FRAMEWORK FOR THE IMPLEMENTATION OF THE REGIONAL STRATEGY FOR MENTAL HEALTH

Pan American Health Organization

Regional Office of the
World Health Organization

FRAMEWORK FOR THE IMPLEMENTATION

OF THE REGIONAL STRATEGY

ON MENTAL HEALTH

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FOREWORD

The 49th Directing Council of the Pan American Health Organization/World Health Organization (PAHO/WHO) adopted a resolution on the Strategy and Plan of Action on Mental Health on 2 October 2009. This event constitutes a significant milestone as it clearly puts mental health on the agenda of the governments of the Americas. The resolution expresses the political and technical will to prioritize and continue to promote the processes of change required in this field. It also calls attention to the need to accelerate the implementation of reforms in most countries.

Several conditions in the field of mental health justify this call for action:

- Mental and neurological disorders account for 22% of the total disease burden in Latin America and the Caribbean.
- The mental health needs of the Region's population are increasing, particularly among vulnerable groups. There are no populations immune to mental disorders, particularly those in conditions of poverty.
- There is a significant treatment gap; i.e.; a high proportion of people with mental disorders do not receive any type of care in the health services.
- Evaluations of mental health programs and services conducted in a large number of countries reveal numerous weaknesses in the response offered.
- The obligations assumed by countries in the field of human rights at the international level strengthen the political will of their respective governments to act decisively in this field.

For PAHO/ WHO, implementation of the resolution also represents a major challenge from the standpoint of delivery of technical cooperation. The new Strategy thus becomes a guide for work over the next 10 years. This technical document is the first step to support countries in this regard.

The objective will be to provide specific suggestions and recommendations for adapting and implementing the Regional Strategy within the various national contexts. The Strategy and Plan of Action on Mental Health defines the vision and the "to do," while the Framework for the Implementation discusses in more detail "how to do it." Both are complementary and chart the way forward for the next 10 years at the national and regional levels. It is hoped that the joint efforts of many national stakeholders—together with those of international cooperation—will achieve substantial changes in the response of health systems to mental health problems.

This document was prepared by a working group composed of professionals with practical and theoretical experience in the field. It was subsequently discussed at the Regional Conference on Mental Health: "20 Years after the Declaration of Caracas," held in Panama City, Panama, in October 2010, and subsequently underwent a second review process.

The Regional Conference was a highly productive meeting whose 140 participants represented nearly every country in the Region and included mental health professionals and experts, ministry of health staff and those of other public institutions, PAHO/WHO collaborating centers, the academia, representatives of NGOs and human rights organizations, as well as mental health services users and their families. The rich variety of perspectives offered by this large, heterogeneous group was mutually enlightening and contributed to the strength of the event's success.

Despite the enormous challenges that lie ahead, I remain optimistic. When we look back, the achievements are many, there are innovative experiences in the Region, and many lessons have been learned. The political will of governments is growing. We have proven that we can overcome myths, stigma, discrimination, and contentment with the status quo.

I wish to express my appreciation to all those who have contributed, directly and indirectly, to the preparation of this document. I do hope that it will become a practical tool for planning and implementing interventions in the mental health field in the Region.

Mirta Roses Periago
Director

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INTRODUCTION

The **Strategy and plan of action on mental health**[1] for the Americas was approved by all the ministers of health of the Hemisphere during the 49th. Directing Council of the Pan American Health Organization/World Health Organization (PAHO/ WHO). The **Strategy** presents a concise but thorough situation analysis and defines five key strategic areas, namely:

1. Development and implementation of national mental health policies, plans and laws;

2. Promotion of mental health and prevention of psychological disorders, with emphasis on the psychosocial development of children;

3. Primary health care-centered mental health services delivery. Determination of priority conditions and implementation of interventions;

4. Human resources development; and

5. Strengthening of the capacity to produce, assess and use information on mental health.

These strategic areas are closely linked and the restructuring processes of mental health services can hardly be successful if any of them is excluded. Moreover, the implementation of actions in one area facilitates the development of the others.

The purpose of this document is to provide countries with a referential framework and concrete recommendations on how to implement the *Regional Strategy*. The document consists of five chapters (one per strategic area), each starting with introductory considerations on the respective subject. Subsequently, it outlines a set of basic proposals for action aimed at the implementation of the *Strategy*. In each case, there is a description of the background that justifies the proposal, followed by objectives and recommendations for the countries. Finally, some indicators are suggested to measure the level of implementation. A variety of options with a rational basis will thus be available at the national and local levels. The proposals for action have been reduced to a bare minimum in order to facilitate the tasks and not to overwhelm those in charge of implementing them.

This framework-document is an important tool that should help countries achieve a better understanding of the basic principles of the **Strategy and plan of action on mental health** and how to apply them. National mental health plans can base their actions on many of these recommendations and proposals, adapting them to their own conditions and priorities. Finally, PAHO/WHO technical cooperation will fully align itself with the Directing Council's mandate and with the demands of the Latin American and Caribbean countries.

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1   Pan American Health Organization. Resolution CD49.R17. Strategy and plan of action on mental health. Washington, DC: PAHO; 2009. Available at: http://new.paho.org/hq/index.php?option=com_content&task=view&id=1640&Itemid=1425&lang=en

This document is the result of a collaborative effort and of a consensus achieved during several months of intensive work. A group of experts (see list of authors by chapters) participated in its preparation. It was subsequently submitted to discussion at the *Regional Mental Health Conference "20 years after the Caracas Declaration"*, held in Panama in October 2010. Lastly, the document underwent a second review process. It was translated into English and finally edited in both languages (English and Spanish) between November 2010 and March 2011.

PAHO/WHO Directing Council's Resolution CD49.R17 of October 2009 provides clear and precise recommendations to the Member States and to PAHO/WHO Secretariat. In addition, the participants at the Regional Mental Health Conference adopted by acclamation a final declaration called the *Panama Consensus[2],* with reflections and commitments to immediate action. Among these, the final idea should be highlighted: *The decade of the leap toward the community: for a Hemisphere with no insane asylums in 2020.* Both documents are included in this introduction and we strongly recommend consulting them.

PAHO/WHO and the Editorial Committee reiterate their recognition for all those who participated in one way or another in the preparation of this document, and hope it will be useful for countries to strengthen their mental health national plans and programs and to implement the restructuring of psychiatric services.

49th DIRECTING COUNCIL
61st 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 defines 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, included 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.

