



# Strategy and plan of action on mental health



**Pan American  
Health  
Organization**



*Regional Office of the  
World Health Organization*



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*Mental disorders are highly prevalent throughout the world  
and are major contributors to morbidity, disability,  
and premature mortality.*

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# Strategy and plan of action on mental health<sup>1</sup>

## Introduction

1. Mental disorders are highly prevalent throughout the world and are major contributors to morbidity, disability, and premature mortality. However, the resources available to tackle the huge burden of mental illness are insufficient, inequitably distributed, and at times inefficiently used. Together, this has led to a treatment gap of more than 75% in low and lower-middle income countries (1). The stigma, social exclusion, and human rights violations that occur around mental illness compound the problem.
2. *There is no health without mental health.* The relationship between physical and mental health is multifaceted. Mental disorders increase risk for communicable and noncommunicable diseases, and contribute to unintentional and intentional injury. Furthermore, many pathologies increase the risk for mental disorder, and this co-morbidity not only complicates help-seeking and treatment, but also influences prognosis (2).
3. In light of the situation, it should be noted that modern scientific progress has improved the comprehension, management, and prognosis of mental disorders, which together with political will, has made this an opportune time for the Pan American Health Organization (PAHO) and its Member States to place mental health in a prominent position on its program of work and to be able to successfully meet these challenges. This Strategy and Plan of Action map out the route to follow in the coming 10 years.
4. The document reflects the contributions received during the consultation process, in the first quarter of 2009, which included ministries of health and other organizations, the Department of Mental Health of the World Health Organization (WHO), PAHO/WHO collaborating centers, PAHO technical programs, and a panel of 42 experts. The recommendations of the 144th Session of the Executive Committee were also considered and included.

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<sup>1</sup> This document (CD 49/11) was approved by the 49th Directing Council of the Pan American Health Organization by Resolution CD49.R17.

## Background

5. The 1990s opened with a historical event for mental health in the Americas: the launch of the Initiative for the Restructuring of Psychiatric Care in the Region at the Caracas Conference in Venezuela, in November 1990 (3). The Caracas Declaration emphasized that services based on the psychiatric hospital have to be replaced with the provision of decentralized, participatory, integrated, continuing, and preventive community-based care (3-4).
6. Subsequently, in 1997 and 2001, the PAHO Directing Council addressed the subject of mental health and issued resolutions urging the Member States to include mental health among their priorities and to intensify activities in this area (5-6). In 2001, WHO devoted the World Health Report (7) to mental health and promoted activities designed to put this issue on the global political agenda, and both PAHO and the majority of the Member States participated in these efforts. The “Regional Conference on Mental Health Services Reform: 15 years after the Caracas Declaration” (Brasilia, November 2005) (8-9) evaluated the progress made and set new directions for the work.
7. The countries of the Region adopted the Health Agenda for the Americas 2008-2017 (10) with the intention of guiding collective action by national and international actors interested in helping to improve peoples’ health. The Agenda defines areas of action in which mental health appears both explicitly and implicitly.
8. The 48th PAHO Directing Council (2008) adopted the Strategic Plan 2008-2012 (11). Objective 3 of the Plan focuses on the prevention and reduction of the disease burden, disability, and premature death from chronic noncommunicable conditions, *mental disorders*, violence, and injuries.
9. In October 2008, WHO presented the Mental Health Gap Action Program: Scaling up care for mental, neurological, and substance use disorders (mhGAP) (1). This program is grounded on the best available scientific evidence and offers a package of strategies and activities to scale up care for people with mental, neurological, and substance use<sup>2</sup> disorders.
10. The aforementioned PAHO and WHO program documents and resolutions provide the background and basis for this Strategy and Plan of Action.

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<sup>2</sup> The term “substance use” refers to all psychoactive substances, regardless of their legal status, including alcohol, illicit drugs, and psychotropic drugs used for nonmedical purposes.

## Current situation analysis

### *Prevalence and burden of mental disorders. Treatment gaps*

11. Epidemiological studies tend to find different prevalence rates depending on the methodology used, the types of disorders included in the research, and the time frame. Nevertheless, it is calculated that 25% of people (one in four) suffer from one or more mental or behavioral disorders in their lifetime (1, 7).
12. Mental and neurological disorders account for 14% of the global burden of disease. About 30% of the total burden of noncommunicable diseases is due to these diseases and almost three-fourths of the global burden of neuropsychiatric disorders is in low and lower-middle income countries (1). In 1990, it was calculated that 8.8% of the disability-adjusted life years (DALYs) in Latin America and the Caribbean could be attributed to psychiatric and neurological disorders; in 2004, this burden had grown to 22% (12-13) (see figure in Annex A).
13. A compilation of the major epidemiological studies on mental disorders in Latin America and the Caribbean in the last 20 years (12) gives us a sense of prevalence and of the treatment gap. *Treatment gap* refers to the proportion of sick people who need care and do not receive it. As the table shows, the gap is quite wide and could even be underestimated since, usually, co-morbidity is not taken into account, nor is the quality or effectiveness of treatment. The following table summarizes some of the results:

<b>Trastorno</b>	<b>Average Prevalence (per 100 adults) (12 months)</b>	<b>Treatment Gaps (%)</b>
Non-affective psychoses	1.0	37.4
Major depression	4.9	58.9
Dysthymia	1.7	58.8
Bipolar disorder	0.8	64.0
Anxiety disorder	3.4	63.1
Panic disorder	1.0	52.9
Obsessive compulsive disorder	1.4	59.9
Alcohol abuse or dependence	5.7	71.4

*Source:* Kohn R, Levav I, Caldas de Almeida JM, Vicente B, Andrade L, Caraveo-Anduaga JJ, Saxena S, Saraceno B: Los trastornos mentales en América Latina y el Caribe: Asunto prioritario para la salud pública. Rev. Panam. Salud Pública 2005; 18 (4/5): 229-240, 2005.

14. It is also important to consider that there are many conditions and emotional and social needs, especially related to traumatic situations, which are not necessarily mental illnesses and that should not be treated medically, for which appropriate psychosocial interventions can be very effective. In this regard, groups that are highly vulnerable or are in special situations should be carefully assessed. During natural disasters or armed conflicts, an increase in psychosocial problems is expected, as predictable emotional reactions to highly significant traumatic events; in these cases, morbidity due to mental disorders also increases (13).

15. Suicide is a complex phenomenon that has local and regional manifestations. Each year, around 1 million people die from suicide in the world, of which some 63,000 are in the Americas, corresponding to an age-adjusted mortality rate of 7.4 per 100,000 population (2000–2004) (14). Mental illness is linked to suicide mortality. In adolescents, the main causes of death are external, and include accidents, homicide, and suicide (15). Several countries of the Region have a considerable problem with underreporting of suicide mortality.
16. Abuse of or dependence on alcohol or other psychoactive substances, such as illicit drugs or prescription psychotropic drugs, are also growing problems, for which there is a wide treatment gap. However, adequate public services to deal with this situation are not available.
17. Epidemiological research around the world has systematically demonstrated that mental and behavioral disorders affect between 10% and 15% of children and adolescents (7). In Latin America and the Caribbean, according to several selected studies, the specific prevalence (at the time of the study) for any disorder varies from 12.7% to 15% (16). These are the first manifestations of conditions that are, sometimes, going to last for a lifetime in adults and provide a unique opportunity to intervene early on and effectively. The treatment gap for children and adolescents is still greater than that for adults (17).
18. Malnutrition can stunt children's cognitive, emotional, and social development, causing permanent disability. Furthermore, in situations where food is scarce, children frequently do not receive appropriate psychosocial stimulation, which exacerbates the problem (18). Some disorders, such as epilepsy and intellectual disability, can be related to birth trauma and their incidence can be reduced through appropriate prenatal care. Reducing childhood infections and immunizing children decrease the risk of brain damage (19).
19. Some countries have identified eating disorders (anorexia nervosa and bulimia) as an important problem in their milieu. In general, these have been regarded as diseases of developed Western countries, high-income population groups, and adolescent girls or young women. However, available information suggests that all ethnic and socioeconomic groups can be affected (20–21).
20. Mental disorders in the elderly, such as depression and cognitive decline, are common and have a significant impact on their lives. Long-term care for elderly people with physical disabilities and/or mental illness is another problem; the complexity of their care represents a heavy burden that often impacts their caretakers (who are occasionally elderly themselves). Life expectancy is increasing in the Region, with a rise in the proportion of people over age 60, which means that many countries will have to give priority to these problems in their mental health plans (22).
21. Mental disorders, substance abuse, and violence against women and children are risk factors for HIV/AIDS. A recent WHO report pointed out that the prevalence of mental disorders in patients with HIV/AIDS is substantially higher than in the general population. Similarly, there is a high prevalence of HIV/AIDS in people with prolonged mental illness (23).

