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PLAN OF ACTION ON MENTAL HEALTH

Introduction

1. Mental disorders are highly prevalent throughout the world and are major contributors to morbidity, disability, and premature mortality. However, the resources allocated by countries to tackle this burden are insufficient, are inequitably distributed, and, at times, inefficiently used. Together, this has led to a treatment gap that, in many countries, is more than 70%. The stigma, social exclusion, and discrimination that occur around people with mental disorders compound the situation *(1, 2).*

2. *There is no health without mental health*. This message clearly expresses the need for a comprehensive approach to health and emphasizes the links between physical and psychosocial aspects of the health-disease process. Mental disorders increase risk for other diseases and contribute to unintentional and intentional injury. Furthermore, disease, whether communicable or non-communicable, increases risk for mental disorders. Coordinated care and treatment of mental disorders and other physical conditions can improve outcomes for both *(2, 3).*

3. The World Health Organization (WHO) conceptualizes mental health as a "state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" *(4).*

4. In 2013, the World Health Assembly approved the Comprehensive mental health action plan 2013-2020 *(4).* Also in 2013, the Directing Council of PAHO adopted its Strategic Plan 2014-2019 *(5).* In view of the foregoing, at the regional level, it has been decided to review the Plan of Action on Mental Health, adopted in 2009, in order to update it and align it with the PAHO Strategic Plan and with the WHO Comprehensive mental health action plan *(2, 4)*.

Background

5. The Declaration of Caracas (1990) was a historical milestone in the Americas, which underscored that psychiatric-hospital centered care had to be replaced with

decentralized, participatory, integrated, continuing, preventive, and community-based services, respecting the exercise of human rights *(6, 7)*.

6. In 1997 and 2001, the Directing Council of PAHO addressed the subject of mental health and issued resolutions that urged Member States to include mental health among their priorities *(8, 9)*. The regional conferences on mental health held in Brasilia, in 2005, and in Panama, in 2010, evaluated the road traveled *(10, 11, 12)*. In 2007, the countries of the Region approved the Health Agenda for the Americas 2008-2017 *(13)*.

7. In recent years, the following extremely important programming documents have been approved:

a) Mental Health Gap Action Programme (mhGAP), WHO, 2008; mhGAP Intervention Guide (mhGAP-IG), WHO, 2010 (*14, 15*).

b) Strategy and Plan of Action on Mental Health, PAHO, 2009; Strategy and Plan of Action on Epilepsy, PAHO, 2011 (*2, 16*).

c) Global strategy to reduce the harmful use of alcohol, WHO, 2011; Plan of Action to Reduce the Harmful Use of Alcohol, PAHO, 2010 (*17, 18*).

d) Strategy on Substance Use and Public Health, PAHO, 2011; Plan of Action on Psychoactive Substance Use and Public Health, PAHO, 2010 (*19, 20*).

e) Political declaration on non-communicable diseases (NCDs), UN, 2011; Comprehensive global monitoring framework, WHO, 2013; Plan of Action for the Prevention and Control of Noncommunicable Diseases, PAHO, 2013 (*21, 22, 23*).

f) Strategic Plan 2014-2019, PAHO (*5*).

g) Comprehensive mental health action plan 2013-2020, WHO (*4*).

h) Regional Meeting of Users of Mental Health Services and their Families, sponsored by PAHO and the Government of Brazil, which issued the Brasilia Consensus, 2013 *(24)*.

Situation Analysis

8. The fundamental considerations of the situation analysis used as the basis for development of the regional Strategy and Plan of Action on Mental Health, approved in 2009, are still valid *(2)*. A recent review of several epidemiological studies done in the Region found 12-month prevalences for any mental disorder from 18.7% to 24.2%. Median 12-month prevalence rates in the adult population for some disorders are: non-affective psychosis, 1.0%; major depression, 5.2%; and alcohol abuse/dependence, 4.6% *(25, 26)*.

9. In terms of burden and prevalence, depression continues to be the leading mental disorder, and is twice as frequent in women as in men. From 10% to 15% of women in industrialized countries and from 20% to 40% of women in developing countries suffer from depression during pregnancy or the postpartum period *(2, 26, 27)*.

10. The Region is experiencing a demographic transition, which is posing a challenge that mental health services must address. Mental and neurological disorders in the elderly, such as Alzheimer's disease, other dementias, and depression, contribute significantly to the burden of noncommunicable diseases. In the Americas, prevalence of dementia in the elderly (aged >60 years) ranges from 6.46% to 8.48%. Projections indicate that the number of people with dementia will double every 20 years *(28)*.

11. Availability of data on mental health services has increased understanding of the magnitude of the treatment gap. Among adults with severe and moderate affective, anxiety, and substance use disorders, the median treatment gap is 73.5% for the Region of the Americas, 47.2% for North America, and 77.9% for Latin America and the Caribbean (LAC). The treatment gap in LAC is 56.9% for schizophrenia, 73.9% for depression, and 85.1% for alcohol *(25)*.

12. In the Americas, 65,000 people die from suicide every year. The age-adjusted suicide rate, per 100,000 population, is 7.3 (11.5 for men and 3.0 for women). Suicide is the third leading cause of death in the group aged 20 to 24 years, and fourth in the groups aged 10 to 19 and 25 to 44. The population aged >70 years has the highest rate (12.4 per 100,000 population). The most commonly used methods are suffocation, firearms, and poisoning (from pesticides, in particular). In LAC, the age-adjusted rate is 5.2 (8.4 in men and 2.1 in women). Mortality from suicide continues to be higher in men than in women (male-female ratio of 3.8); however, women report more suicide attempts *(29)*.

13. In our Region, violence is an important social-health problem. Violence against women, which affects one out of every three women, gives rise to multiple health consequences, ranging from depression to death *(30)*. Physical punishment of children is frequent in many parts of Latin America and the Caribbean. For example, according to national surveys conducted in some countries, more than one third of women, and at least half of men reported that they had been hit during childhood *(31)*.