Panama Consensus

The Pan American Health Organization/World Health Organization (PAHO/WHO), with the Government of Panama as co-sponsor, convened the Mental Health Regional Conference in Panama City from 7 to 8 October 2010.

The participants included mental health workers from the public sector of the Region of the Americas, national health authorities, representatives of human rights organizations, nongovernmental organizations, academic institutions, and PAHO/WHO Collaborating Centers, as well as users of mental health services and family members.

The participants having noted:

That it has been 20 years since the *Regional Conference for the Restructuring of Psychiatric Care* celebrated in Caracas, Venezuela, an event that marked a historical milestone in the development of all aspects of mental health care at the hemispheric and global level.

That in 1997 and 2001 the Directing Council of PAHO/WHO adopted resolutions requesting the Member States to prioritize mental health and submitted proposals for action.

That the participants of the *Regional Conference on Mental Health Services Reform,* held in Brazil in November 2005, adopted the *Brasilia Principles,* which take note of the new technical and cultural challenges facing mental health.

That in 2008 the World Health Organization formally launched the *Mental health Gap Action Programme: Scaling up care for mental, neurological and substance use disorders* (mhGAP).

Observing with concern:

That, on the one hand, mental disorders and disorders stemming from the use of psychoactive substances (particularly, the harmful use of alcoholic beverages) represent a heavy burden in terms of morbidity, mortality and disability, and on the other, that there is a significant gap in care, which means that a large number of the people affected have no access to adequate diagnosis and treatment.

That while countries have made great strides in the past two decades, serious constraints persist with regard to the effective implementation of national mental health policies and plans, as well as legislation consistent with international human rights instruments.

That despite widespread hemispheric support for the *Caracas Declaration* and the many efforts made in the past two decades by different agencies in the countries, the action taken to reduce the overwhelming dominance of the psychiatric hospital in the model of care is still inadequate.

Favorably noting:

That in September 2009, the Directing Council of PAHO/WHO for the first time adopted a **Strategy and plan of action on mental health** through *Resolution CD40.R17*, which offers clear and viable guidelines and criteria for addressing the issue of mental health.

That in May 2010, WHO for the first time approved a *Global strategy to reduce the harmful use of alcohol* (WHA 63.13) and in September 2010, the Directing Council of PAHO, also for the first time, approved a *Strategy on substance use and public health* (CD50/18).

That the **Strategy and plan of action on mental health** and the *Strategy on substance use and public health are consistent with the Mental health Gap Action Programme* (mhGAP) and with the *Global strategy to reduce the harmful use of alcohol,* especially as they relate to application of the basic packages of interventions in health services based on primary care.

That in October 2010, the Directing Council of PAHO for the first time adopted a specific resolution on *Health and human rights* (CD50.R8) that issues recommendations for protecting human rights in the context of health systems.

That there have been many successful innovative local and national activities, and that both governments and society at large have gradually realized the importance of mental health problems in terms of health and their social and economic impact.

They call on governments and other national actors to:

Promote implementation of the ***Strategy and plan of action on mental health*** through a process consistent with the particular conditions of each country to guarantee an appropriate response to current and future mental health needs.

Strengthen the community mental health care model in every country in the Region to ensure eradication of the insane asylum system in the coming decade.

Recognize protection of the human rights of mental health services users as a basic objective, especially their right to live independently and be part of the community.

Identify current and emerging challenges in national situations that demand an appropriate response by the mental health services, especially psychosocial problems in children, adolescents, and women, as well as population groups in special and vulnerable situations.

Increase the allocation of resources to mental health programs and services and ensure appropriate, equitable distribution of these resources, so that they are adequate to the growing burden of mental and substance use disorders, in the understanding that investing in mental health means contributing to overall health and well-being, as well as to the social and economic development of countries.

The decade of the leap toward the community:
for a Hemisphere with no insane asylums in 2020.

Done in Panama City, on the 8th day of October 2010.

STRATEGIC AREA No. 1

DEVELOPMENT AND IMPLEMENTATION OF NATIONAL MENTAL HEALTH POLICIES, PLANS AND LEGISLATION, AND PROTECTION OF HUMAN RIGHTS IN MENTAL HEALTH

I. INTRODUCTION

The 49th Directing Council of the Pan American Health Organization/World Health Organization (PAHO/WHO) adopted Resolution CD49.R17 of 2 October 2009, which urged Member States to *"include mental health as a priority within national health policies, through the implementation of mental health plans that are concordant with the different problems and priorities of the countries..."* and to *"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"* (1).

The Resolution responded to the recommendations submitted in the **Strategy and plan of action on mental health** (2), which PAHO/WHO submitted for discussion to the Member States during the aforementioned Directing Council. The document states that *"the existence of appropriate policies and plans enables to have a broad, strategic vision of integrated mental health in public health-sector policy and facilitates the organization of services grounded in a community model."* With regard to legislation on mental health, the document adds that such legislation *"provides a legal framework for promoting and protecting the human rights of people with mental disorders."* The Strategy also emphasizes that, in order to meet these targets, it will be necessary to close the enormous gap that exists in the Region between the growing mental health needs of the population and the scant budgetary resources allocated, compounded by their inequitable distribution.

Since effective execution of these policies and plans constitutes an enormous challenge, the document calls for actions to mobilize all of society by establishing "*effective partnerships*" with other stakeholders, *"strengthening ... existing commitments,"* and *"finding new partners,"* such as consumers of mental health services and their families.

These considerations give rise to four clear operational objectives:

• To promote development, implementation, and evaluation of mental health policies and plans, with social mobilization as an integral part of those actions;
• To develop legislation consonant with the regional and international commitments that the countries have acquired;
• To close the budgetary gap so that investments in mental health are commensurate with the burden of disease, and redirect the allocation of resources to permit the restructuring of psychiatric care; and
• To create or strengthen mental health partnerships with all stakeholders, both internal and external to the health sector.

II. Background and frame of reference

Mental health policy and national mental health plans

The existence of rationally conceived policies and plans, based on an analysis of the mental health situation in each country, and consistent with the overall social policies of the state, facilitates the planning, organization, coordination, and management of mental health programs and services. As a result, it becomes more feasible to prevent, either totally or partially, the fragmentation of these interventions, increase their effectiveness, identify key actors and facilitate agreements among them. It also helps ensure an adequate budgetary allocation and an appropriate distribution of budgetary resources. In other words, the efforts of leaders in the field of mental health, as in the public health sector as a whole, should be guided by a rational framework for decision-making and should be approved through a democratic, participatory process involving all stakeholders, including, specially, consumers and their families (3). Indeed, as the **Strategy and plan of action on mental health** points out, this participatory deliberation and development process makes it possible to identify the groups most in need of care with a view to planning with equity.