22. There are multiple points of intersection between mental and reproductive health, especially for women; for example, psychological problems related to pregnancy, childbirth, and the postpartum period; adolescent pregnancy; sexual violence; sexually transmitted diseases; surgery on reproductive organs; stillbirths and miscarriage; menopause; and infertility. There is scientific evidence that depression is the most important mental health condition for women worldwide, and it occurs twice as often in women as in men. From 20% to 40% of women in developing countries suffer from depression during pregnancy or the postpartum period (24).
23. Violence, in its different manifestations, is a major problem in our Region. Mental health services are involved in the sectoral response, both in prevention and in victim assistance; nevertheless, the different types of interventions need to be systematized and improved upon. Regarding gender-based violence, in seven countries for which data is available, from 14% to 52% of women aged 15 to 49 have suffered physical violence, and from 4% to 15% have been victims of sexual violence perpetrated by their husbands or partners (25), with the subsequent negative impact on their physical and mental health.
24. The “Commission on Social Determinants of Health” (WHO, 2005) compiled scientific evidence on possible measures to promote health equity (26). Structural determinants (unequal distribution of power, money, and resources) and living conditions as a whole constitute the social determinants of health, which are the cause of most health inequalities. Social justice is an essential issue that affects the way people live, their probability of becoming ill, and their risk of dying. Studies conducted around the world in the last 20 years indicate a close relationship between poverty and the health status of the population. Mental illness can contribute to deepening poverty and, furthermore, poverty increases the risk of a mental disorder (27).

### *Policies, plans, services, and availability of resources*

25. Countries have major limitations in their information systems regarding mental health, such that we can also speak of an *information gap*. The assessment of mental health systems done by PAHO/WHO (28, 30) in Latin American and Caribbean countries clearly identified deficiencies in mental health services and resources. The indicators for mental health human resources lag far behind those of high-income countries. Furthermore, the supply of nurses must also be considered, which is essential in many countries. Training programs (college and graduate-level) are limited in length, do not always serve people’s actual needs, and continue to use curative and hospital-based models.
26. Of countries reporting, 76.5% (28) have a national mental health plan; however, their implementation levels are low. Similarly, 75% have legislation on mental health; but, in many cases, these laws are incomplete, scattered, and do not meet international standards. There is a median of 2.6 psychiatric beds per 10,000 population; an assessment of their distribution found that 80.6% are in psychiatric hospitals and only 10.3% are in general hospitals. Another problem found is that psychoactive drugs are not within the reach of most of the population.
27. A WHO report on Child and Adolescent Mental Health Resources (17) emphasized the lack of

appropriate mental health services for this population group, even though most countries are signatories to the Convention on the Rights of the Child. Well-designed programs for mental health promotion and prevention are limited or have not received sufficient attention in the Region and are not always well linked to other particularly pertinent sectors, such as education, for example.

28. In many countries, user and family-member movements are weak: there are few organizations, their membership is small, they are not very active, and they have little or no involvement in the design and implementation of mental health plans.
29. Currently, work is being done with WHO to collect and analyze data on the status of policies, programs, services, human resources, and funding for the prevention and treatment of psychoactive substance use disorders.
30. PAHO and WHO have cooperated with several countries on *mental health system assessments*, using the WHO-AIMS methodology and standardized instrument (29), which compiles and analyzes data on 155 indicators. To date, the countries that have concluded this assessment are: Belize, Brazil, Chile, Costa Rica, Dominican Republic, El Salvador, Guatemala, Guyana, Honduras, Jamaica, Nicaragua, Panama, Paraguay, Suriname, and Uruguay. The assessment is in progress in: Anguilla, Antigua and Barbuda, Argentina, Bolivia, Cuba, Ecuador, Grenada, Montserrat, Peru, Saint Lucia, Trinidad and Tobago, and Turks and Caicos. The goal is for all countries to finalize the assessment in the next biennium (2010-2011).
31. Despite the extent of the burden of mental disorders, health services have little response capacity, which is manifested by the current treatment gaps. There is also a considerable gap in funding and resources. In Latin America and the Caribbean, mental and neurological disorders account for 22% of the disease burden. However, in several of the countries that have been assessed, the calculated percentage of the health budget allocated to mental health is less than 2.0% (13, 30).<sup>3</sup> Other fundamental funding-related problems are (30): (a) the budget allocated to mental health cannot always be clearly determined; and, (b) the breakdown of the expenditure, in many cases, shows that from 85% to 90% of the mental health budget goes to large psychiatric hospitals for the care of confined patients. Future estimates should spell out other elements more precisely, such as funds from other government sources, the private sector, nongovernmental organizations, and international donors. The foregoing figures illustrate the need not only to increase the budget in absolute terms, but also to evaluate redirecting resources from psychiatric hospitals to ambulatory and community-based systems. The expenditure should be consistently aimed at meeting the mental health needs of the population.

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<sup>3</sup> See WHO-AIMS Country Reports published on the Web pages of PAHO: [http://new.paho.org/hq/&index.php?option=com\\_content&task=view&id=445&Itemid=1106](http://new.paho.org/hq/&index.php?option=com_content&task=view&id=445&Itemid=1106) and WHO: [http://www.who.int/mental\\_health/who\\_aims\\_country\\_reports/in/index.html](http://www.who.int/mental_health/who_aims_country_reports/in/index.html).

### Overview, strong points, and priorities

32. Unquestionably, if we assess the development of mental health services in Latin America and the Caribbean, taking the Caracas Declaration (1990) as a benchmark, most countries show notable progress. Mental health is included in initiatives for the renewal of primary health care (PHC). There are numerous successful experiences, as well as lessons learned in the implementation of community mental health models; additionally, exchanges among countries have been very positive. Furthermore, many Member States are developing social protection policies for vulnerable groups. Today, we are able to state that most people with mental disorders respond well to treatment, and are able to recover, live a productive life, and contribute positively to the development of their families and communities. In short, there are strong points that give us reason to be optimistic.
33. However, current and emerging challenges require appropriate responses. Among them, it is important to mention (8-9): (a) services for vulnerable groups; (b) psychosocial problems of childhood and adolescence; (c) suicidal behavior; (d) problems related to alcohol; and, (e) increases in different kinds of violence. It remains a priority to continue working to restructure mental health services, within the framework of primary health care-based systems and integrated delivery networks, as well to strengthen intersectoral mental health promotion initiatives.