Policies, Plans, Legislation, and Organization of Services

14. Thirty-four countries and territories in Latin America and the Caribbean have implemented the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) *(32, 33)*. According to this study, only six countries and territories in LAC do not have mental health policies and plans. In contrast, only eight countries do have specific up-to-date mental health laws. With respect to the financial situation, 73% of countries assign from 1% to 5% of the health budget to mental health. Furthermore, of the 27 countries with psychiatric hospitals, 20 allocate more than 50% of the mental health budget to these institutions; and 14 of those 20 assign over 80% *(33)*.

15. The organization of mental health services is not uniform in LAC. Some countries have implemented innovative community-based solutions. Many others still have a highly centralized system, where the response to problems of people with mental disorders and alcohol or other substance disorders is concentrated in psychiatric hospitals, with limited or no development of health services at the primary or secondary level. In

LAC, 86.6% of psychiatric beds are in psychiatric hospitals, 10.6% are in general hospitals, and only 2.7% are in community residences *(33)*.

16. Primary care has played a limited role in the mental health area, although the situation is gradually changing. In the past three years, 15 countries have been training primary care personnel, using mhGAP Intervention Guides.

17. From the standpoint of human resources, the disparity among countries is great. It is observed that, where the psychiatric hospital is at the base of the system, most of the available resources are found concentrated there. In Latin America and the Caribbean, there is a median of 2.1 psychiatrists, 6.0 nurses, and 4.2 psychologists per 100,000 population *(33)*.

18. WHO-AIMS revealed the paucity of information on mental health. In many countries, data are difficult to obtain and sometimes nonexistent, and health information systems do not include mental health indicators.

19. The Strategy and Plan of Action on Mental Health, adopted by PAHO in 2009, was implemented during the period 2010-2013 with positive outcomes and shows that many countries have achieved substantial progress; nevertheless, there is still a long way to go. Noteworthy progress has been made, including the following: *a)* several countries have continued with sustainable processes to reduce the number of psychiatric hospital beds, through alternatives in decentralized outpatient services; *b)* in the last three years, work has been done to integrate a mental health component into primary health care; and *c)* several countries have drafted and passed mental health laws that incorporate international human rights instruments.

20. On the other hand, the treatment gap is the great challenge we are facing today. Tearing down barriers to access to services as part of a universal coverage policy is the key, and this includes integration of mental health into general health services.

Draft Plan of Action, 2015-2020

21. The Plan of Action reflects the experience gained in our Region and expresses the commitment of the governments. It sets a period of six years for its implementation (2015-2020). The Plan is based on an overall view of the Region; however, marked differences persist among the countries and even within an individual country. For this reason, there should be flexibility in its implementation, in particular to adapt the proposed results and indicators as necessary and adjust them to the specifics of the countries and to cultural contexts. Furthermore, in federal countries, the shared jurisdictional responsibility between national and subnational governments should be taken into account.

22. *Vision*: A region in which mental health is valued, promoted, and protected, mental disorders are prevented, and where persons with these disorders are able to exercise their human rights and to access both health and social care that is timely and

high-quality, to attain the highest possible level of health and to contribute to the well-being of families and communities.

23. *Goal:* Promote mental well-being, prevent mental disorders, offer care, enhance recovery, and promote the human rights of persons with mental disorders, to reduce morbidity, disability, and mortality.

24. This document is aligned with the PAHO Strategic Plan 2014-2019 and the WHO Comprehensive mental health action plan 2013-2020, with special attention to results, indicators, and targets that are matching. The Plan contains the following lines of action:

a) Develop and implement mental health policies, plans, and laws, to achieve effective governance.

b) Improve the response capacity of mental health services, to provide comprehensive, quality care in community-based settings.

c) Prepare and implement programs for promotion and prevention in mental health and alcohol and substance use, with particular attention to the life cycle.

d) Strengthen information systems, scientific evidence, and research.

25. The Plan of Action is based on four cross-cutting themes, according to the provisions of the PAHO Strategic Plan: gender, equity, ethnicity, and human rights. Gender inequalities—in interaction with other social determinants of health—explain differences in exposure to risks and in mental health outcomes for women and men. From this perspective, when putting mental health care into practice, it should take into account gender-based living conditions and specific needs.

26. The ethnicity perspective involves an intercultural approach in mental health services. It is necessary to have personnel that know and respect cultural and religious knowledge and beliefs, as well as the language of different people, and integrates these elements into their work. The exercise of human rights is fundamental for responding to the burden of mental illness within a framework of respect for human dignity. A set of relevant international instruments on human rights is currently available *(2, 34)*.

Line of Action 1: Develop and implement mental health policies, plans, and laws, to achieve effective governance.

27. The design and implementation of national mental health policies, plans, and laws, based on scientific data and in accordance with international human rights instruments, is a challenge that requires a joint effort by the public sector with other key entities. Leadership and commitment from governments and health workers are essential to develop comprehensive mental health plans integrated into public policies and facilitate the organization of a community-based service model that promotes and protects the human rights of persons with mental disorders and their families *(2, 4)*.

28. Civil society plays a key role in the preparation and implementation of plans and laws, in particular through associations of users of mental health services and their families, peer support groups, social support groups, community integration and participation, and the promotion of effective and appropriate services. In the first year of implementation of the Plan a baseline will be established to measure progress of the civil society role.

29. Legislation on mental health provides a legal framework for promoting and protecting the human rights of people with mental disorders *(2, 4, 34)*. When mental health is addressed both in independent legislation (law) and when it is integrated into other laws on health and capacity, these should codify the principles, values, and basic objectives of international human rights instruments, and be consistent with the best international technical standards.

Objective 1.1. Develop and implement national mental health policies or plans that are aligned with regional and global mental health plans.**

Indicator:

1.1.1 Number of countries that have a national mental health policy or plan in line with regional and global mental health plans.
Baseline (2013): 22.* Target (2020): 30.

Objective 1.2. Draft and implement national mental health laws consistent with international human rights instruments.**

Indicator:

1.2.1 Number of countries that have national mental health laws consistent with international human rights instruments.
Baseline (2013): 8.* Target (2020): 18.