Once adopted by the highest governmental authorities, the mental health policy is no longer an isolated technical document, but becomes a key instrument that lays the strategic foundation for action on a national scale. Although a mental health policy as a strategic framework is usually adopted at the national level, in countries with a federal structure there can exist policies at provincial, state and regional level, depending on the country's administrative structure.

It is important to note that the fewer resources a country has, the greater the need to develop and implement policies, plans, and programs. However, paradoxically, countries with fewer resources frequently do not follow an explicit plan, either because no plan has been formulated or updated or, simply, because an existing plan has not been implemented. As common sense dictates, if you don't know where you're going, it's impossible to choose the best route to get there or even know whether you've reached the desired destination. Given the overwhelming needs, the limited resources and the demand for effective action, misspent time and public funds implies a serious breach of trust by the mental health sector with the population. Furthermore, the mere existence of a plan makes it possible to inform the population and health personnel as to which priorities will be served, which resources are available to provide these services, which strategies and actions will be implemented, and in which areas their involvement is expected.

It is common knowledge that secondary and tertiary prevention activities carried out within the framework of policies, plans, and programs help improve the quality of life of people with mental disorders and their families. They facilitate consumers integration in the community, increase their ability to work, diminish the symptoms of their disorders, reduce social and psychological dysfunction, prevent co-morbidity with physical and substance use disorders, and reduce premature mortality. Without questioning the merit of all those actions, one can point out that the potential range of available interventions in mental health is much broader (3, 4); indeed, preventive activities remain almost or completely absent from the picture in most cases.

Indeed, the principal and traditional focus, both for society at large and for professionals in the sector, has been on curative action, and to some extent, psychosocial rehabilitation. Therefore, it is common to find that policies, plans, and legislation ignore interventions aimed at primary prevention and health promotion. Given this lack of a tradition of primary prevention and mental health promotion, plans should include them as priorities on the health agenda and provide ways of translating them into concrete actions (see Strategic Area No. 2). That is why the **Strategy and plan of action on mental health** (1) clearly states: *"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."*

It is up to mental health professionals to take responsibility to socialize knowledge about the existence of these two areas of mental health action, and, as a result, increase the population's decision-making capacity, in general, and of decision-makers, in particular. That capacity must be based on the knowledge that different types of mental health interventions are available and that they are based on existing scientific evidence or on best practices. It should be noted that the limitation or absence of such interventions is a transgression of omission from the human rights standpoint.

Mental health legislation

In addition to a national mental health policy and national mental health plan, countries need to be guided by legislation on mental health. This is an essential component of the efforts to bring about a true cultural change when it comes to mental health, both within the health sector and in the larger society. In this regard, the broader the debate that precedes the adoption of a mental health law in a given country (whether at the federal or provincial/state level), the greater the potential it has to become a powerful agent of change in all respects. This is what happened in various countries, such as Argentina and Brazil, when the national mental health law drafts were discussed. These were both later approved by their respective parliaments.

Box 1 summarizes the basic principles of Mental Health Law No. 2440 passed in the Province of Río Negro, Argentina (5), which was also preceded by broad mobilization of public opinion.

Box 1. Basic Principles of Mental Health Law No. 2440*, Province of Río Negro, Argentina.

- Physical restrictions should be applied to people with mental disorders only in exceptional, clearly specified situations;
- Mental illness does not automatically imply disability;
- The exercise of civil rights is required for recovery;
- Changing practices and infrastructure helps to avoid transinstitutionalization and new services based on the asylum model;
- Reintegration of a person with a mental disorder into the community should be coordinated by the most appropriate members of the team, regardless of their academic degree;
- Hospitalization in a general hospital, if necessary, is a last resort, after all other therapeutic options have been exhausted;
- Diverse therapeutic services and resources should be made available to meet the needs of each individual, where he or she lives or nearby; and
- Intersectoral coordination strategies should be adopted.

*Approved by the Legislature of the Province of Río Negro on 11 September 1991. Enacted by Decree 1466, Official Bulletin 909.

Legislation provides a legal framework for promoting and protecting the human rights of people with mental disorders and those of their families and communities, that should guide the development of policies and plans as well as programs and services at all levels of care (6). The advantage of having a mental health law is that it codifies and consolidates basic principles, offering a general framework for mental health actions over a longer time period than a government term. To put the changes into operation, regulations should be drafted for the implementation of the law and be made known to the public at large.

Human rights in mental health

Among other things, Resolution 49.17 of PAHO/WHO Directing Council (1) calls on Member States to continue strengthening their legal frameworks with a view to protecting the human rights of people with mental disorders and achieving effective application of the laws.

This Resolution ratifies a consensus that dates back several decades. In 1946, the Member-States of the World Health Organization agreed on a fundamental international principle whereby *"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition ..."*[2] More recently, in 2007, the ministers and secretaries of health, in the Health Agenda for the Americas (2008–2017),[3] renewed their commitment to the aforementioned international principle and recognized that the *"principles and values"* enshrined in this instrument include *"human rights."* In order to exercise

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[2]   The WHO Constitution was adopted by the International Health Conference held in New York from 19 June to 22 July 1946 and was signed on 22 July 1946 by the Representatives of 61 States.

[3]   The Health Agenda for the Americas (2008–2017) was approved in Panama on 3 June 2007. The Agenda is a high-level policy instrument on health-related matters that guides the preparation of future national health plans and the strategic plans of all organizations interested in health cooperation with the countries of the Americas. This instrument is available at http://www.paho.org/English/DD/PIN/Health_Agenda.pdf .

the right to the enjoyment of the highest attainable standard of health, "*…the countries should work toward achieving universality, access, integrity, quality and inclusion in health systems that are available for individuals, families, and communities ….*"

It should be noted that health protection as a human right is enshrined in 19 of the 35 Constitutions of the PAHO/WHO Member States (Bolivia, Brazil, Chile, Cuba, the Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Uruguay, and Venezuela).

