental health policies and programs backed by firm political resolve are implemented.

### **1.6 *Situation of the Services***

Although there are variations throughout the Region, the organization of psychiatric care and the situation of the services reveal troubling deficiencies. Care is usually based in mental hospitals, institutions with low coverage and limited access that often carry a stigma. Not infrequently, such institutions are geographically, physically, or socially isolated, and the human rights of their patients are violated, either by omission or commission. Furthermore, there is little or no integration of these services with the general health system. This type of structure does not take it into account that the network of mental health care is broader and includes the individual (self-care), the family, social support groups, community leaders, health workers, and the different levels of health care (16). It also ignores the fact that there is a range of specialized services that differ according to the changing psychopathological and psychosocial needs of the patient. A service structure so conceived will not permit the health sector reform adopted by the countries (including decentralization, social participation, intra- and intersectoral linkages, health promotion) to be fully implemented.

The situation of the services is doubly worrisome in light of the fact that the undergraduate and graduate training provided in mental hospitals does not offer health professionals—whether specialized or not—the opportunity to acquire the knowledge, skills, and attitudes needed to exercise an integrated practice in the community and ensure their rapid incorporation into the programs for the control of affective disorders, epilepsies, and psychoses.

### **1.7 PAHO Policies**

The Program on Mental Health is responsible for interpreting and carrying out the resolutions of the XXIV Pan American Sanitary Conference regarding the Organization's Strategic and Programmatic Orientations, 1995-1998 in the Program's area of responsibility (2). From these resolutions emerge new challenges for the mental health programs of the Region, with respect to promoting social policies to improve the quality of life of the individual, the family, and society in general, and strengthening the interaction between health and human development of which it is a part.

### **1.8 Scientific and Technical Advances**

The scientific and technical advances in the mental health field are considerable. If they proceed at the present rate, even further progress can be anticipated in our knowledge of the brain, psychology, and social psychiatry. Intervention models and technology resources have also increased, and if properly implemented, can produce the desired impact on the health of the populations. It is the Program's responsibility to duly apply these new developments in its technical cooperation and to disseminate them in the countries.

## **2. General Objective of the Program on Mental Health**

The general objective of the Program on Mental Health of the Division of Health Promotion and Protection is to provide technical cooperation to the countries to promote mental health, prevent mental disorders at all levels, and focus on the psychosocial aspects of health and social development. The Program utilizes the functional approaches common to all the technical units (promotion of policies, plans and programs; training; mobilization of resources; research; information, and direct technical cooperation) in order to collaborate with the countries of the Region to foster the preservation and recovery of mental health and health in general, and to promote human development.

### **3. Spheres of Action of the Program on Mental Health**

- Control of neuropsychiatric disorders;
- promotion of mental health and primary prevention of psychiatric disorders;
- intervention in the psychosocial factors affecting health and development.

#### **3.1 *Control of Psychiatric Disorders***

The Program's technical cooperation, based on the needs identified in the countries, is currently geared more toward the control of psychiatric disorders than toward the other two components.

The restructuring of psychiatric care, which PAHO initiated jointly with the countries and regional and international organizations, is an initiative aimed at reorienting this type of care to respond more effectively to the needs of the populations and to promote "community-based care that is decentralized, participatory, integrated, continuous, and preventive" (Declaration of Caracas, 1990). The initiative is a response to the orientation still present in the organization of psychiatric care, its isolation from the rest of the health sector and other social sectors, and the stigma associated with psychiatric disorders (17,18).

Implementation of the initiative is complex. Technical cooperation is therefore provided through several means, which support:

- monitoring respect for human rights (21);
- strengthening the entire network of care, which includes the mobilization of community agents inside and outside the health sector;
- action to involve consumers in programs and services;
- promotion of legislative reform that will establish the legal framework for reorienting the services and safeguarding human rights;
- action to adapt teaching at the university and postgraduate levels to community needs;
- operational research;

- promotion of a social and professional culture consistent with the principles of the Initiative (14).

Technical cooperation is guided by the Declaration of Caracas, adopted in November 1990 by the Regional Conference on the Restructuring of Psychiatric Care in Latin America, which brought together professionals, politicians, jurists, social communicators, and users and was sponsored by several international agencies, among them WHO and the OAS (17). The initiative is monitored periodically by the Program (14). Despite formidable obstacles, the results indicate that virtually all the Latin American countries have taken some sort of action to reorient their psychiatric services. For example, the initiative has been debated in the national legislatures and the media in seven countries, thus enabling societies to make more informed decisions on the type of care best suited to their culture and technical resources. The Program has recently launched activities to study the cost of community care in order to generate information that will facilitate more objective decision-making.