* Baseline data taken from regional WHO-AIMS (assessment report on mental health systems) *(33)*. Furthermore, these baselines will be reviewed in 2015 to be updated.

** Result and indicator match PAHO Strategic Plan 2014-2019 *(5)*.

Line of Action 2: Improve the response capacity of mental health services, to provide comprehensive, quality care in community-based settings.

30. A community mental health model is grounded on basic principles adopted and adapted by each country to organize service delivery. Its cornerstones include decentralization, inclusion of a mental health component in primary health care and in general hospitals, the existence of a service network, social participation, intersectoral coordination, and a human rights approach. It also implies the delivery of services that are culturally appropriate, equitable, and free from discrimination based on gender, race or ethnic group, sexual orientation, social class, or other conditions *(2, 4)*.

31. An unfinished task in the Region is the restructuring of mental health services in order to put an end to psychiatric hospitals that, in many countries, still consume most of the resources dedicated to mental health. Development of a community model involves planning new services and alternatives that offer comprehensive and continuous care that make it possible to replace psychiatric hospitals. A recommended strategy is to use the resources of current psychiatric hospitals to establish specialized services in general hospitals and in the community *(35)*.

32. Community-based mental health services should base their approach on recovery, with emphasis on the support that people with mental disorders need to reach their own aspirations and goals. Among other tasks, these services should be "listening and responding to individuals' understanding of their condition and what helps them to recover; working with people as equal partners in their care; offering choice of treatment and therapies, and in terms of who provides care; and the use of peer workers and supports, who provide each other with encouragement and a sense of belonging, in addition to their expertise" *(4)*. Furthermore, the role of other sectors is fundamental to supporting people according to their needs for employment, housing, education, participation in community activities, etc.

33. An integrated approach to mental disorders that combines psychosocial and pharmacological interventions is the most effective. Availability of essential psychotropic drugs in community outpatient services and in primary health care is crucial *(36)*.

34. Systematic evaluation of mental health services guarantees that quality care is provided and that the human rights of service users and their family members are respected. The WHO *Quality Rights* project offers instruments and a methodology, which have begun to be adapted and implemented in the Region *(37)*.

35. Services should be responsive to the needs of vulnerable groups, especially those who are socioeconomically disadvantaged; the homeless mentally ill; people living with HIV/AIDS; women and children who are victims of violence; survivors of violence; lesbian, gay, bisexual, and transgendered people (LGBT); indigenous peoples; migrants and displaced persons; persons deprived of liberty; and minority groups within the national context. The term "vulnerable group" is used in this Plan to refer to individuals or a set of people that have acquired that vulnerability due to exposure to specific situations and conditions in their environment (not, of course, intrinsic weaknesses or lack of capacity). Each country should apply the term "vulnerable group" in accordance with its own context and characteristics.

36. Exposure to adverse life events, such as natural or man-made disasters, armed conflicts, civil unrest, continuing domestic violence, and forced migration or displacement, has physical and mental health consequences. Therefore, availability of mental health services and psychosocial support should be assured when planning the response by the health sector and other sectors.

37. Having the right number and equitable distribution of appropriately skilled mental health workers is central to the expansion of services. Vocational training (college) and continuing education (graduate level) should reflect the policies for the integration of mental health into general health services, including primary health care. Specialized professionals should facilitate the training, support, and supervision of non-specialized personnel; for example, so that they can identify people with mental health problems and care for them or refer them to a more appropriate service, if available. Supporting and training family members and caregivers of people with mental disorders will also contribute to increasing the response capacity of mental health services.

38. When planning expansion of mental health services, ensuring equitable access to efficient care, treatment, and recovery support is essential. To this end, efforts to study and maximize the use of telemodalities (such as mobile telephones, video links, Internet) should be undertaken, to guarantee access to mental health services in remote and neglected communities.

39. Increasing and decentralizing mental health services make it possible to gradually reduce the number of psychiatric hospital beds, which basically offer custodial care services. By setting up specialized services in the community (outpatient and in general hospitals), and integrating a mental health component into primary health care, the role of psychiatric hospitals should be gradually reduced. Integration of a mental health component into primary health care and other health care settings (e.g., emergency departments, criminal justice system, school health clinics) is essential for development of equitable service delivery, in addition to being a crucial strategy for bridging the mental disorders treatment gap.

Objective 2.1. Increase outpatient service coverage for mental health.*

Indicator:

2.1.1 Number of countries that have increased the rate of persons seen in outpatient mental health facilities above the regional average (975/100,000 population). Baseline (2013): 19.** Target (2020): 30.

Objective 2.2. Reduce role of psychiatric hospitals.

Indicator:

2.2.1 Number of countries where psychiatric hospitals have reduced the number of beds by at least 15%.
Baseline (2013): 0. Target (2020): 10.

Objective 2.3. Integrate mental health component into primary care.*

Indicator:

2.3.1 Number of countries that have integrated a mental health component into primary care.
Baseline (2013): 15.*** Target (2020): 25.

* Result and indicator match PAHO Strategic Plan 2014-2019.
** Baseline data taken from regional WHO-AIMS (assessment report on mental health systems) *(32)*.
***Technical Unit on Mental Health and Substance Use Report.

Line of action 3: Prepare and implement programs for promotion and prevention in mental health and alcohol and substance use, with particular attention to the life cycle.

40. The role of other sectors is crucial in the area of promotion and prevention, because mental health and substance use problems are influenced by social and economic determinants, including, for example, income level, employment status, education level, family cohesion, discrimination, violations of human rights, and exposure to adverse life events, including sexual violence, child abuse, and neglect *(4)*.

41. The early stages of life present an important opportunity to work on prevention, as up to 50% of mental disorders in adults begin before the age of 14 years. Opportunities also exist for preventive intervention with the elderly to improve quality of life, facilitate social integration, and reduce or prevent disability *(2, 4)*.

42. Interventions to promote mental health and prevent mental disorders should include support for antidiscrimination laws and regulations, and information campaigns against stigmatization and human rights violations *(4)*.