Human rights treaties are general instruments for the defense of human rights that protect all people, without distinction of race, color, gender, language, religion, political affiliation, national origin, social group, economic position, or any other characteristic. Hence, people with mental disabilities are protected by instruments such as the *Universal Declaration of Human Rights*; the *International Covenant on Civil and Political Rights*; the *International Covenant on Economic, Social and Cultural Rights*; the *American Declaration on the Rights and Duties of Man*; and the *American Convention on Human Rights* and its *Additional Protocol in the Area of Economic, Social, and Cultural Rights*.[4]

In particular, article 12 of the *International Covenant on Economic, Social and Cultural Rights* recognizes the right of every person to the enjoyment of the highest attainable standard of physical and mental health. Furthermore, in 1996, the Committee on Economic, Social and Cultural Rights adopted General Comment No. 5, which specifies the application of the *International Covenant on Economic, Social and Cultural Rights* to people with mental and physical disabilities.[5]

The international *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (1984) is also relevant to people with mental disabilities. Article 16, for example, imposes on States Parties the obligation to prevent acts that constitute cruel, inhuman, or degrading treatment or punishment. A practical example is the application, in some psychiatric institutions, of electroconvulsive treatment (ECT) without following protocols or regulations (such as the administration of anesthesia and muscle relaxants). In many cases there is no clear medical justification for its application and, occasionally, ECT seems to be used as punishment.

Not only adults are protected. The *Convention on the Rights of the Child*, an international instrument applicable to people up to 18 years of age, recognizes in article 23 that a child or adolescent with a mental or physical disability should enjoy a full and decent life under conditions that ensure dignity, promote self-reliance, and facilitate the child's active participation in the community. Article 25 recognizes that a child who has been placed in an institution for the care, protection, or treatment of his or her physical or mental health has the right to a periodic review of the treatment provided and all other circumstances relevant to his or her admission.

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4   Vásquez J, Caldas de Almeida JM. DOSSIER OMS. Salud mental y derechos humanos: un nuevo enfoque. Mental Health and Specialized Programs Unit, Pan American Health Organization, Washington, DC; 2002.

5   The General Comments, produced by the bodies charged with monitoring compliance with human right treaties, are an important source of interpretation of the articles in the treaties.

Article 18 of the *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights* (Protocol of San Salvador) states that *"Everyone affected by a diminution of his physical or mental capacities is entitled to receive special attention designed to help him achieve the greatest possible development of his personality. The States Parties agree to adopt such measures as may be necessary for this purpose."*

The *American Convention on Human Rights* (*"Pact of San Jose de Costa Rica"*) also offers certain guarantees and rights that are especially relevant regarding the protection of the rights of people with mental disabilities. Article 4 affirms that every person has the right to have his or her life respected. The right to personal integrity is firmly established in article 5, which is particularly relevant because of the physical abuse to which people with disabilities are often exposed, especially those who are confined to psychiatric institutions. With respect to process, article 25 provides that every person has the right to simple and prompt recourse, or any other effective recourse, to a competent court or tribunal previously established by law, with due judicial guarantees and within a reasonable time. These provisions are intended to ensure that the person is protected against acts that violate his or her human rights and fundamental freedoms. The right to personal liberty established in article 7 is important for all people confined to psychiatric institutions without guarantee of due process; in many such cases, the original circumstances that led to hospitalization have disappeared.

Finally, a treaty that has recently entered into force is the *United Nations Convention on the Rights of Persons with Disabilities.* Its purpose is to promote, protect, and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all people with disabilities and to promote respect for their inherent dignity. People with disabilities include those who have long-term physical, mental, intellectual, or sensory impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others (article 1). Article 12 is of particular relevance to the protection of people with mental disorders. It establishes the obligation of States Parties to ensure that "*all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests."*

In short, these treaties, which are binding on the States Parties, require that they provide protection to prevent the violations of human rights and fundamental freedoms that frequently take place in the context of mental health care and commonly affect people with mental disabilities. These rights include the right to be treated with humanity and respect; the right to voluntary admission to psychiatric institutions; the right to privacy; the right to freedom of communication; the right to vote; the right to receive treatment in the community; the right to give informed consent before receiving any treatment; the right to appeal to an independent and impartial tribunal to determine the legality of detention in a psychiatric institution; the right to judicial guarantees; the right to work; the right to social security; the right to the enjoyment of physical and mental health; and the right to education, among others.

There are other agreements that, though not binding, provide guidelines to ensure best practices. These "international human rights standards"[6] are considered principles or directives and are embodied in declarations, resolutions, or recommendations issued by international bodies.

The *Declaration on the Rights of Mentally Retarded Persons*[7] marked the first time the United Nations called on countries to adopt measures to protect people with mental disabilities (the outdated term "retarded" has since been replaced by "*intellectual disability*"). In 1975, the United Nations General Assembly approved the *Declaration on the Rights of Disabled Persons*, which establishes that people with disabilities have the same civil and political rights as other people. Subsequently, the *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (1991)[8] established minimum human right standards for mental health practice, representing international consensus on the matter.

The World Conference on Human Rights, which was held in Vienna in 1993, reaffirmed that international human rights law protects people with mental and physical disabilities and that governments should adopt domestic legislation to safeguard those rights. In accordance with the recommendations of the World Conference on Human Rights, the United Nations General Assembly approved the *Standard Rules on the Equalization of Opportunities for Persons with Disabilities*[9] as the guiding instrument for the development of public policies. The Standard Rules reiterate the objectives of prevention, rehabilitation and equal opportunity established by the *World Programme of Action Concerning Disabled Persons* of 1982.

There are also technical guides and documents and public policy principles that are valuable sources of interpretation of human rights conventions and can be used to design policies, plans, and programs. Among the most useful is the *Caracas Declaration* (7), adopted in 1990 by the Regional Conference on the Restructuring of Psychiatric Care in Latin America convened by PAHO/WHO. This declaration points out that admission to psychiatric hospitals, as a single or principal form of treatment, isolates patients from their natural environment and causes greater disability. The Declaration establishes a clear link between mental health services and human rights, concluding that antiquated mental health services endanger the human rights of patients. The Declaration also points out that resources and care for people with mental illness should guarantee their dignity and respect their human rights, and that appropriate and rational treatment should be provided to people with mental disorders, making every effort to keep them in their communities (7).

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6   International human rights standards or guidelines also belong to the sphere of public international law and are, for the most part, directives established in declarations, recommendations and reports approved by the United Nations General Assembly, the General Assembly and other organs of the Organization of American States (OAS), the Office of the United Nations High Commissioner for Human Rights, the United Nations Human Rights Council, and the agencies or committees created by the human rights treaties of the United Nations and the OAS. Unlike the binding treaties ratified by PAHO Member States, these standards or guidelines do not have binding force. However, they establish important recommendations that can be incorporated in national plans, policies, legislation, and practices that seek to protect the health of the most vulnerable people. Furthermore, they constitute an important guide for interpreting the provisions of the international human right treaties linked to the health of such people.