### Human rights of persons with mental disabilities

34. Mental health is necessary for the exercise of human rights and participation in civil, social, and economic life; at the same time, the exercise of human rights and freedoms is essential for persons with mental disabilities, who have the same rights as all other citizens. For example, the presence of barriers (*de facto* or *de jure*) that limit access by persons with mental disabilities to health services, restrictions on their personal freedom and freedom of movement, the lack of job opportunities, their exclusion from education systems, their participation in medical studies without their informed consent, and inadequate living conditions in psychiatric institutions jeopardize their physical and mental health and impede the enjoyment of their basic human rights (31).<sup>4</sup>
35. In many countries, specific problems have been identified in psychiatric hospitals, such as: (a) completely unregulated involuntary admission of patients; (b) little control over the use of physical restraints or isolation of patients; and (c) problems with court-ordered confinement of people with supposed mental disorders who have committed unlawful or criminal acts. The establishment of an adequate relationship with the justice sector and the creation of forensic psychiatric units are necessary actions in some countries.
36. The application of human rights instruments in the context of mental health is still limited in the Region,

<sup>4</sup> See Technical Document CD 47/15 of the Directing Council (“Disability: Prevention and Rehabilitation in the Context of the Right to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health and other Related Rights”) of 16 August 2006. Available online at: <http://www.paho.org/english/gov/cd/CD47-15-e.pdf>.

which is why it is important that the development and implementation of mental health policies, plans, and legislation be in keeping with Inter-American and United Nations conventions, declarations, and recommendations (see Annex C).

## Proposal: Strategic framework and plan of action

37. The Strategy and Plan of Action embodies the experience gained in the Americas, particularly over the last two decades, and expresses the commitment of the governments of the Region. Implementation covers a 10-year period (2010-2019).<sup>5</sup>

### *Principles and values*

- a) Universality, access, and inclusion.
  - b) Equity in mental health.
  - c) Pan American solidarity, understood as collaboration among countries.
  - d) Respect for the fundamental human rights of people with mental disorders.
  - e) Social participation in the design, implementation, and evaluation of mental health policies.
  - f) Use of the best available scientific evidence.
  - g) Additional protection on mental health matters for vulnerable groups.
  - h) Mental health considered within community historical and cultural frameworks.
  - i) Mental health as a component of comprehensive health care.
  - j) Responsibility and accountability.
38. Gender, ethnic, and cultural perspectives, and the approaches of primary health care, health promotion, human rights, and social protection are cross-cutting themes covering all strategic areas. Care for vulnerable or at-risk groups with special needs will require priority consideration.
39. In support of the implementation of this Strategy and Plan of Action, PAHO will work in collaboration with other organizations, adopt an integrated approach in which different programs participate, assign special importance to priority countries, and mobilize resources. PAHO will cooperate technically with countries for the development of their mental health policies and plans; it will support the systematic review and dissemination of information and the best scientific evidence to strengthen services; and it will promote the dissemination of best practices, innovative models, and lessons learned, in addition to encouraging cooperation among countries.

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<sup>5</sup> The activities and proposed indicators, organized by strategic area, are contained in Annex B.

40. *Vision:* The Pan American Health Organization heads collaborative efforts for Member States to attain the enjoyment of optimal mental health by all people of the Americas and to foster the well-being of their families and communities.
41. *Purpose:* Strengthen the integrated response of the health sector and other related sectors, through the implementation of appropriate plans for the promotion of mental health and the prevention, treatment, and rehabilitation of mental and substance use disorders, grounded in the best available scientific evidence.

## Strategic Areas

### *Strategic Area No. 1: Development and implementation of national mental health policies, plans, and laws*

42. The existence of appropriate policies and plans enables having a broad, strategic vision of integrated mental health in public health-sector policy and facilitates the organization of services grounded in a community model. Legislation on mental health provides a legal framework for promoting and protecting the human rights of people with mental disorders (32).<sup>6</sup> Resource allocation is crucial to implementation of the plans; calculating the funding gap is a first necessary step in planning.
43. Implementation of national mental health policies and plans is a challenge requiring effective partnerships, strengthening of existing commitments, and finding new partners; in this regard, the role of user and family-member organizations is especially relevant. In the Region, the PAHO/WHO Collaborating Centers specializing in mental health and substance abuse have experience in joint efforts with PAHO, as well as accrued capacities and experience that are a strong point for country cooperation.

### Objectives

- 1.1 To have national mental health policies and plans being implemented in the countries and to ensure that mental health is included in the general health policy.
- 1.2 To have a mental health legislative framework in accordance with the human rights conventions, declarations, and recommendations of the Inter-American system and the United Nations system.
- 1.3 To have the financial and human resources necessary for the implementation of mental health plans, as well as to ensure that the resources are used primarily in outpatient mental health services linked with the community and primary health care.
- 1.4 To create and strengthen the health sector's partnerships with other actors for the development and implementation of national mental health plans.

<sup>6</sup> Recommended resource: WHO Resource Book on Mental Health, Human Rights, and Legislation. WHO. Geneva, 2006 (32).

### *Strategic Area No. 2: Promotion of mental health and prevention of psychological disorders, emphasizing the psychosocial development of children*

44. To reduce the burden from mental disorders, it is essential to focus on the promotion of mental health and the prevention of psychological disorders. Mental health promotion forms part of the broader framework of public health and suggests an approach other than the curative, one that emphasizes *protection of the positive attributes of mental health and promotion of a state of well-being* (33). Risk and protection factors have been identified for the different stages of life, and many of them can change. There is also evidence that programs aimed at children and interventions early in life are effective (34–35).
45. Promotion and prevention interventions can be targeted to factors that perpetuate poor health and to specific population groups. It is necessary to work in particular settings (schools are crucial), although work and community settings should also be addressed. The “Healthy Settings” strategy (healthy communities, schools, and workplaces) is a process including advocacy, multisectoral coordination, and social mobilization, in which mental health should be a component to contribute to integrated human development. Other important elements are public awareness, the role of the mass media, the use of community resources, and the involvement of other sectors (7, 33, 35). Stigmatization and discrimination directed at people with mental disorders is one of the biggest obstacles that needs to be overcome in the community, within a framework of fostering inclusive human development.

#### **Objective**

- 2.1 To include the component of mental health promotion and prevention of psychological and substance use disorders in mental health plans, ensuring the implementation of special activities with children and adolescents.

### *Strategic Area No. 3: Primary health care-centered mental health services delivery. Determination of priority conditions and implementation of interventions*

46. A community mental health model is grounded on the basic principles adopted by each country to organize service delivery; among its cornerstones are decentralization, social participation, and the inclusion of a mental health component in primary health care.<sup>7</sup> It also implies the delivery of services that are culturally-appropriate, equitable, and free from discrimination based on gender, ethnic group, or other conditions. Furthermore, the links indigenous communities have between traditional systems for dealing with mental health problems and formal public services should be addressed. Delivery of community services to people with prolonged mental illness continues to be a crucial problem and a challenge for countries.
47. The WHO Mental Health Gap Action Program (mhGAP) (1) identifies a number of priority diseases on the basis that they represent a high burden of mortality, morbidity, and disability and cause large economic costs or are associated with violations of human rights. These are: (a) depression; (b)

<sup>7</sup> Recommended resource: The WHO Mental Health Policy and Service Guidance Package, WHO (36).

schizophrenia and other psychotic disorders; (c) suicide; (d) epilepsy; (e) dementia; (f) disorders due to use of alcohol and illicit drugs; and, (g) mental disorders in children. As a part of mhGAP, WHO is preparing a package of essential interventions for the care of these diseases. The countries of the Region have also identified other problems that can require attention: mental health protection in disasters, mental health of the elderly, mental health and HIV/AIDS, and domestic violence. Decisions must be made at the national level concerning these intervention priorities and modalities.

### Objectives

- 3.1 To ensure delivery of comprehensive, continuing mental health services in the entire health system, emphasizing decentralization and primary health care.
- 3.2 To select priority diseases at the country level and put into practice a package of essential interventions at the different levels, emphasizing primary health care.

### *Strategic Area No. 4: Human resources development*

48. Mental health programs depend, to a large extent, on properly trained human resources. Building the mental health skills of health workers (especially those who work in primary health care) is fundamental to improving service delivery. However, it is unlikely that traditional methods for personnel training can offer an appropriate response to the mental health needs of the population, which means there will be a need for new and different approaches to skills-building (37).
49. It is necessary to review the curricula of training schools, both at the graduate and post graduate levels, as well as in continuing education. Mental health core competencies should be widely disseminated, especially among community agents and personnel that are not part of a service (among others, caregivers for people with mental disorders). Furthermore, it is necessary to have specialists capable of handling complex cases, who can give training, perform supervision, and provide ongoing support to health workers. Mental health training programs should be located in community-based outpatient mental health services and primary health care centers, and not in psychiatric hospitals.