43. It is important for promotion and prevention programs to concentrate on evidence-based interventions that are appropriate to the context in which they are used. Programs can include these actions, among others: the nurturing of core individual attributes in the formative stages of life, early identification and treatment of emotional or behavioral problems in childhood and adolescence, promotion of healthy living conditions, strengthening of community protection networks that tackle violence, and social protection for the poor *(4)*.

44. Interventions to prevent suicide include reducing access to lethal means (in particular, firearms, bridges without barriers, pesticides, and medicines or drugs), responsible reporting by the media, and early recognition and treatment of mental disorders such as depression. It is essential to identify people at risk, monitor persons with suicidal ideation and previous suicide attempts, and provide immediate care to those who attempt suicide.

45. The trend in the rate of suicide has remained stable in the Americas during the 20 years from 1990 to 2009. A slight decrease in rates was noted in North America (the United States and Canada), while a slight increase was observed in LAC. This is explained because the North American countries have reliable registries and carry out programs to address these problems. In LAC, on the contrary, underreporting is likely in many countries, which means that when information systems and registries improve, an increase in rates can be foreseen. Based on this study of trends, it is predicted that mortality from suicide will remain stable, even though many countries will improve their registries and will carry out programs for the prevention of suicidal behavior *(28)*.

Objective 3.1. Implement mental health promotion and prevention programs.

Indicator:

3.1.1 Number of countries with operational multisectoral mental health promotion and prevention programs.
Baseline (2013): 20.* Target (2020): 25.

Objective 3.2. Implement mental of suicide prevention programs.

Indicator:

3.2.1 Annual number of suicide deaths per 100,000 population.**
No increase in the regional suicide rate by 2020 compared to 2013: 7.3/100,000 population.***

* Baseline obtained from evaluation of the PAHO Strategic Plan 2008-2014 (SO3, RER 3.5, Indicator 3.5.2). The baseline will need to be reviewed during 2015 to confirm the real implementation of these programs and whether they meet basic technical requirements.
** Indicator and target match impact indicator in the PAHO Strategic Plan 2014-2019.
*** See paragraph 45.

Line of Action 4: Strengthen information systems, scientific evidence, and research.

46. Health information systems should regularly collect and report data on mental health service delivery, which should be broken down, at a minimum, by sex, age, race or ethnic group, and diagnosis. These data should be used routinely for evaluation and to report to authorities, and as a basis for improvement and expansion of services. The basic set of indicators suggested in the WHO Plan of Action will be reviewed, for its adaptation and gradual implementation by the countries of the Region.

47. According to the WHO-AIMS assessment, in LAC, 66% of psychiatric hospitals and 62% of outpatient facilities have functioning information systems and regularly provide information. Most of the available information comes from psychiatric hospitals, and refers to number of beds and admissions, according to sex, age, and diagnoses, with very little information on other parameters, such as involuntary admissions. Information from outpatient services is more varied; occasionally, the number of contacts is reported, but there is almost never a case registry *(33)*.

48. Only a few countries have existing scientific research and produce data. To provide scientific evidence for interventions for the promotion, prevention, and treatment of mental disorders, research should encompass scientific activities ranging from discovery to service delivery, taking national priorities into account.

Objective 4.1. Strengthen information systems by integrating a basic set of mental health indicators that are systematically compiled and reported annually.

Indicator:

4.1.1 Number of countries with a basic set of agreed upon mental health indicators, systematically compiled and reported annually.
Baseline (2013): 21.* Target (2020): 30.

***** Baseline obtained from evaluation of the PAHO Strategic Plan 2008-2014 (SO3, RER 3.3, Indicator 3.3.2). The baseline will need to be reviewed during 2015 to confirm the current status of health information systems and whether mental health data meet the minimum requirements of the set of basic indicators proposed by PAHO/WHO.

Monitoring, Analysis, and Evaluation

49. This action plan contributes to achievement of the goals for Category 2 in the PAHO Strategic Plan. Monitoring and evaluation of this Plan will be aligned with the Organization's results-based management framework and its performance evaluation processes. Progress reports will be prepared based on information available at the end of each biennium. Mid-term and final evaluations of the Plan will be done to determine the strengths and weaknesses of its overall implementation, causal factors of the successes and failures, and future actions.

50. The sources for the necessary information are: *a)* PAHO/WHO mortality database; *b)* WHO-AIMS country reports updated every five years; *c)* other country reports, requested from Ministries of Health; *d)* reports from the Regional Mental Health and Substance Use Unit; and *e)* compilation of the research.

Financial Implications

51. It is estimated that the cost of implementation of the *Plan* for the 6-year period (2015-2020) will be $13,880,080.00. The estimated gap is 39% of the total budget. The fixed staff that currently makes up the Unit is sufficient to cover implementation of the Plan of Action in the six-year period; the funding gap is primarily for operating expenses for technical cooperation with the countries and for temporary contracting necessary for expert support in specific activities. It will be important to forge partnerships and identify donors who support the plan. Similarly, it is expected that the Member States will prioritize the issue and allocate resources to improve their community-based mental health programs and services. Cooperation and experience sharing among countries will be important, for which it will be necessary to mobilize financial resources.

Action by the Executive Committee

52. The Executive Committee is requested to review this Plan of Action on Mental Health, which includes a proposed resolution (Annex A), and to make any observations and recommendations it deems pertinent.

Annexes

References

1. Saraceno B, Freeman M, Funk M. Public mental health. In: Oxford Textbook of Public Health, 5th ed. New York: Oxford University Press; 2009, pp. 1081-1100.