The reorientation of the services toward the community will facilitate the implementation of community programs to control affective disorders, epilepsies, and psychoses by reducing the prevalence of untreated disorders and their impact on individuals and society. With this in mind, the goal is to utilize the resources at both the primary care level (e.g., for the identification and management of the clinical intervention) and in the community, both inside and outside the health sector (e.g., mobilization of support groups), in addition to adopting public policies (e.g., to permit the full exercise of citizenship) and relying on the mass media (e.g., to eradicate or reduce the stigma). This reorientation will also make it possible to improve the delivery of care to the population groups at greatest risk, such as indigenous peoples and the victims of armed conflict and displacement.

This initiative, which has focused on Latin America, will be studied in the English-speaking Caribbean at a subregional meeting scheduled for late 1997, with a view to improving care.

### **3.2 *Promotion of Mental Health and the Primary Prevention of Psychiatric and Emotional Disorders***

This is a new area of technical cooperation that is being carried out in fulfillment of the Regional Plan of Action for Health Promotion in the Americas (CE113/15, 2 May 1994) approved by the Governing Bodies. This component includes:

- (1) Support for activities to raise the level of mental health on society's scale of values through the mobilization of key figures in the countries, such as the First Ladies (19), utilization of the mass media, and the forging of intra- and

intersectoral alliances. The purpose of the latter is to integrate mental health knowledge and techniques into the policies, programs, and services of other sectors.

- (2) Promotion of behavioral changes to encourage the adoption of healthy lifestyles (3), e.g., the reduction of violent behavior; incentives to promote peaceful relationships.
- (3) Coordination with other PAHO units and international and regional organizations (e.g., OAS, UNICEF, UNESCO, Instituto Interamericana del Niño) for joint implementation of a regional plan of action to promote the psychosocial and mental development of children that has two principal components: promotion of early childhood development (affective, social, and cognitive) and reduction of violence against children (corporal punishment and child abuse). This plan is being discussed by subregion, so that the countries will adopt analogous strategies with integrated and intersectoral characteristics.

The possibilities open to the Program in the promotion of mental health are numerous, despite the relative newness of the conceptual and operational frameworks and the relative scarcity of empirical evidence. With this in mind, the Program is preparing documents to orient its technical cooperation efforts.

With regard to the primary prevention of mental and psychosocial disorders, in 1988 WHO prepared a document that lists effective interventions (21), some of which are found in the Interagency Regional Plan of Action to Promote the Mental Health and Psychosocial Development of Children (10).

### **3.3 *Psychosocial Aspects of Health and Development***

Activities in this sector vary. They include: (1) technical support to promote the inclusion of behavioral components into training for health workers to increase the effectiveness of their interventions; and (2) the dissemination of knowledge and techniques that will enable communities to better stimulate human development. The Program seeks to provide technical support to countries directly or indirectly affected by the armed conflicts in the Region, which have created a number of high-risk population groups (e.g., displaced persons, refugees, and people suffering from trauma).

#### **4. Functional Approaches of the Program on Mental Health**

The functional approaches employed are identical to those of the other technical units at PAHO. The following description completes the information provided in previous sections.

##### **4.1 *Mobilization of Resources***

###### **4.1.1 *In the Pan American Health Organization***

The Program recognizes that the spheres of action for which it is responsible need to be shared with other technical units and with the Representative Offices in the countries. Indeed, one indicator of the Program's success is the degree to which mental health is indivisible from every technical cooperation activity undertaken by PAHO. Activities are currently coordinated with the majority of the technical units and the Representative Offices.

###### **4.1.2 *With PAHO/WHO Collaborating Centers***

Continued working relations with eight Centers make it possible to substantially increase the technical response capability. Three of these Centers have been providing sustained collaboration in the Initiative for the Restructuring of Psychiatric Care since 1990.

###### **4.1.3 *With International and Regional Organizations***

Active working relations have been established with numerous organizations, coordinating advocacy on behalf of mental health and mental patients and facilitating the promotion of policies and the development of programs and services.

###### **4.1.4 *In the Countries***

The technical cooperation of the Secretariat is possible when there is a national mental health unit in the country that has sufficient political, scientific, and technical authority and resources to permit the discharge of its responsibilities and to better utilize the technical support made available. In this regard, some countries, despite PAHO's efforts, do not have a specialized unit at the ministerial level or only partially fulfill the aforementioned characteristics.