### Objective

- 4.1 To train health workers, improving their mental health skills, ensuring they are consistent with their function in the health system.

### *Strategic Area No. 5: Strengthen capacity to produce, assess, and use information on mental health*

50. An adequate assessment of the mental health system will facilitate priority setting and intervention planning. The health sector's registry and information systems are a key element in bridging the existing information gap and supporting service management; they should not just be a simple data collection

mechanism but rather should become a tool for action. Epidemiological surveillance can include rapid assessment procedures, sentinel sites, etc. It will be necessary to develop easily obtainable mental health indicators; each country will have to decide which indicators should be measured, how often, and what mechanisms should be used for data collection. Research on mental health is also a vital area that we need to strengthen in Latin America and the Caribbean.

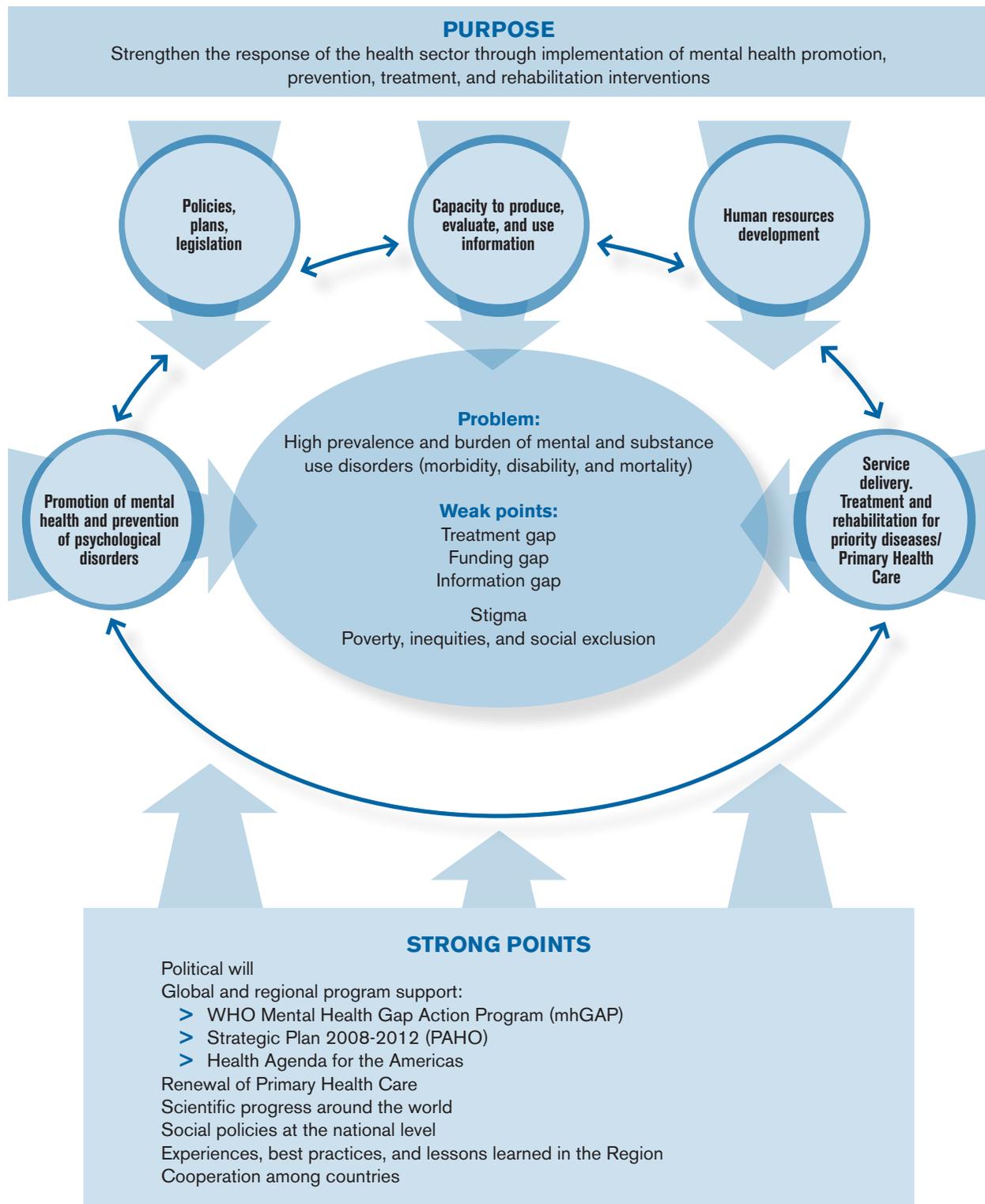
### Objectives

- 5.1 To comprehensively assess mental health systems in the countries, establishing baselines and monitoring the situation.
- 5.2 To improve the mental health component of National Information Systems, ensuring regular collection and analysis of core mental health data.
- 5.3 To strengthen research on mental health within the parameters of each country's needs and available resources.

## Ten key recommendations to countries

- a) Develop, review, and implement the national mental health plan.
- b) Advance the reviewing and updating of the legislative framework on mental health.
- c) Evaluate current funding for mental health, setting short, medium, and long term goals, in addition to studying opportunities for mobilization of resources.
- d) Have an entity or mechanism for intersectoral coordination on mental health.
- e) Define and implement specific activities—within the framework of the National Mental Health Plan—for promotion and prevention centered on children and adolescents.
- f) Review the organization of mental health services and carry out needed changes, emphasizing decentralization and strengthening the mental health component of primary health care.
- g) Put into practice a package of essential interventions targeting mental diseases or disorders considered to be priorities in the national context.
- h) Develop a mental health training program based on needs management skills, aimed at health workers (especially those working in primary health care).
- i) Assess the mental health system using the WHO methodology, with monitoring of progress to be done every five years, at a minimum.
- j) Strengthen the National Health Information System to improve collection and regular analysis of a core set of mental health data.

51. The following illustration provides an overview of the Strategy and Plan of Action.



## Action by the Directing Council

52. The Directing Council is requested to:

- a) Review the information in this document and explore the possibility of adopting the resolution recommended by the 144th Session of the Executive Committee.
- b) Regard mental health as a priority and support strengthening of the health sector's response to this issue. We find ourselves at an opportune time in history for addressing this issue, since 2010 will mark the 20th anniversary of the Caracas Declaration, a milestone of special importance that marked the formal beginning of the process to restructure mental health services in the Region and that had the support of the Member States. As a result, it can be a year to devote special efforts to the implementation of the present Strategy and Plan of Action.

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## 49<sup>th</sup> DIRECTING COUNCIL 61<sup>st</sup> SESSION OF THE REGIONAL COMMITTEE

Washington, D.C., USA, 28 September–2 October 2009

### RESOLUTION CD49.17

## Strategy and plan of action on mental health

### *THE 49th DIRECTING COUNCIL,*

Having studied the report of the Director *Strategy and Plan of Action on Mental Health* (Document CD49/11);

Recognizing the burden from mental and substance abuse disorders—morbidity, mortality, and disability—in the world and in the Region of the Americas in particular, as well as the existing gap in the number of sick people who do not receive any type of treatment;

Understanding that there is no physical health without mental health and that an approach to the health-disease process is necessary not only from the perspective of care for impairments, but also from the angle of protecting positive health attributes and promoting the wellbeing of the population, and, in addition, that from the public health perspective, there are psychosocial and human behavior factors that perform a crucial function;

Considering the context and framework for action offered by the Health Agenda for the Americas, the PAHO Strategic Plan 2008–2012, and the WHO Mental Health Gap Action Program: Scaling up care for mental, neurological, and substance abuse disorders (mhGAP), which reflect the importance of the issue and define strategic objectives for addressing mental health; and