2. Pan American Health Organization. Strategy and Plan of Action on Mental Health [Internet]. 49th Directing Council of PAHO, 61st Session of the Regional Committee of WHO for the Americas; 2009 Sep 28−Oct 2; Washington (DC), United States. Washington (DC): PAHO; 2009 (Document CD49/11 and Resolution CD49.R17) [cited 2013 Dec 5]. Available from: http://www2.paho.org/hq/dmdocuments/2009/MENTAL_HEALTH.pdf http://new.paho.org/hq/dmdocuments/2009/CD49.R17 (Eng.).pdf

3. Prince, M. et al. Global Mental Health 1. No health without mental health. In The Lancet, Global Mental Health [Internet]. *The Lancet* 2007 Sep 8; 370(9590):859-877 [cited 2014 Jan 31]. Available from: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61238-0/fulltext

4. World Health Organization. Comprehensive mental health action plan 2013-2020 [Internet]. Geneva: WHO; 2013 [cited 2014 Jan 31]. Available from: http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf?ua=1

5. Pan American Health Organization. Strategic Plan of the Pan American Health Organization 2014-2019 [Internet]. 52nd Directing Council of PAHO, 65th Session of the Regional Committee of WHO for the Americas; 2013 Sep 30−Oct 4; Washington (DC), United States. Washington (DC): PAHO; 2013 (Official Document 345) [cited 2014 Jan 31]. Available from: http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=22850&Itemid=270&lang=en

6. González Uzcategui R, Levav I. (eds.) Reestructuración de la atención psiquiátrica: bases conceptuales y guías para su implementación: memorias de la Conferencia Regional para la Reestructuración de la Atención Psiquiátrica = Restructuration of psychiatric care: conceptual basis and implementation guidelines: Annals of the

Regional Conference on Restructuring of Psychiatric Care. Washington (DC): PAHO; 1991 (document HPA/MND 1.91).

7. Pan American Health Organization. Declaration of Caracas [Internet]. Adopted in Caracas, Venezuela, on 14 November 1990 by the Conference on the Restructuring of Psychiatric Care in Latin America within the Local Health Systems. Washington (DC): PAHO; 1990 [cited 2014 Jan 31]. Available from: http://www2.paho.org/hq/dmdocuments/2008/DECLARATIONOFCARACAS.pdf

8. Pan American Health Organization. Mental Health [Internet]. 40th Directing Council of PAHO, 49th Session of the Regional Committee of WHO for the Americas; 1997 Sep 22-23; Washington (DC), US. Washington (DC): PAHO; 1997 (Resolution CD49.R19) [cited 2014 Jan 31]. Available from: http://www1.paho.org/English/GOV/CD/ftcd_40.htm

9. Pan American Health Organization. Mental Health [Internet]. 43 Directing Council of PAHO, 53rd Session of the Regional Committee of WHO for the Americas; 2001 Sep 24-28; Washington (DC), United States. Washington (DC): PAHO; 2001 (Resolution CD43.R10) [cited 2014 Jan 31]. Available from: http://www1.paho.org/english/gov/cd/cd43.r10-e.pdf

10. Rodríguez J, González R. (eds.) La reforma de los servicios de salud mental: 15 años después de la Declaración de Caracas [Internet]. Washington (DC): PAHO; 2007 [cited 2014 Jan 31]. Available from: http://www2.paho.org/hq/dmdocuments/2009/Reforma%20de%20las%20servicos%20de%20sald%20mental.pdf

11. Pan American Health Organization; Ministry of Health of the Federative Republic of Brazil; World Health Organization. The Brasilia Principles [Internet]. Regional Conference on Mental Health Services Reform – 15 years after the Caracas Declaration; 2005 Nov 7-9; Brasilia (Brazil). Washington (DC): PAHO; 2006 [cited 2014 Jan 31]. Available from: http://www2.paho.org/hq/dmdocuments/2008/principles_of_Brazilia.pdf

12. Pan American Health Organization. Panama Consensus [Internet]. Regional Conference on Mental Health; 2010 Oct 7-8; Panama City (Panama). Washington (DC): PAHO; 2010 [cited 2014 Jan 31]. Available from: http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=19535&Itemid=270

13. Pan American Health Organization. Health Agenda for the Americas 2008-2017 [Internet]. Presented by the Ministers of Health of the Americas in Panama City; 2007 Jun 3; Panama. Washington (DC): PAHO; 2007 [cited 2014 Jan 31]. Available from: http://www.paho.org/hq/index.php?option=com_content&view=article&id=1976:health-agenda-for-the-americas20082017&Itemid=0&lang=en

14. World Health Organization. mhGAP: Mental Health Gap Action Programme: Scaling up care for mental, neurological, and substance use disorders [Internet]. WHO: Geneva; 2008 [cited 2014 Jan 31]. Available from: http://new.paho.org/hq/index.php?option=com_content&task=view&id=326&Itemid=259

15. World Health Organization, Mental Health Gap Action Programme. mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings [Internet]. WHO: Geneva: 2011 [cited 2014 Jan 31]. Available from: http://www.who.int/mental_health/publications/mhGAP_intervention_guide/en/

16. Pan American Health Organization. Strategy and Plan of Action on Epilepsy [Internet]. Washington (DC): PAHO; 2011 [cited 2014 Jan 31]. Available from: http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=24657&Itemid=270&lang=en

17. World Health Organization. Global strategy to reduce the harmful use of alcohol [Internet]. Geneva: WHO; 2010 [cited 2014 Jan 31]. Available from: http://www.who.int/entity/substance_abuse/alcstratenglishfinal.pdf?ua=1

18. Pan American Health Organization. Plan of Action to Reduce the Harmful Use of Alcohol [Internet]. 51st Directing Council of PAHO, 63rd Session of the Regional Committee of WHO for the Americas; 2011 Sep 26-30; Washington (DC), United States. Washington (DC): PAHO; 2011 (Document CD51/8, Rev. 1) [cited 2014 Jan 31]. Available from: http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=14607&Itemid=

19. Pan American Health Organization. Strategy on Substance Use and Public Health [Internet]. 50th Directing Council of PAHO, 62nd Session of the Regional Committee of WHO for the Americas; 2010 Sep 27–Oct 1; Washington (DC), United States. Washington (DC): PAHO; 2010 (Document CD50/18, Rev. 1; and Resolution CD50.R2) [cited 2014 Jan 31]. Available from: http://www2.paho.org/hq/dmdocuments/2010/CD50-18-e.pdf http://www.paho.org/hq/dmdocuments/2010/cd50.r2-s.pdf