The Program employs two modalities of cooperation among countries: (1) subregional action groups that make it possible to maximize the use of regional and international technical cooperation (one group has been established in Central America

and another in the Andean Subregion, while a third one in the English-speaking Caribbean is currently being envisaged); and (2) bilateral and multilateral activities.

#### **4.2 *Promotion of Policies, Plans, and Programs***

The Program promotes the formulation, implementation, monitoring, and evaluation of national mental health plans that interpret the health and human development policies and that are part of the national plans (21). The national plan outlines a systematic intersectoral response to the national situational diagnosis. Notwithstanding the efforts to date, countries that have up-to-date national plans duly sanctioned by the authorities are still in the minority.

#### **4.3 *Human Resources Development***

This is a central aspect of technical cooperation, since in the absence of duly trained resources, it is only with difficulty that the transformations alluded to in the other sections can be carried out. The professional areas in which resources need to be developed are: (1) master's programs in public health and mental health; (2) the education of psychiatrists; (3) the education of physicians; (4) the education of psychologists; (5) the training of nursing professionals in mental health; and (6) the training of community agents outside the health sector.

##### **4.3.1 *Master's Programs in Public Health and Mental Health***

Responding to the need for highly specialized technical personnel, the Program promotes the establishment of training programs in mental health in Latin America and the Caribbean, within the framework of the master's programs of the schools of public health. Today, no less than four new university programs are in operation in Latin America that offer a master's degree, with some support from PAHO. This effort would be facilitated if training fellowships were made available to increase the teaching cadres. Some financial resources are also needed to permit greater cooperation among universities at this initial stage of their development (23).

##### **4.3.2 *Education of Psychiatrists***

Concerning the education of psychiatrists, an objective of the Program is to foster curriculum changes that incorporate the progress made in the neurosciences, the social sciences, and social communication and that respond to the Initiative for the Restructuring of Psychiatric Care (24). Progress in this respect has been limited, for reasons of tradition and ideology.

#### 4.3.3 *Education of Physicians*

The objective is to provide technical cooperation in the design and implementation of training programs for physicians that will enable them to competently handle aspects of behavior related to the preservation and recovery of health and to recognize and treat the most frequent psychiatric and psychosocial disorders, especially depression, epilepsies, and psychoses; all of this emphasizing human values in the practice of medicine. To this end, the Program promotes the modification of curriculum contents and teaching locales--changes that are still difficult to achieve for the reasons cited above.

#### 4.3.4 *Education of Psychologists*

The objective is to promote the training of psychologists who can be integrated into public health and mental health interventions in health promotion and disease prevention at all levels. This group of professionals is frequently the most numerous in some countries. Training, however, is currently geared more toward individual interventions than toward community-based practice, despite the fact that psychologists are the profession best suited to working with communities in the field of health when behavior is involved. In addition, given the scarcity of human resources in mental health care, psychologists could acquire additional knowledge and skills that would give them a polyvalent capability.

#### 4.3.5 *Education of Nursing Professionals in Mental Health*

The purpose of the cooperation carried out jointly with the respective technical unit at PAHO is to increase the current limited number of highly trained professionals, to increase their competence, and to collaborate in the professionalization of nursing auxiliaries. The training to be strengthened is for both hospital and community care.

#### 4.3.6 *Training of Community Agents Outside the Health Sector*

The objective of this activity is to train selected leaders of the community in the identification and management of the most frequent mental disorders and psychosocial problems, the early referral of patients to the health services when appropriate, the fostering of self-care, the encouragement of support groups, and the promotion of healthy lifestyles. This activity has begun with police officers and will continue with the clergy.

#### 4.4 *Research*

The main objective is to furnish technical cooperation to the countries to promote the development of investigators who will provide planners and administrators with data and facilitate rational decision-making in mental health. This purpose demands: (1) epidemiological studies for situational diagnosis and program evaluation in the specialized services and other levels of care; and (2) research in the social sciences that provides information on the sociocultural and economic processes associated with the preservation, loss, and recovery of health. Several studies promoted by the Program have been financed by PAHO.

#### 4.5 *Dissemination of Knowledge and Information*

The objective of the Program is to produce and disseminate scientific and technical information, with a view to increasing and updating the knowledge of professionals, the community, and experts in the programs and services. To facilitate its work, PAHO collaborates with the Centro Regional de Información en Salud Mental (CRISAMEN, Buenos Aires), which is part of a PAHO/WHO Collaborating Center, jointly producing materials for administrators, educators, and investigators.