Observing that the Strategy and Plan of Action on Mental Health addresses the principal work areas and define areas for technical cooperation to serve the different mental health needs of the countries,

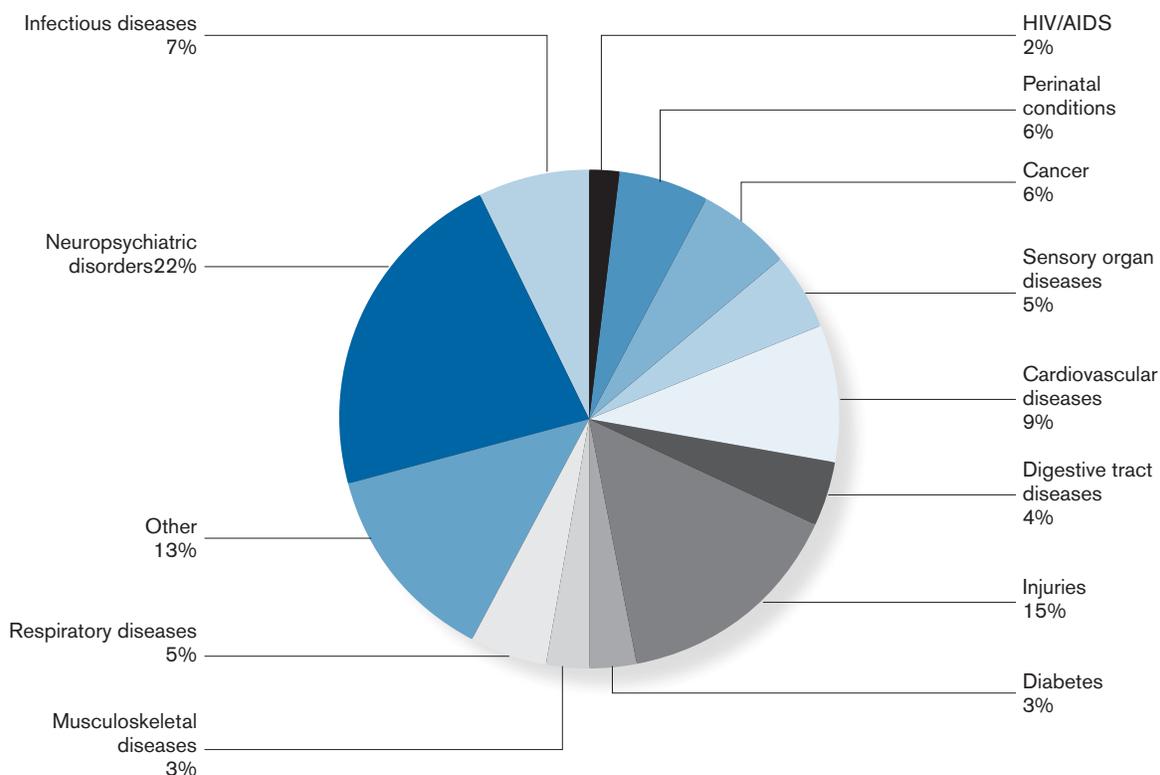
## RESOLVES:

1. To endorse the provisions of the Strategy and Plan of Action on Mental Health and its implementation within the framework of the special conditions of each country in order to respond appropriately to current and future mental health needs.
2. To urge Member States to:
  - a) include mental health as a priority within national health policies, through the implementation of mental health plans that are consonant with the different problems and priorities of the countries, in order to maintain the achievements made and advance toward new goals, especially with regard to reducing existing treatment gaps;
  - b) promote universal, equitable access to mental health care for the entire population, through strengthening mental health services within the framework of primary health care-based systems and integrated delivery networks and continuing activities to eliminate the old psychiatric hospital-centered model;
  - c) continue working to strengthen the legal frameworks of the countries with a view to protecting the human rights of people with mental disorders and to achieve the effective application of the laws;
  - d) promote intersectoral initiatives to promote mental health, with particular attention to children and adolescents and on coping with the stigma and discrimination directed at people with mental disorders;
  - e) support the effective involvement of the community and of user and family-member associations in activities designed to promote and protect the mental health of the population;
  - f) regard mental health human resources development as a key component in the improvement of plans and services, through the development and implementation of systematic training programs;
  - g) bridge the existing mental health information gap through improvements in the production, analysis, and use of information, as well as through research, with an intercultural and gender approach; and
  - h) strengthen partnerships between the public sector and other sectors, as well as with nongovernmental organizations, academic institutions, and key social actors, emphasizing their involvement in the development of mental health plans.

3. To request the Director to:
  - a) support the Member States in the preparation and implementation of national mental health plans within the framework of their health policies, taking into account the Strategy and Plan of Action, endeavoring to correct inequities, and giving priority to care for vulnerable and special-needs groups, including the indigenous populations;
  - b) collaborate in the assessment of mental health services in the countries to ensure that appropriate corrective measures grounded on scientific evidence are taken;
  - c) facilitate the dissemination of information and the sharing of positive, innovative experiences, as well as the available resources in the Region, and promote technical cooperation among the Member States;
  - d) promote partnerships with governmental and nongovernmental organizations, as well as with international organizations and other regional actors in support of the multisectoral response that is required in the process of implementing this Strategy and Plan of Action.

## BURDEN OF DISEASE, LATIN AMERICA AND THE CARIBBEAN

Percent – DALYs, 2004



*Source:* Chart created by the PAHO Regional Project on Mental Health, Disability, and Rehabilitation, using the WHO database (Health Statistics and Health Information Systems/Global Burden of Disease (GBD)).

## PLAN OF ACTIVITIES

The strategies and objectives set forth in the *Strategy and Plan of Action* are based on an overall view of Latin America and the Caribbean, their principal problems, and advances in the field of mental health; however, in the Region marked differences persist among the countries and even within individual countries. Additionally, many governments have already made substantial progress in certain of the areas mentioned in the document that, at the same time, could be deficient in other nations. For this reason, all the recommendations in the Plan should be carefully analyzed in the national context, in line with existing social and health conditions. PAHO's technical cooperation will concentrate on building capacities in health systems so they can provide appropriate mental health care.

### *Strategic Area No. 1: Development and implementation of national mental health policies, plans, and laws.*

#### Indicators

Indicator	Baseline 2008	Target
Number/percentage of countries implementing a national mental health plan.	26 / 74%	100% (2015) 100% (2019)
Number/percentage of countries that have applied international human rights regulations in the review and formulation of mental health legislation.	13 / 37%	60% (2015) 80% (2019)
Number/percentage of countries that have the mental health budget identified and broken down, with short, medium, and long range goals.	N/A	40% (2015) 70% (2019)
Number of countries that have functioning intersectoral coordinating mechanisms on mental health.	N/A	60% (2015) 80% (2019)
Number of countries with organizations of users or family-members of patients that are actively involved in the national mental health plan.	N/A	40% (2015) 70% (2019)

N/A: Not available.

Carefully review and adjust baseline in 2010.

#### Objective 1.1

To have national mental health policies and plans being implemented in the countries and to ensure that mental health is included in the general health policy.

#### *Regional level activities*

- 1.1.1 Cooperate technically with countries to design/reformulate/strengthen and to implement national plans and policies for mental health and disorders caused by substance abuse; the inclusion and formulation of programs and specific sections will be promoted, according to identified needs and priorities.
- 1.1.2 Compile, evaluate, and disseminate innovative experiences and lessons learned in the countries of the Region.
- 1.1.3 Promote projects of technical cooperation among countries.