20. Pan American Health Organization. Plan of Action on Psychoactive Substance Use and Public Health [Internet]. 51st Directing Council of PAHO, 63rd Session of the Regional Committee of WHO for the Americas; 2011 Sep 26-30; Washington (DC), United States. Washington (DC): PAHO; 2011 (Document CD51/9) [cited 2014 Jan 31]. Available from: http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=14583&Itemid=

21. United Nations. Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases [Internet].

66th Session of the United Nations General Assembly, 3rd Plenary Session; 2011 Sep 19; New York (United States). New York: UN; 2011 (Document A/RES/66/2) [cited 2014 Jan 31]. Available from: http://daccess-ods.un.org/access.nsf/Get?OpenAgent&DS=A/RES/66/2&Lang=E

22. World Health Organization. Draft comprehensive global monitoring framework and targets for the prevention and control of noncommunicable diseases. Formal Meeting of Member States to conclude the work on the comprehensive global monitoring framework, including indicators, and a set of voluntary global targets for the prevention and control of noncommunicable diseases: Report by the Director-General. [Internet]. 66th World Health Assembly; 2013 May 20−28; Geneva (Switzerland). Geveva: WHO; 2013 (Document A66/8) [cited 2014 Jan 31]. Available from: http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_8-en.pdf

23. Pan American Health Organization. Plan of Action for the Prevention and Control of Noncommunicable Diseases [Internet]. 52nd Directing Council of PAHO, 65th Session of the Regional Committee of WHO for the Americas; 2013 Sep 30−Oct 4; Washington (DC), United States. Washington (DC): PAHO; 2013 (Document CD52/7, Rev. 1) [cited 2014 Jan 31]. Available from: http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=22841&Itemid=270&lang=es

24. Pan American Health Organization; Ministry of Health of Brazil. Brasilia Consensus [Internet]. 1st Regional Meeting of Users of Mental Health Services and their Families, 2013 Oct 15−17; Brasilia (Brazil). Brasilia: PAHO-Ministry of Health; 2013 [cited 2014 Apr 15]. Available from: http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=24574&Itemid=270&lang=en

25. Kohn, R. Treatment Gap in the Americas [Internet]. Washington (DC); 2013 (Technical Document) [cited 2014 Jan 31]. Available from: http://www.paho.org/hq/index.php?option=com_docman&task=doc_view&gid=23178&Itemid=270&lang=en

26. Rodríguez J, Kohn R, Aguilar S. Epidemiología de los trastornos mentales en América Latina y el Caribe [Internet]. Washington (DC): Pan American Health Organization; 2009 (Scientific and Technical Publication No. 632) [cited 2014 Jan 31]. Available from: http://iris.paho.org/xmlui/bitstream/handle/123456789/740/9789275316320.pdf?sequence

27. World Health Organization. Mental health aspects of women's reproductive health: a global review of the literature [Internet]. Geneva: WHO; 2009 [cited 2014 Jan 31]. Available from: http://www.who.int/reproductivehealth/publications/general/9789241563567/en/

28. World Health Organization; Alzheimer's Disease Internationl. Dementia: a public health priority [Internet]. Geneva: WHO; 2012 [cited 2014 Jan 31]. Available from: http://www.who.int/mental_health/publications/dementia_report_2012/en/

29. Organización Panamericana de la Salud. Informe regional sobre la mortalidad por suicidio. Washington (DC): OPS. Por publicarse en el 2014.

30. World Health Organization; United Nations Population Fund. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence [Internet]. Geneva: WHO; 2013 [cited 2014 Jan 31]. Available from: http://www.who.int/reproductivehealth/publications/violence/9789241564625/en/

31. Speizer, I.S., et al. (2008) Dimensions of child punishment in two Central American countries: Guatemala and El Salvador = Dimensiones del castigo infantil en dos países de América Central: Guatemala y El Salvador [Internet]. *Rev Panam Salud Publica* 2008. 23(4): p. 247-256 [cited 2014 Jan 31]. Available from: http://www.scielosp.org/scielo.php?script=sci_arttext&pid=S1020-49892008000400004&lng=en&nrm=iso

32. World Health Organization. World Health Organization assessment instrument for mental health systems [Internet]. Geneva: WHO; 2005 (WHO-AIMS Version 2.2.) [cited 2014 Jan 31]. Available from: http://www.who.int/mental_health/evidence/AIMS_WHO_2_2.pdf.

33. Pan American Health Organization. WHO-AIMS: Report on Mental Health Systems in Latin America and the Caribbean [Internet]. Washington (DC): PAHO; 2013 [cited 2014 Jan 31]. Available from: http://www.paho.org/hq/index.php?option=com_docman&task=doc_view&gid=21325&Itemid=

34. Pan American Health Organization. Health and Human Rights: Concept Paper [Internet]. (CD50/12). 50th Directing Council of PAHO, 62nd Session of the Regional Committee of WHO for the Americas; 2010 Sep 27−Oct 1; Washington (DC), United States. Washington (DC): PAHO 2010 [cited 2014 Jan 31]. Available from: http://www2.paho.org/hq/dmdocuments/2010/CD50-12-e.pdf

35. Caldas de Almeida J, Cohen A (eds.). Innovative mental health programs in Latin America & the Caribbean [Internet]. Washington (DC): PAHO; 2008 [cited 2014 Jan 31]. Available from: http://www.paho.org/hq/index.php?option=com_content&view=article&id=193&Itemid=247&lang=es

36. World Health Organization. Pharmacological treatment of mental disorders in primary health care [Internet]. WHO: Geneva; ©2009 [cited 2014 Jan 31]. Available from: http://whqlibdoc.who.int/publications/2009/9789241547697_eng.pdf?ua=1