7   G. A. res. 2856 (XXVI), 26 UN GAOR Supp. (No. 29) p. 93. UN Doc. A/8429 (1971).

8   G. A. res. 46/119.46 UN GAOR Supp. (No. 49) p. 189, UN Doc. A/46/49 (1991).

9   Standard Rules on the Equalization of Opportunities for Persons with *Disabilities*, G. A. res. 48/96, 48 UN GAOR Supp. (No. 49) p. 202, UN. Doc. A/48/49 (1993).

In 1996, WHO prepared the "Guidelines for the promotion of human rights of persons with mental disorders[10]." In September 2006, the 47th Directing Council of PAHO/WHO adopted a Resolution entitled "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." This Resolution sets a precedent with respect to the recognition of health as a human right by the Ministers of Health, the use of international human rights conventions and standards as important tools in the health field, and the role of PAHO/WHO in its work with regional and international human rights organizations.

In 1997 and 2001, the Directing Council of PAHO/WHO adopted two resolutions on mental health, urging Member States to prioritize mental health in their governmental agendas. Both documents supported and reaffirmed the validity of the principles set forth in the *Caracas Declaration*.

In October 2010, the 50th Directing Council of PAHO adopted Resolution CD 50.R8 on "Health and human rights"[11] in which the Ministers of Health of the Americas committed themselves to working for the improvement of the right to the enjoyment of the highest attainable standard of health and other human rights related to groups in vulnerable situation. The resolution makes specific reference to the use of human rights instruments in the context of mental health and urges PAHO/WHO Member States to:

a) Strengthen the technical capacity of their health authority to work with the corresponding governmental human rights entities, such as ombudspersons' offices and human rights secretariats, to evaluate and oversee the implementation of the applicable international human rights instruments related to health;

b) Strengthen the technical capacity of the health authority to provide support for the formulation of health policies and plans consistent with the applicable international human rights instruments related to health;

c) Support PAHO/WHO's technical cooperation in the formulation, review and, if necessary, reform of national health plans and legislation, incorporating the applicable international human rights instruments, especially those related to the protection of groups in vulnerable situations;

d) Promote and strengthen training programs for health workers on the applicable international human rights instruments;

e) Formulate and, if possible, adopt legislative, administrative, educational, and other measures to disseminate the applicable international human rights instruments on protecting the right to the enjoyment of the highest attainable standard of health and other related human rights among the appropriate personnel in the legislative and judicial branches and other governmental authorities; and

f) Promote, as appropriate, the dissemination of information among civil society organizations and other social actors on the applicable international human rights instruments related to health, to address stigmatization, discrimination, and exclusion of groups in vulnerable situations.

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10   World Health Organization. Guidelines for the promotion of human rights of persons with mental disorders. Division of Mental Health and Prevention of Substance Abuse. Geneva: WHO; 1996 (WHO/NMH/MND/95.4).

11   Pan American Health Organization. Resolution CD50.R8. Washington, DC: PAHO; 2010. Available at: http://new.paho.org/hq/index.php?option=com_content&task=blogcategory&id=1178&Itemid=643

Furthermore, the Inter-American Commission on Human Rights (IACHR) of the Organization of American States (OAS), in accordance with its function of issuing declarations, publications, and reports concerning vulnerable groups, and following the recommendations of PAHO/WHO, adopted the *Recommendation for promotion and protection of the rights of the mentally ill.*[12] Concrete illustrations of these developments are the case of "Víctor Rosario Congo v. Ecuador,"[13] the precautionary measures adopted in the case of the psychiatric hospital of Paraguay,[14] and the case of "Ximenes Lopes v. Brazil,"[15] decided under the auspices of the IACHR and the Inter-American Court of Human Rights.

Other examples of the application of international norms and standards are the decisions of the Supreme Court of Justice of Argentina with respect to the cases of Ricardo Alberto Tufano, Luis Alberto Hermosa, and R. M. J.

Of course, "transgressions of omission", when it comes to the human rights of particular population groups should be a matter of concern to everyone in a country, just as "transgressions of commission", i.e. actual violations of those rights, have begun to be.

III. Current status of policies, plans, legislations and human rights in Latin America and the Caribbean

Findings of the WHO-AIMS Study

A systematic review of the degree of implementation of the actions enables the countries to identify the factors that foster change and those that hinder it. To facilitate this process, the World Health Organization developed the Assessment Instrument for Mental Health Systems (WHO-AIMS) (8). With the support of PAHO/WHO, this instrument has already been applied in numerous countries of Latin America and the English-speaking Caribbean (see Strategic Area No.5).

12   Annual Report of the Inter-American Commission on Human Rights (IACHR), OAS/Ser./L/V/II,111, doc. 20 rev., 16 April 2001.

13   With regard to the case of "Víctor Rosario Congo" (April 1999), the report approved by the IACHR establishes a precedent that it is "pertinent to apply special standards to the determination of whether the provisions of the Convention have been complied with in cases involving persons suffering from mental illnesses" or detainees in psychiatric hospitals, who are considered to be a particularly vulnerable group. In this report, the IACHR determined that the government of Ecuador had violated the right of Víctor Rosario Congo to physical, mental, and moral integrity, to life, and to judicial protection. IACHR Report 63/99, Case 11.427, Ecuador, 13 April 1999.

14   Article 25 of the Rules of Procedure of the Inter-American Commission on Human Rights establishes that in serious and urgent cases the Commission may, on its own initiative or of an interested party, request that the state concerned adopt precautionary measures to prevent irreparable harm to persons. See also: Mental Disability Rights International: "OAS Human Rights Commission orders Paraguay to end horrendous abuses in national psychiatric facility", December 18, 2003.

15   This decision established state responsibility for the acts or omissions of non-state health institutions and, at the same time, affirmed the existence of *"the violation of the right to access to effective remedies and judicial guarantees associated with the investigation of the events",* since *"every person who is in a situation of vulnerability is entitled to special protection, because the State has special duties that it must fulfill in order to satisfy general obligations of respect and guarantee of human rights."* Inter-American Court of Human Rights, Ximenes Lopes v. Brazil, ruling of 4 July 2006.

[xiv] Cohen H, ed. Salud mental y derechos humanos. Vigencia de los estándares internacionales. Buenos Aires: Pan American Health Organization; 2009.

The findings of this study are summarized below with regard to the areas considered in this chapter: mental health policies, national mental health plans, legislation, and human rights.