### *National level activities*

- 1.1.4 Write or review and put into practice the national policy and plan on mental health and treatment of substance use disorders; ensure that the planned interventions are grounded in the best scientific evidence and that this evidence is available and easy to understand by service providers, users, and family members, as well as by political decision-makers. The Plan should promote and forge ties with other health programs.
- 1.1.5 Identify vulnerable groups that may require specific measures to meet their mental health needs; for example, victims of violence, ethnic minorities, migrants, extremely poor communities, people with disabilities, etc.
- 1.1.6 Develop specific programs or sections within the framework of the mental health Plan, in accordance with the priorities identified at the national level. It is suggested that the following be considered:
  - a) Abuse of alcohol and other psychoactive substances.
  - b) Mental health in childhood and adolescence.
  - c) Mental health of the elderly.
  - d) Mental health protection in disasters and emergencies.
  - e) Prevention and control of suicidal behavior.
  - f) Addressing violence from a mental health perspective.
  - g) Mental health and HIV/AIDS.
- 1.1.7 Evaluate the design and implementation of pilot/demonstration activities or projects, when circumstances merit.

### **Objective 1.2**

To have a mental health legislative framework in accordance with the human rights conventions, declarations, and recommendations of the Inter-American system and the United Nations system.

### *Regional level activities*

- 1.2.1 Cooperate technically with the countries in order to review and update the current legislative framework in the field of mental health.

### *National level activities*

- 1.2.2 Promote—to governmental, legislative, and civil society bodies—the review and updating of the legislative framework and legal regulations in effect in the area of mental health, as well as their effective application.
- 1.2.3 Review and take appropriate measures on procedures or situations that, in psychiatric hospitals, could constitute violations of the human rights of confined people (such as involuntary admissions, physical restraints, isolation, and poor institutional conditions).
- 1.2.4 Forge systematic ties with the judicial sector and human rights agencies to ensure the use of current law and protection of the human rights of people with mental disorders.

### Objective 1.3

To have the financial and human resources necessary for the implementation of mental health plans, as well as to ensure that the resources are used primarily in ambulatory community- and PHC-based mental health services.

#### *Regional level activities*

- 1.3.1 Cooperate with countries in order to evaluate the financing and the costs of the plans and mental health services.
- 1.3.2 Cooperate and support countries in the mobilization of resources.

#### *National level activities*

- 1.3.3 Review the funding and costs of the national mental health Plan and related services as well as the breakdown of the expenditure, and identify funding needs.
- 1.3.4 Set short, medium, and long term goals for funding mental health service delivery (primarily in the health sector and, if possible, also in other sectors, such as education, justice, and social protection) to achieve the effective implementation of the plan. Also suggested is not only evaluating increasing resources devoted to mental health, but also redirecting them from psychiatric hospitals to community-based ambulatory services and primary health care.
- 1.3.5 Identify and apply to possible funding sources and donors.

### Objective 1.4

To create and strengthen the health sector's partnerships with other actors for the development and implementation of national mental health plans.

#### *Regional level activities*

- 1.4.1 Cooperate with countries in order to strengthen the intersectoral coordination and favor the creation of networks.
- 1.4.2 Support the movement of users and of family members having to do with mental health; at a regional level; facilitate encounters, exchanges between countries, and the dissemination of lessons learned.
- 1.4.3 Strengthen the alliances with regional partners as in collaborating centers, academic institutions, professional associations, NGOs, international cooperation agencies and the United Nations system, donors and with governmental agencies.

#### *National level activities*

- 1.4.4 Identify the main partners at the national level; strengthen partnerships through the creation of an intersectoral coordination structure or entity.
- 1.4.5 Promote social participation as part of the process for the development, implementation, and evaluation of mental health plans.

- 1.4.6 Support, by the public sector, for user and family-member movements and actively include them in the development of mental health plans and advocacy work. Some examples of this could be: facilitate and support meetings and experience sharing, provide support for educational activities, facilitate the first meetings, etc.

*Strategic Area No. 2: Promotion of mental health and prevention of psychological disorders, emphasizing the psychosocial development of children*

**Indicators**

Indicator	Baseline 2008	Target
The regional frame of reference technical document for the development of mental health promotion and prevention programs targeted to children and adolescents, prepared by a group of experts and published.	N/A	1 (2011) 1 reviewed (2019)
Number/percentage of countries that are implementing the promotion-prevention component within the framework of their national mental health plans.	0	60% (2015) 100% (2019)

N/A: Not available.

Carefully review and adjust baseline in 2010.

**Objective 2.1**

To include the component of mental health promotion and prevention of psychological and substance use disorders in mental health plans, ensuring the implementation of special activities with children and adolescents.

*Regional level activities*

- 2.1.1 Provide technical cooperation to countries for the selection, formulation, and implementation of measures aimed at the promotion of mental health and the prevention of psychological and substance use disorders. WHO and the Region have materials, guidelines, and methodological tools that serve this purpose.

*National level activities*

- 2.1.2 Include a section in the national mental health Plan aimed at promotion and prevention, selecting the most effective activities (on the basis of available scientific evidence) that can be viable in the national context, emphasizing children and adolescents.
- 2.1.3 The following settings are recommended for implementing the interventions: schools (these are crucial), workplaces, the community, the social protection sector, the judicial sector, primary health care services, and mental health services.
- 2.1.4 Ensure that the following elements are included as a priority in mental health care for children and adolescents: (a) early intervention to foster psychosocial development; (b) support for parents and families; (c) community programs to support young children that include opportunities for early childhood education; (d) school-based psychosocial programs; and (e) early diagnosis and appropriate treatment of psychological disorders.

- 2.1.5 Develop and implement a public education program that includes working with the mass media.
- 2.1.6 Develop and implement a program to fight stigma, discrimination, and social exclusion of people with mental illness.
- 2.1.7 Have the health sector seek intersectoral cooperation, which is of special importance in the area of promotion and prevention.

*Strategic Area No. 3: Primary health care-centered mental health services delivery. Determination of priority conditions and implementation of interventions*

**Indicators**

<b>Indicator</b>	<b>Baseline 2008</b>	<b>Target</b>
Number/percentage of countries that have a program for the organization and development of mental health services ranging from primary health care to specialized services.	N/A	60% (2015) 100% (2019)
Number/percentage of countries that have identified the priority mental health conditions in their national context and are executing a series of basic interventions to address them at the different levels.	N/A	60% (2015) 80% (2019)
Mortality from suicide (per 100,000 population) broken down by country, age group, sex, and method used.	7.4	Keep rate below current level of 7.4

N/A: Not available.

Carefully review and adjust baseline in 2010.

*Regional level activities*

- 3.1.1 Collaborate technically with countries for a staggered organization of the delivery of services, with an emphasis on decentralization and the primary health care.
- 3.1.2 Compile, evaluate, and disseminate innovative experiences and lessons learned.
- 3.1.3 Promote and support the technical cooperation among countries.

*National level activities*

- 3.1.4 Organize mental health services based on a community model and consonant with the characteristics of the country's health system and available resources. It is important to consider, among other things, the following:
- (a) Decentralization, through the creation of a varied, stratified portfolio of mental health services that includes the following: (i) transformation of psychiatric hospitals and design of alternatives for services (mental health units in general hospitals, community residences, day centers, community services, etc.); in many countries of our region this may be one of the foremost challenges that will have to be faced

- when developing a mental health plan. (ii) add a mental health component to primary health care, raising the problem-solving capacity of the first level of care. This is a high priority, even in countries that have more resources.
- (b) Determine who will be responsible for implementing the interventions at the different levels.
  - (c) Examine coverage and equity in access to services, especially for poor, rural groups, as well as minority groups.
  - (d) Priority care for groups with special needs or in specific situations (for example, the elderly, people with intellectual disabilities, indigenous peoples, victims of different types of violence or disasters, etc.).
  - (e) Create or improve mental health services for children and adolescents.
  - (f) Strengthen appropriate mechanisms for referrals and for feedback.
  - (g) Promote community participation, improving acceptance and use of services.
  - (h) Have a basic list of (psychopharmaceutical) drugs and make them accessible to the public, to support implementation of essential interventions.
  - (i) Evaluate and overcome administrative barriers that limit interventions (for example, primary health care physicians must have essential psychoactive drugs and prescribe them).
  - (j) Establish relationships or ties with traditional or community systems of care for mental disease, especially in rural areas and where indigenous people live.
  - (k) Promote intersectoral work for implementation of the interventions.
- 3.1.5 Develop and implement, within the framework of the national Plan, a program of health services and psychosocial rehabilitation for people with serious, prolonged mental illness, many of them possibly discharged from hospitals, which will require the support of other sectors (for example, housing, labor, social protection, finance, justice, etc.) and coordination with them.
- 3.1.6 Create or improve services for the treatment of disorders related to the abuse of alcohol and other psychoactive substances.
- 3.1.7 Evaluate and implement, in collaboration with the judicial sector, modalities for mental health services delivery for sick people who have committed unlawful or criminal acts.
- 3.1.8 Establish standards and regulations for the different facets of care for mental disorders and psychoactive substance use disorders, as well as for the corresponding services, that include minimum criteria for quality and respect for human rights. It is recommended that countries work on accreditation processes.