37. World Health Organization. WHO QualityRights Tool Kit: assessing and improving quality and human rights in mental health and social care facilities [Internet]. Geneva: WHO; 2012 [cited 2014 Jan 31]. Available from: http://apps.who.int/iris/bitstream/10665/70927/3/9789241548410_eng.pdf?ua=1

Pan American Health Organization
World Health Organization
REGIONAL OFFICE FOR THE Americas

154th SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 16-20 June 2014

CE154/15
Annex A
Original: Spanish

PROPOSED RESOLUTION

PLAN OF ACTION ON MENTAL HEALTH

THE 154th SESSION OF THE EXECUTIVE COMMITTEE,

Having reviewed the proposed *Plan of Action on Mental Health* (document CE154/15),

RESOLVES:

To recommend that the Directing Council adopt a resolution written in the following terms:

PLAN OF ACTION ON MENTAL HEALTH

THE 53rd DIRECTING COUNCIL,

Having reviewed the *Plan of Action on Mental Health* (document CD53/__);

Recognizing that there is a high prevalence of mental and substance use disorders in the world and that they are major contributors to morbidity, disability, and premature mortality, and that, in addition, there is a wide treatment gap;

Understanding that there is no health without mental health, conceptualized not only as the absence of disease, but as a "state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community";

Considering that, in 2009, the Directing Council of PAHO adopted the Strategy and Plan of Action on Mental Health; and that, in 2013, the World Health Assembly approved the Comprehensive mental health action plan 2013-2020, and that also that same year, PAHO adopted its Strategic Plan 2014-2019, it is advisable and necessary to

update our regional Plan of Action on Mental Health and align it with the PAHO Strategic Plan and with the WHO Comprehensive mental health action plan;

Observing that the Plan of Action on Mental Health addresses the lines of action fundamental for responding to the various of mental health needs of the countries,

RESOLVES:

1. To approve the *Plan of Action on Mental Health* and its implementation in the context of the special conditions of each country, in order to respond to current and future mental health needs.

2. To urge Member States to:

a) include mental health as a priority within national health policies, in order to ensure the implementation of mental health plans that consider the deficit and unequal distribution of resources in some countries;

b) strengthen, develop, review and, if necessary, reform country legal frameworks and their implementation, in order to protect the human rights of people with mental disorders;

c) support the involvement of civil society, and in particular user and family-member associations, in the planning and implementation of activities to promote and protect the mental health of the population;

d) promote universal and equitable access to mental health care for the entire population, through strengthening the response capacity of mental health services within the framework of integrated service networks; with particular emphasis on reducing the existing treatment gap;

e) continue efforts to shift from a psychiatric-hospital centered model to a community-based model that integrates a mental health component into primary health care and general hospitals, and that establishes decentralized, outpatient mental health services, close to where people live;

f) ensure an appropriate response by mental health services to the particular characteristics of vulnerable or special-needs groups;

g) ensure delivery of mental health services and psychosocial support in emergencies and disasters;

h) regard mental health human resources development as a key component in the improvement of the response capacity of services and in particular primary care, for which regular training programs are essential;

i) promote intersectoral initiatives to promote mental health and prevention of mental disorders, with particular attention to the life cycle; and on coping with the stigma and discrimination directed at people with mental disorders;

j) undertake specific suicide prevention interventions that include improvement of information and surveillance systems;

k) bridge the existing mental health information gap through improvements in the production, analysis, and use of information, as well as through research; and

l) strengthen multisectoral governmental partnerships, and partnerships with nongovernmental organizations, academic institutions, and other key social actors.

3. To request the Director to:

a) support Member States in the preparation, review, strengthening, and implementation of national mental health plans and legal frameworks that use this Plan of Action as a reference, endeavoring to correct inequities and giving priority to care for vulnerable and special-needs groups;

b) collaborate in the assessment of mental health programs and services in the countries so that appropriate actions are undertaken based on an existing situation assessment;

c) prepare and disseminate among the Member States a complementary technical document with recommendations on practical options for implementing this plan in the countries, and on measurement of the suggested indicators;

d) facilitate dissemination of information and experience sharing, and promote technical cooperation among the Member States; and

e) promote partnerships with governmental and nongovernmental organizations, as well as with international organizations and other regional and subregional entities in support of the comprehensive response that is required in the process of implementing this Plan of Action.

Pan American Health Organization

World Health Organization
REGIONAL OFFICE FOR THE Americas

CE154/15
Annex B

Report on the Financial and Administrative Implications of the Proposed Resolution for PASB

1. Agenda item: 4.6 - Plan of Action on Mental Health

2. Linkage to Program and Budget 2014-2015:

a) Categories: 2, Noncommunicable Diseases and Risk Factors.

b) Program areas and outcomes: 2.2, Mental Health and Psychoactive Substance Use Disorders.
Outcome 2.2: Increased service coverage for mental health and psychoactive substance use disorders.

3. Financial implications

a) Total estimated cost for implementation over the lifecycle of the resolution (estimated to the nearest US$ 10,000, including staff and activities): For implementation of the Plan of Action it will be necessary to forge partnerships as well as to identify external donors who support the initiative. The estimated gap is 39% of the total budget for the entire 2015-2020 period, concentrated primarily in operating expenses.

It is calculated that the cost of implementation of the Plan of Action for the 6-year period (2015-2020) will be:

Contracting personnel: $8,794,080 (63%) (includes staff currently contracted for mental health, alcohol, and substance use)
Operating/activity expenses: $5,086,000 (37%)
Total: $13,880,080

b) Estimated cost for the 2014-2015 biennium (estimated to the nearest US$ 10,000, including staff and activities):

2014-2015 Biennium (Biennial Work Program, limited to 2015 since the Directing Council will adopt the Plan in September 2014, which means that in practical terms implementation will start in 2015).

Estimated costs for one year (2015):
Contracting personnel: $1,365,680 (fixed staff of the MH-SU Unit) (59%)
Operating/activity expenses: $ 931,000 (41%)
Total: $2,296,680

c) Of the estimated cost noted in (*b*), what can be subsumed under existing programmed activities?: The fixed staff that currently makes up the Mental Health and Substance Use Unit is sufficient to address implementation of the Plan of Action in this biennium and the next one (2015-2017); the funding gap is primarily in temporary contracting that will be necessary for obtaining the support of experts in specific activities and for operating expenses for technical cooperation.