### 5. **Human and Financial Resources of the Program on Mental Health for the 1997-1998 Biennium**

Program resources for the biennium 1997-1998 are detailed in the table below:

Human Resources: 1 Regional Advisor (75%)  
1 Secretary (75%)

Financial Resources (in US\$)

<b>Origin of the Funds</b>	<b>1997</b>	<b>1998</b>
PAHO regular budget	55,000	100,000
WHO, Nations for Mental Health	120,000	120,000
European countries	55,000	45,000
Private sector	124,500	20,000
NIMH (U.S.A.)	8,000	-
<b>Total</b>	<b>362,500</b>	<b>285,000</b>

## **6. Future Trends**

During the next quadrennium the Program should increase its involvement in PAHO's general projects (e.g., healthy communities) in order to offer technical cooperation to the countries that integrates behavioral aspects into other areas typically offered by the technical units. It should also to respond to the demands generated by the epidemiological transition under way in the Region, which requires a greater contribution from the behavioral sciences. Finally, the Program should collaborate with the countries in the implementation of primary prevention interventions of proven effectiveness and of acceptable cost-benefit. All of this should be achieved while consolidating the Initiative for the Restructuring of Psychiatric Care currently under way, which, if successful, will make it possible to free human resources to tackle priority problems that are growing in magnitude.

## **7. Request to the XL Directing Council**

The XL Directing Council is requested to examine the Program's orientation, review its objectives and strategies, and draw up a series of recommendations geared toward: (1) increasing support for promotion and prevention in mental health through the formulation of public policies and national mental health plans closely linked to the national health and human development plans; (2) ensuring the inclusion of mental health services in the care provided by the health services; (3) supporting the restructuring of psychiatric care in all its strategic components; (4) implementing community programs to reduce the prevalence of untreated disorders and the psychosocial impact of affective disorders, epilepsies, and psychoses; (5) conducting activities to promote mental health and the psychosocial development of children; (6) strengthening the managerial capacity of the divisions/departments of mental health (or in their absence, establishing them); and (7) fostering the development of technical personnel to serve as leaders in the mental health programs.

The joint activities of the countries and the Secretariat will enable the peoples of the Americas to address their mental health and general health needs with greater possibilities of success.

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EXECUTIVE COMMITTEE OF  
THE DIRECTING COUNCIL

PAN AMERICAN  
HEALTH  
ORGANIZATION

WORKING PART OF  
THE REGIONAL COMMITTEE

WORLD  
HEALTH  
ORGANIZATION



## RESOLUTION

CD40/15 (Eng.)  
Annex

CE120.R20

### MENTAL HEALTH

*THE 120th MEETING OF THE EXECUTIVE COMMITTEE,*

Having seen the report on mental health (Document CE120/19),

#### *RESOLVES:*

To recommend to the Directing Council the adoption of a resolution in the following terms:

*THE XL MEETING OF THE DIRECTING COUNCIL,*

Having seen the report on mental health (Document CD40/15);

Taking into account that the mental health care needs of the population are growing as a result of the demographic changes under way in the Region of the Americas and the widening scope of the field of mental health;

Aware of the existence of technologies that make it possible to control psychiatric disorders; and

Considering that actions for the promotion of mental health and the psychosocial development of children complement those promoted by the World Summit for Children,

#### *RESOLVES:*

1. To urge the Member States to:
  - (a) formulate and implement national mental health programs articulated with health programs in general;

- (b) intensify support for efforts to reorient mental health services to ensure that community care will be provided, in keeping with the initiative for the restructuring of psychiatric care described in Document CD40/15;
- (c) actively promote and support the inclusion of mental health services in every health insurance or payment plan and every health care services program;
- (d) develop programs for the treatment of affective disorders, epilepsies, and psychoses;
- (e) strengthen or carry out actions for the promotion of mental health and the psychosocial development of children, with special emphasis on the early years;
- (f) support training for the managers of mental health programs in the schools of public health;
- (g) make efforts to improve the legislation to protect the human rights of psychiatric patients.

2. To request the Director to:

- (a) continue technical cooperation with the countries and intensify it, as financial resources permit;
- (b) continue supporting the inclusion of mental health topics in all health forums and activities, and in joint activities with other agencies of the inter-American system;
- (c) express the Organization's appreciation for the generous collaboration being provided by European regions and communities, and its thanks to the WHO Collaborating Centers in the Region;
- (d) support programs to train leaders specializing in mental health.

*(Adopted at the seventh plenary session,  
26 June 1997)*