Mental health policy

The WHO-AIMS study results were, in general uneven. Some countries have no mental health policy at all, thus implying the need to advocate for the development and adoption of a policy that expresses the political will of the government. Other countries have a policy dating to a previous governmental administration, pointing to a need to update it or expand it according to the guidelines proposed by PAHO/WHO (3). In some cases, it might be scattered throughout the policies of other health areas, suggesting the advisability to create a single document to facilitate its easy access to all involved parties.

At times the inquiry found a conceptual and practical confusion as to what constitutes a policy and what constitutes the National Mental Health Plan (NMHP).

National Mental Health Plan

The World Health Organization Mental Health Atlas 2005 showed that 76.5% of the countries in the Americas have a national mental health program; however, not all of these plans are up to date or complete. Another key problem is the extent to which such plans are implemented, the implementation being generally low.

The results of the WHO-AIMS evaluations show that the time has arrived for governments in the majority of the countries to develop (or update), and actively implement a national mental health plan. It is not enough to have a plan on paper; it must be put into practice.

The issue of financing requires a detailed analysis. In principle, the results of the WHO-AIMS study show an obvious gap in this regard. Indeed, in almost all the Latin American and Caribbean countries that completed the study, the allocation for mental health within the total public sector health budget is far from adequate, given the high burden of mental illness. The mental health share ranges from 0.2% to 7.0%, with a median below 1.5%. Such meager budget allocations appear to continue historical funding patterns and do not reflect current epidemiological evidence (9).

Furthermore, in nearly every country, the distribution of the mental health budget is strikingly unbalanced. Two decades after the *Caracas Declaration*, the bulk of the budget is still allocated to psychiatric hospitals, with only a small proportion invested in community-based care and ambulatory services. Indeed, the evaluation clearly showed that in the majority of countries (except for some, such as Belize, Chile, Brazil, and Panama) the distribution of the mental health budget does not take the epidemiological reality into account, nor the aforementioned international and regional commitments (4). Importantly, to change this situation will depend largely on the management of the mental health system itself and not on factors external to it.
Mental health legislation

The situation with respect to legislation is also heterogeneous. In some countries the law on the books is obsolete or inconsistent with modern international standards. Taking the English-speaking Caribbean, for example, in Suriname, the legislation dates back to 1912; in Guyana, to 1930; in Belize, to 1957; in Dominica, to 1987; and in Jamaica, to 1997, where that law is currently under review. Sometimes provisions on mental health are scattered across several pieces of legislation. The results of the study underscore the clear need to advocate for the updating and adoption of a law specifically focused on mental health. The law adopted in Brazil about a decade ago, as well as the new Mental Health Law (No. 26,657) adopted in Argentina in December 2010, can serve as models in other countries.

Human rights and mental health

Closely linked to legislation is the monitoring of human rights. The current status of human rights was analyzed by the WHO-AIMS evaluations and by special workshops held in recent years, where the situation of mental health legislation was also explored, with special reference to human rights. The following summary outlines the results of these two series of exercises. (Possible inconsistencies between the results of the two processes reflect both differences in the sources of information they used and the fact that they took place in different years.)

The WHO-AIMS results described below have been grouped by subregion. In most cases they refer to monitoring activities and human resources training on human rights.

Central America and the Dominican Republic:

According to the WHO-AIMS evaluation, each of the seven countries in this subregion has a human rights review body, but it does not carry out regular systematic activities. This body is usually called the Procuraduría de los Derechos Humanos (Human Rights Office) or the Defensoría del Pueblo (Office of the People's Advocate), and is an autonomous state organ. In Costa Rica it has the authority to impose sanctions. The two psychiatric hospitals in Costa Rica, as well as one of the two in Guatemala, were reviewed or inspected to evaluate the respect for the human rights of people admitted in the year prior to the study. Only 27% of the psychiatric hospitals in the Central American countries and the Dominican Republic have a review system, while none of the community services report having surveillance and review mechanisms.

South America:

Brazil, Chile, and Peru have national organizations that carry out actions in this area. The Brazilian Center on Human Rights and Mental Health began operating in 2006; it has specific objectives but has not carried out an inspection of mental health institutions. Chile has had a National Commission for the Protection of People with Mental Illness since 2001. Half the institutions have carried out staff training activities, but there have been few on-site inspections. In Peru, the Office of the People's Advocate carries out inspections, denounces violations, and prepares documentation. However, the rest of the countries of the subregion reported no such organizations or activities.

The English-speaking Caribbean:

Belize has a commission for voluntary monitoring and reports. In 2006, all staff of the psychiatric hospitalization services received at least one day of human rights training. Dominica has no national monitoring body, but the law contains a provision on psychiatric hospitalization that an interested party could resorts to its use when hospitalization is considered unjustified. Guyana has a regional office with the capacity to review human rights violations, but it has not provided personnel with training on human rights. Jamaica has a national human rights commission, but it does not have the authority to impose sanctions for violations. In 2007, all psychiatric hospital staff had training on human rights, as did 7.0% of personnel in other in-patient facilities. Suriname has a national monitoring organization, but did not report on the training of mental health services personnel.

In conclusion, despite the importance of activities to raise the awareness of mental health workers about human rights and the conducting of some state inspections to monitor respect for human rights in psychiatric institutions, the majority of the countries studied reported few or no activities of this nature. In the absence of regular and systematic monitoring activities, violations can be expected to occur. In addition, the threshold of tolerance in this respect can be high, since personnel are not fully aware of the existence and gravity of such violations.

For more details on the results of the WHO-AIMS study, visit the PAHO and WHO websites:
new.paho.org/hq/index.php?option=com_content&task=view&id=445&Itemid=259
www.who.int/mental_health/who_aims_country_reports/en/index.html

Data compiled at the special workshops held from 2001 through 2004

During the special workshops held from 2001 through 2004, substantial information was compiled on the status of mental health policies, plans, and legislation in 17 countries, with particular attention to human rights[16]. These data are summarized in Table 1.

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16   For more information about the 19 educational workshops on human rights held in the Region of the Americas, see the following publication: Pan American Health Organization. Supporting the implementation of mental health policies in the Americas: A human rights law-based approach. Findings, trends and targets for public health action. Washington, DC: PAHO; 2010.
http://new.paho.org/hq/index.php?option=com_content&task=view&id=4357&Itemid=643&lang=en

Table 1. Status of mental health policies, plans, and legislation in 17 countries in relation to human rights.