### Objective 3.2

To select priority diseases at the country level and put into practice a package of essential interventions at the different levels, emphasizing primary health care.

#### *Regional level activities*

- 3.2.1 Identify and prepare a regional group of experts to advise countries on the determination of priority conditions, as well as on the formulation and implementation of the necessary essential interventions.

- 3.2.2 Promote the dissemination and implementation of brief interventions in relation to the risk of alcohol consumption and of other psychoactive substances in the environment of primary health care and in services for populations of greater risk.
- 3.2.3 Compile, evaluate, and disseminate innovative experiences and lessons learned.
- 3.2.4 Promote and support the technical cooperation among countries.

#### *National level activities*

- 3.2.5 Determine which mental illnesses or conditions should be considered as priorities in the national context and, based on this, prepare and implement guidelines or protocols for essential interventions at the different levels of the health system and define responsibilities (emphasizing primary health care). Because of the relationship between suicidal behavior and mental disorders and given the severity of the problem in the majority of the countries, it is recommended that this be considered a priority. The WHO intervention packages can serve as a template or be adapted to local conditions; each country should define the scope of implementation (national, in certain areas, or in pilot projects).
- 3.2.6 The interventions should consider the life cycle (especially children, adolescents, and the elderly), gender, and the particular sociocultural features of the population groups.

### *Strategic Area No. 4: Human resources development*

#### **Indicator**

<b>Indicator</b>	<b>Baseline 2008</b>	<b>Target</b>
Regional competency- and needs-based mental health training model aimed at health workers and emphasizing primary health care, prepared and published.	N/A	1 (2012) 1 reviewed (2015-2019)

N/A: Not available.

Carefully review and adjust baseline in 2010.

#### **Objective 4.1**

To train health workers, improving their mental health skills, ensuring they are consistent with their function in the health system.

#### *Regional level activities*

- 4.1.1 Cooperate with the countries for the development and implementation of mental health training for health workers.
- 4.1.2 Create a regional working group made up of professionals with proven track records, with support from collaborating and academic centers, to design a model for mental health training for health workers, with emphasis on primary health care, based on the necessary competencies for meeting the needs of the population.

- 4.1.3 Ensure that educational needs are met through the design of different training modalities and technologies (at national, subregional, and regional levels), among others, virtual courses/ distance learning. To this end, it is vital to work in collaboration with the ministries of health, academic institutions, and collaborating centers.
- 4.1.4 Review and reach consensus on basic principles for graduate-level (specialized) mental health programs in the countries of the Region (psychiatry residency, graduate-level training in nursing, and health psychology).
- 4.1.5 Prepare and disseminate the best available scientific information to supports the design of training processes.
- 4.1.6 Foster cooperation among countries for human resources development.

#### *National level activities*

- 4.1.7 Have an up-to-date database of mental health human resources, which will serve as a basis for planning.
- 4.1.8 Formulate systematic training plans before and during service delivery for health workers, with curricula based on the development of needs-based competencies, and ensure that training processes include subject matter on human rights.
- 4.1.9 Ensure in-service supervision in support of training processes.
- 4.1.10 Formulate expanded training plans that include informal service providers, community agents, and workers from other sectors related to mental health (for example, police officers, judges, and teachers).
- 4.1.11 Evaluate the professional profiles for nursing and plan different modalities for college and graduate-level education in order to involve these professionals in specific mental health functions. The nurse can be a vital resource in many countries.
- 4.1.12 Ensure equitable access to technical information and to the best available scientific evidence.
- 4.1.13 Collaborate with the universities and schools of health human resources education, to include and improve mental health subject matter in college and graduate-level curricula. This subject matter should concur with the community mental health care model, as well as with a human rights focus.

## Strategic Area No. 5: Strengthen capacity to produce, assess, and use information on mental health

### Indicators

Indicator	Baseline 2008	Target
Number/percentage of countries that have assessed their mental health system using the WHO-AIMS methodology of WHO*.	15 / 43%	100% (2012)
Number/percentage of countries that have reassessed their mental health system using the WHO-AIMS methodology.	0	50% (2019)
Number/percentage of countries that regularly compile and analyze essential mental health data (broken down, at a minimum, by sex and age) in their health information system.	20 / 57%	80% (2015) 100% (2019)
Regional document on methodology for the development of mental health indicators published through a consultative process and involving a group of experts.	N/A	1 (2011)
Regional report on mental health services published (based on WHO-AIMS)	N/A	1 (2013) 1 (2019)
Report regional on suicide, published.	N/A	1 (2010) 1 (2018)
Regional report on alcohol abuse, published	N/A	1 (2010) 1 (2015)
Regional database on alcohol, available	N/A	1 (2010)
ATLAS Report on resources for treatment and prevention of alcohol and other psychoactive substance use disorders, available	N/A	1 (2011) 1 (2017)

N/A: Not available.

Carefully review and adjust baseline in 2010.

\* [http://www.who.int/mental\\_health/evidence/AIMS\\_WHO\\_2\\_2.pdf](http://www.who.int/mental_health/evidence/AIMS_WHO_2_2.pdf)

### Objective 5.1

To comprehensively assess mental health systems in the countries, establishing baselines and monitoring the situation.

#### Regional level activities

- 5.1.1 Collaborate technically with the countries to put into practice the instrument for mental health system assessments (WHO AIMS) in the countries and follow up the evolution of the obtained baseline.
- 5.1.2 Prepare and disseminate subregional and regional reports and data concerning the status of mental health and mental disorder services caused by psychoactive substance abuse.

#### National level activities

- 5.1.3 Assess the status of the mental health system using the WHO standardized methodology (WHO-AIMS). Each country can select the indicators it considers essential or tracers for closer follow-up. The repetition of successive assessments (for example, every 5 years) using WHO-AIMS (in whole or in part) can provide a good procedure for monitoring based on a baseline. The objective is to identify the capacity of mental health systems to meet the mental health needs of the population.

### Objective 5.2

To improve the mental health component of National Information Systems, ensuring regular collection and analysis of core mental health data.

#### *Regional level activities*

- 5.2.1 Cooperate technically with countries to introduce and improve the mental health component in health information within the national systems, using tools elaborated by WHO and other organizations.
- 5.2.2 Create a group of experts and carry out a regional consultation to establish mental health indicators and make the pertinent recommendations.
- 5.2.3 Elaborate and disseminate reports and subregional and regional data on information and indicators on mental disorders and substance abuse.

#### *National level activities*

- 5.2.4 Strengthen mental health registry and data-processing systems to reduce the current information gap. It is necessary to define the essential data that should be included in the system and mechanisms for data collection, ensuring that records are disaggregated by sex, age, and other variables that may be included.
- 5.2.5 Ensure reliable records and monitor mortality from external causes, especially suicide.
- 5.2.6 Establish epidemiological surveillance mechanisms appropriate to the national context.
- 5.2.7 Institute periodic analysis of the available mental health information, using it as a planning and management tool.
- 5.2.8 Prepare and disseminate annual mental health reports.

### Objective 5.3

To strengthen research on mental health within the parameters of each country's needs and available resources.