Contracting personnel: $1,315,680 (93%)
Operating/activity expenses: $100,000 (7%)
Total: $1,415,680
Annual gap: $881,000

4. Administrative implications

a) Indicate the levels of the Organization at which the work will be undertaken: The work is planned to be centered on needs of Member States. Priority countries are of special importance, which are those with less developed mental health programs and services (according to the assessments) and those subject to humanitarian emergencies, such as disasters, armed conflict, displaced persons, and violence. Vulnerable and special-needs groups should also be a focus of attention.

The Plan will be implemented at three levels:

- Regional: Mobilization of resources; advocacy; and preparation and dissemination of technical, methodological, and training documents. It offers technical cooperation to the countries for implementation of national mental health plans and for monitoring and evaluation.
- Subregional: Decentralization of technical cooperation in the mental health area is an achievement that began in 2004 and maintaining it is essential. This has made it possible to bring collaboration closer to the countries and ensure support for Member States that need it. It facilitates cooperation among countries, discussion of common problems, and experience sharing. Relations with subregional integration entities (SICA, MERCOSUR, UNASUR, CARICOM) happen at this level.
- National: Development and implementation of national mental health plans under the direction of the ministries of health, with the involvement of other sectors and institutions; this involves support and supervision of local levels. PAHO will provide technical cooperation to countries based on jointly identified needs.

b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile: Current staffing is sufficient for the first two bienniums. It would be advisable, for the last period of the Plan, 2018-2020, to hire a professional with a public health and neurology background, at the regional level, to work on neurological diseases, in particular those for which we already are carrying out technical cooperation actions or those that have Governing Bodies mandates, such as epilepsy and dementias.

c) Time frames (indicate broad time frames for the implementation and evaluation):

- 2014: Approval of the Plan of Action by the Directing Council.
- 2015: Beginning of Plan of Action implementation.
- 2016 and 2018: Biennial evaluations.
- 2020: Final evaluation.

ANALYTICAL FORM TO LINK AGENDA ITEM WITH ORGANIZATIONAL MANDATES

1. Agenda item: 4.6- Plan of Action on Mental Health

2. Responsible unit: Noncommunicable Diseases and Mental Health/ Mental Health and Substance Use (NMH/MH)

3. Preparing officer: Dr. Jorge J. Rodríguez

4. List of collaborating centers and national institutions linked to this Agenda item:

- PAHO/WHO Collaborating Center for Mental Health Training and Policy/Dalhousie University. Halifax, Canada.
- PAHO/WHO Collaborating Center for Reference and Research in Mental Health / McGill University. Montreal, Canada.
- PAHO/WHO Collaborating Center, Center for Addiction and Mental Health (CAMH), Toronto, Canada.
- PAHO/WHO Collaborating Center, National Institute of Psychiatry "Ramón de la Fuente Muñiz." Mexico City, Mexico.
- PAHO/WHO Collaborating Center–Nursing and Mental Health. School of Nursing, University of Alberta, Canada.
- National Institute of Mental Health of Panama City, Panama.
- Mental Health Unit of the Center for Demography and Health (CIDS)/ National Autonomous University of Nicaragua-León. León, Nicaragua.
- Institute of Mental Health of the School of Public Health, University of Córdoba. Córdoba, Argentina.
- Department of Psychiatry and Mental Health of the Medical School, University of Concepción, Chile.
- Department of Psychiatry, University of the West Indies, Mona Campus.
- School of Medicine, Loma Linda University, California, United States.
- Alpert Medical School, Brown University, Providence, United States.
- Substance Abuse and Mental Health Services Administration, United States.
- Andalusian Foundation for the Social Integration of the Mentally Ill (FAISEM). Andalusia, Spain.
- Seventh-day Adventist Church.
- World Federation for Mental Health (WFMH).
- Latin American Psychiatric Association (APAL).

5. Link between Agenda item and Health Agenda for the Americas 2008-2017:

The following links are underscored:

- Statement of Intent: paragraphs 2 and 3.
- Principles and Values: paragraphs 9, 10, 11, and 12.
- Situation Analysis and Health Trends in the Americas: paragraphs 15, 16, 19, 20, 22, 26.
- Areas of Action: paragraphs b, c, e, and f.

6. Link between Agenda item and the PAHO Strategic Plan 2014-2019:

- Linked with Impact Goal #7 (suicide rate).
- Its main link is with Category 2 (Noncommunicable Diseases and Risk Factors).
- Program area 2.2 Mental Health and Psychoactive Substance Use Disorders: Outcome 2.2, Indicator 2.2.1.
- In the PAHO Program and Budget for 2014-2015, it is linked with Outputs 2.2.1, 2.2.2, and 2.2.3.
- The Area of Mental Health and Psychoactive Substance Use Disorders will require effective interprogrammatic work with the other categories and programs.

7. Best practices in this area and examples from countries within the Region of the Americas:

Here we mention several countries with successful and innovative mental health practices and experiences that could be sources of lessons learned, though these are not the only ones (in alphabetical order):

- Argentina: A mental health law that includes the most up-to-date technical and international human rights standards, and which was developed with broad social participation. Work experience with the judicial sector and the human rights area. Several provinces have successful service models (de-institutionalization and community care).
- Belize: Model for decentralized outpatient mental health services, based on PHC, with nurses trained in mental health at the district level.
- Brazil: A national mental health policy developed with broad social participation, reduction of psychiatric beds, establishment of psychosocial health care centers, and social rehabilitation programs for the long-term mentally ill.
- Chile: Development and sustained implementation of a national mental health plan, based on a community-based model and linked to PHC. Financial insurance for service delivery packages for mental conditions.
- Cuba: Development of community mental health centers. Successful suicide prevention program.
- Panama: Reform of the psychiatric hospital, with a substantial reduction in beds and decentralization of services.

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