	Lack of conformity of laws, policies, and/or plans with human rights norms and standards	Existence of deficiencies in laws, policies, and/or plans with respect to the rights of people with disabilities	General examination and/or review of national laws, policies, and plans to guarantee consistency with human rights norms and standards	Protection of the human rights of vulnerable groups among people with mental disabilities
Antigua			✓	
Argentina	✓		✓	
Barbados	✓	✓	✓	✓
Belize	✓			✓
Chile				✓
Costa Rica	✓			
Dominican Republic	✓		✓	✓
Ecuador			✓	
El Salvador	✓	✓	✓	✓
Grenada		✓	✓	
Guatemala				✓
Honduras	✓	✓	✓	
Nicaragua	✓	✓	✓	✓
Panama	✓	✓	✓	✓
Paraguay			✓	
Peru		✓		✓
St. Lucia			✓	

These data, collected during the workshops, confirmed results obtained with the WHO-AIMS. They showed:

- Absence and/or insufficiency of national legislation, policies, and plans related to mental health that are consistent with international standards on the human rights of people with mental disabilities;
- Need for more specific attention to the human rights of people with mental disabilities who are members of disadvantaged groups (e.g. women, children, the elderly, indigenous peoples) or in special situations (e.g. post-disasters);
- Absence of national legal frameworks with provisions to protect the civil, political, economic, social, and cultural rights of people with mental disabilities;
- Lack of commitment or systematization of national human rights mechanisms and organisms, with regard to the promotion and protection of the human rights of people with mental disabilities;
- Little information among consumers and their families about how to access the mechanisms available to deal with violations;
- Failure of judges to enforce national and international human rights norms and standards

in situations related to the admission, confinement, and case review of persons with mental disorders or disabilities in psychiatric institutions; and

- Absence and/or insufficiency of national legislation and/or policies that support and facilitate the delivery of community-based mental health services.

IV. PROPOSALS FOR ACTION

1. Promote the development and implementation of a national mental health policy.

The mental health policy of a state represents a short-, medium- and long-term strategic vision that provides the framework for implementing a series of activities through the National Mental Health Plan. It should not be necessary for each incoming administration to draft an entirely new policy. Rather, a policy can be carried over, fully or in part, from one administration to the next, thus lending greater stability and continuity to the mental health system. In any case, the mental health policy is expected to incorporate the principles and provisions established in international human rights instruments, particularly the *United Nations Convention on the Rights of Persons with Disabilities*[17].

To operate without a policy is like piloting a ship without a course or compass. This also applies to the national mental health plan and programs. Usually, each political party running in an election, whether presidential or legislative, presents a general platform and specific policy proposals for all the areas in which it will take action if elected. Professionals, technical personnel and all others that deal with mental health in diverse sectors should advocate for the development of an explicit policy on mental health, one that both responds to the psychosocial needs of the population and respects the international and regional declarations and resolutions the country has subscribed.

By way of example, the following are some principles that should be part of every policy:

- Access: mental health care should be delivered within reach of the population, taking into account, among others, geographic, financial and administrative factors;
- Equity: services and programs should provide care at all levels, in accord with people's different needs (that is, more should be provided to those who need more);
- Comprehensiveness: mental health care should have sufficient human resources and infrastructure to meet the diverse needs of people of all ages and all social and ethnic groups;
- Division of responsibilities: each mental health service should assume responsibility for comprehensive care of the population within a defined territory;
- Effectiveness: actions at all levels should be evidence-based and appropriate to the environment within which they are carried out, including costs;
- Coordination: human services within the health sector (maternal and child care, health promotion) and outside the health sector (social security, education, work, and housing agencies, among others) should coordinate their interventions at all levels (mental health promotion, primary prevention, treatment and rehabilitation); and
- Safeguards to ensure the respect for human rights.

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17   The *United Nations Convention on the Rights of Persons with Disabilities* entered into force on 3 May 2008. Text available at: http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf

It goes without saying that a policy should be implemented through operational plans and specific programs. It is essential that the leadership of the health sector and the mental health sector in particular, along with other stakeholders, especially consumers, families, and community leaders, actively and closely monitor the implementation of policy in the public arena and, when relevant, in the semipublic and private arenas as well.

Objectives

- To ensure that political parties running for elections include a clearly formulated mental health policy proposal within the framework of the general health policy. This proposal should be made public early so as to allow an informed debate; and
- To ensure that the policy vision includes all levels and areas of action of mental health (including substance abuse) in the public and semipublic sectors, and, when relevant, in the private sector.

Recommendations

- Provide continuous support to the mental health intra- and intersectoral coordination group or mechanism in their advocacy activities for the development and sustained implementation of the policy at all levels and in all areas of mental health activity (e.g. example, community-based care, human resources development, research, protection of human rights of consumers and their families, etc.);
- Ensure that the policy, while reflecting the vision of elected officials, also takes into account the latest scientific advances, i.e. it should incorporate the most updated available evidence, as well as the informed opinion of as many sectors involved;
- Improve coordination among mental health professionals so that their proposals, which are supposed to be incorporated into the national mental health policy, are, as far as possible, consensual and easily understood by decision makers;
- Ensure that the national mental health policy is faithful to the *Convention on Human Rights of Persons with Disabilities* and other international instruments and standards, as well as to the general principles and recommendations derived from PAHO and WHO Governing Bodies Resolutions (10, 11, 12);
- Adopt a definition of disability that includes all people with mental disorders, regardless of their degree and duration, in harmony with the language of the *Convention on Human Rights of Persons with Disabilities*;
- Promote training of consumers and their families in accordance with international human rights instruments and emerging recommendations, as well as the strengthening of their networks by developing local and regional activities;
- Promote advocacy activities regarding the respect for human rights by professionals and mental health workers, mainly in the psychiatric hospital staff; and
- Ensure, both in prisons' facilities and in extramural spaces, the necessary measures concerning prevention, care and social reintegration, so that the detainees or the released have the necessary resources to address problems caused by mental disorders and substance use.

Indicators

- Political parties running for elections and the government administration have health policy proposals that include the component of mental health and substance use, as well as attention to other psychosocial problems, including aspects related to human rights; and
- The national or provincial mental health intra- and intersectoral coordination group carries out advocacy and monitoring activities concerning the development and implementation of the mental health policy.

2. Promote the development and implementation of a National Mental Health Plan.

The World Health Organization has defined the characteristics and components of a national mental health plan (NMHP) (4). Here it should suffice to emphasize that policy becomes operational through a NMHP. Its development should be led by a technical team at the ministerial level, in close collaboration and democratic consultation with multiple actors (for example, consumers, family members, health and mental health workers, managers and administrators, government agencies, organizations representing minorities, professional associations, universities, NGOs, traditional healers, religious and community leaders). This serves to obtain input from different perspectives, achieve greater consensus and a more comprehensive approach, thus ensuring full implementation.