#### *Regional level activities*

- 5.3.1 Support investigation in mental health field, in collaboration with scientific and academic institutions, as well as with PAHO/WHO collaborating centers; promote multicenter studies.
- 5.3.2 Make information visible and accessible in virtual spaces (PAHO and collaborating centers' websites).
- 5.3.3 Elaborate and disseminate information and subregional and regional data on more important research and investigations in the field of mental health and mental disorders caused by substance abuse

*National level activities*

- 5.3.4 Compile and analyze the existing epidemiological studies and research on mental health in the country.
- 5.3.5 Decide, in the national context, which new research studies will be given priority, so that they can meet the mental health needs of the population.
- 5.3.6 Strengthen cooperation among institutions at the national level in the field of mental health research.

**Plan of Activities/ Country Key Points**

<b>Strategic Area</b>	<b>Objectives</b>	<b>Activities</b>
<b>1.</b>	Policies and plans	Implementation of mental health policies and plans. Special attention to vulnerable groups. Specific issues: alcohol, childhood and adolescence, the elderly, disasters, suicidal behavior, violence, mental health-HIV/AIDS.
	Legislation	Promote review of the legislative framework on mental health. Protection of the human rights of people with mental disorders. Ties with the judicial sector.
	Financial and human resources	Definition of funding for the mental health plan and breakdown of the expenditure. Goals-setting and search for funding sources.
	Partnerships	Intersectoral coordination structure. Social participation. Support movements of users and family-members of patients.
<b>2.</b>	Promotion and prevention, with emphasis on children and adolescents	Promotion and prevention in the framework of the national mental health Plan. Determination of settings for the intervention (emphasis on schools). Work with children and adolescents. Public education and the mass media. Fight against stigma and discrimination. Intersectoral management.
<b>3.</b>	Service delivery, with emphasis on primary health care	Community model/organization of services (transformation of psychiatric hospitals, decentralization, primary health care). Psychosocial care and rehabilitation for people with serious, prolonged mental illness. Services for psychoactive substance use disorders. Regulation and accreditation.
	Priority conditions	Determination of priority conditions. Package of essential interventions at the different levels (with particular emphasis on primary health care), according to the life cycle.
<b>4.</b>	Human resources development	Database and implementation of mental health training plan for health workers (especially in the primary health care area). Training in other sectors and with community agents. Mental health nursing. Distance learning. Review of college and graduate-level curricula.

Strategic Area	Objectives	Activities
5.	Systems assessment	WHO-AIMS assessment and monitoring of changes.
	Mental health in information systems	Essential mental health data in National Information Systems: collection and analysis. Indicators. Epidemiological surveillance mechanism. Preparation and dissemination of annual mental health reports.
	Research	Compile existing national studies. Promotion of multicenter research.

### Country Indicators:

Each country should develop its own system of indicators, based on the national context and the conditions of its health system, as well as the development level of its mental health services. PAHO will offer technical cooperation based on the needs that the Member States have identified.

Recommended reference documents:

- Instrument for the assessment of mental health systems (WHO-AIMS) that include 155 indicators.  
World Health Organization. Assessment Instrument for Mental Health Systems. WHO AIMS Version 2.2. WHO, Geneva, 2005.  
[http://www.who.int/mental\\_health/evidence/AIMS\\_WHO\\_2\\_2.pdf](http://www.who.int/mental_health/evidence/AIMS_WHO_2_2.pdf)
- WHO Information Systems Module:  
World Health Organization. The Essential Package for Mental Health Policy, Plan and Services.  
[http://www.who.int/mental\\_health/policy/essentialpackage1/en/index.html](http://www.who.int/mental_health/policy/essentialpackage1/en/index.html)  
[http://www.who.int/mental\\_health/policy/services/12\\_info%20system\\_WEB\\_07.pdf](http://www.who.int/mental_health/policy/services/12_info%20system_WEB_07.pdf)

## INSTRUMENTS FOR THE PROTECTION OF HUMAN RIGHTS

1. The Member States of WHO adopted important principles in regard to public health that are enshrined in the preamble to its Constitution. Hence, the Constitution establishes as a fundamental international principle that enjoyment of the highest attainable standard of health is not only a state or condition of the individual, but “(...) one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition...” The Constitution was adopted by the International Health Conference held in New York from 19 June to 22 July 1946 and signed on 22 July 1946 by representatives of 61 States. The International Covenant on Economic, Social, and Cultural Rights (UN), in turn, protects “(...) the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (...)” (Article 12), and the Protocol of San Salvador (OAS) protects “the right to health” (Article 10). Moreover, health protection as a human right is enshrined in 19 of the 35 Constitutions of the Member States of PAHO (Bolivia, Brazil, Chile, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Uruguay, and Venezuela).
  
2. United Nations instruments on the protection of human rights:
  - Universal Declaration of Human Rights (1);
  - International Covenant on Civil and Political Rights<sup>8</sup> (2);
  - International Covenant on Economic, Social, and Cultural Rights<sup>9</sup> (3);
  - Convention on the Rights of the Child<sup>10</sup> (4);
  - Convention on the Rights of Persons with Disabilities<sup>11</sup> (5);
  - Convention on the Elimination of All Forms of Discrimination against Women<sup>12</sup> (6);

<sup>8</sup> Entered into force on 23 March 1976 and ratified by Argentina, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, the United States of America, Uruguay, and Venezuela.

<sup>9</sup> Entered into force on 3 January 1976 and ratified by Argentina, Barbados, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay, and Venezuela.

<sup>10</sup> Entered into force on 2 September 1990 and ratified by Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay, and Venezuela.

<sup>11</sup> Entered into force on 3 May 2008 and ratified by Argentina, Brazil, Chile, Costa Rica, Cuba, Ecuador, El Salvador, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, and Peru.

<sup>12</sup> Entered into force on 3 September 1981 and ratified by Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Lucia, Saint Vincent and the Grenadines, Trinidad and Tobago, Uruguay, and Venezuela.

- Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care<sup>13</sup> (7);
  - Standard Rules on the Equalization of Opportunities for Persons with Disabilities<sup>14</sup> (8).
3. Inter-American system instruments for the protection of human rights:
- American Declaration on the Rights and Duties of Man<sup>15</sup> (9);
  - American Convention on Human Rights<sup>16</sup> (10);
  - Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights “Protocol of San Salvador”<sup>17</sup> (11);
  - Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities<sup>18</sup> (12);
  - Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women<sup>19</sup> (13);
  - Recommendation of the Inter-American Commission on Human Rights (OAS) for the Promotion and Protection of the Rights of the Mentally Ill<sup>20</sup> (14).

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<sup>13</sup> Include guidelines for establishing national mental health systems and evaluating their practices. They refer to the human rights of persons with mental disabilities, especially in the context of psychiatric institutions.

<sup>14</sup> “The purpose of the Rules is to ensure that girls, boys, women, and men with disabilities, as members of their societies, may exercise the same rights and obligations as others.”

<sup>15</sup> OAS Res. XXX. OEA/Ser.L.V/II.82 doc.6 rev.1 at 17 (1992).

<sup>16</sup> Entered into force on 18 July 1978 and ratified by Argentina, Barbados, Bolivia, Brazil, Chile, Colombia, Costa Rica, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Trinidad and Tobago, Uruguay, and Venezuela.

<sup>17</sup> Entered into force on 16 November 1999 and ratified by Argentina, Brazil, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Mexico, Panama, Paraguay, Peru, Suriname, and Uruguay.

<sup>18</sup> Entered into force on 14 September 2001 and ratified by Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Mexico, Nicaragua, Panama, Paraguay, Peru, Uruguay, and Venezuela.

<sup>19</sup> Entered into force on 5 March 1995 and ratified by Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Colombia, Costa Rica, Chile, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Suriname, Trinidad and Tobago, Uruguay, and Venezuela.

<sup>20</sup> Urges States to “promote and implement through legislation and national mental health plans, the organization of community mental health services to achieve the full integration of the mentally ill into society ...”

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