The NMHP derives from the strategic vision laid out by the policy, while also recognizing and incorporating the recommendations set forth in PAHO/WHO Governing Bodies' Resolutions (10, 11, 12). It should contain provisions to ensure respect for the human rights of people with mental disorders and their families. There is consensus on the need to provide equitable care. This means that priority should be given to groups in a situation of vulnerability identified by the scientific literature and, in particular, by studies carried out in the country and/or the Region (13, 14). It is usually recommended that priority be given to:

- Population groups in a situation of vulnerability (children and adolescents; the elderly; those excluded socially for various reasons, such as the homeless, the unemployed, single mothers, migrants, people affected by HIV/AIDS; people who use alcohol and/or use other substances; indigenous peoples and other ethnic/racial groups; people at risk for suicide); and
- Groups in special conditions or situations, such as populations exposed to disasters, violence and extreme poverty.

The NMHP expresses the macro-level response to an evaluation of the situation in the country. To fulfill the purposes of a formulation that is consistent with the needs and resources of the country, the evaluation should cover, at minimum, the following aspects:

- Health needs associated with the population's mental health, identified by, for example, epidemiological studies and those coming from the behavioral, social and economic sciences, with reference to the characteristics (e.g. ethnic, sociopolitical) and status (e.g. economic, employment) of specific population groups;
- Organization and operation of the mental health system, including services and human resources, and, in particular, the status of compliance with international human rights instruments and standards;

- The attitudes of mental health workers and different population groups regarding community-based care of mental health problems; and
- Availability and allocation of financial resources, as well as a realistic projection of those that can be obtained, to ensure that resources will be sufficient to meet the population's needs and support the process of restructuring psychiatric care.

Objectives

- To develop, carry out and monitor the implementation of a National Mental Health Plan (NMHP) and evaluate its impact in a participatory manner, with active involvement of consumers, family members and representatives of the civil society.

Recommendations

- The Ministry of Health should have specific mental health units, adequately staffed and trained, and with adequate budgets, to effectively lead the implementation of all components of the NMHP, ensuring coordination between the fields of mental health and addictions;
- The intra- and intersectoral mental health consultation and coordination group, particularly consumers, families and other civil society groups, should examine to what degree the NMHP corresponds in practice both to the policy and the results of evaluations. In order to fully implement this recommendation it is necessary that the group above audits, monitors, and evaluates the implementation of the NMHP;
- Analyze the allocation of resources to ensure an equitable response to the needs and priorities of different population groups, especially of those in special situations;
- Estimate the financial and human resources necessary for appropriate implementation of the NMHP and disaggregated programs,
- Negotiate an appropriate budget allocation for the areas of mental health and addictions, as well as support funds;
- Sensitize governments so that they assume responsibility for the financial support of civil society groups, particularly consumers and families;
- Plan budget allocations for mental health that are consistent with the community care model. Investment in mental health should prioritize primary health care (PHC), the community-based mental health care network and the specialized outpatient and inpatient care services in general hospitals. This implies a change in the traditional pattern of budget allocations in which psychiatric hospitals consume 80–90% of the investment in mental health. It also implies the establishment of a monitoring mechanism to control the possible decentralization and re-distribution of budget allocations from psychiatric hospitals to general hospitals and community services; and
- Advocate for compliance to the *Caracas Declaration* (1990), the *Brasilia Principles* (2005), the *Panama Consensus* (2010) and Resolution CD 49.R17: **Strategy and plan of action on mental health,** approved by PAHO Directing Council in 2009. Among other reasons, this resolution was adopted by the Member-States to prevent the construction of new psychiatric hospitals, or to expand the existing ones, and to ensure that general hospitals have a minimum number of beds for psychiatric emergencies and addictions.

Indicators

- Each governmental administration has an updated National Mental Health Plan approved at the highest level and consistent with the vision of the country's health policy, with PAHO and WHO Resolutions, with the findings of diagnostic studies and with international human rights instruments and standards;
- There exists an institutional group (or body or appropriate mechanism) for intrasectoral and intersectoral consultation and coordination on mental health and substance use/abuse, with participation of all stakeholders (public sector institutions, associations of consumers and family members, human rights bodies, NGOs and other civil society actors). The group should meet and act regularly and systematically to review and monitor the degree of implementation of the NMHP and the protection of human rights of people with mental disorders; and
- The Office of the Public Prosecutor for Human Rights, Office of the People's Advocate, or similar official body, has formal and regular mechanisms for monitoring the respect for the human rights of people with mental disorders or disabilities, especially those admitted to psychiatric institutions.

3. Promote the development or updating of mental health legislation.

The evaluation of mental health systems carried out in numerous countries of Latin America and the Caribbean (see above) revealed that the mental health legislation in some of them is outdated or incomplete. As a result, those countries lack a legal basis for actions that the mental health system, directly or indirectly, should carry out (promotion, primary prevention, curative care, and psychosocial rehabilitation), and there is no assurance that their laws are in compliance with international norms and standards that guarantee to the people with mental disorders the full enjoyment and exercise of their civil, political, economic, social and cultural rights. As important input, it is advisable to consult the WHO resource book on mental health, human rights and legislation (6) that provides information and recommendations on the content of such legislation and the processes for its development and adoption by national parliaments.

Objectives

- To promote the development or updating of a mental health law that incorporates the standards and spirit of relevant Resolutions of the Governing Bodies of PAHO and WHO as well as of international and regional instruments and standards concerning human rights, disability and mental health; and
- To ensure monitoring of the full implementation of the law by an intrasectoral and intersectoral mental health group or similar.

Recommendations

- Actively advocate for governments to adopt legislation to ensure the care of persons with mental disorders and substance use in both the public and private sectors;
- Take the necessary actions at the national level to develop or update legislation related to all components of mental health. This will require negotiations with the legislative and

executive branches, as well as strong advocacy with all stakeholders and society in general. The first step is usually to generate interest among a group of lawmakers that are motivated and sensitive to the subject, who can present a legislative initiative in the appropriate parliamentary committee;

- Include in the national legislation the provisions of the *Convention on the Rights of Persons with Disabilities* as well as of other international human rights instruments. If appropriate, harmonize national legislation to make it compatible with those international instruments, in particular with article 12 of the above mentioned Convention, as well as with the obligations related to the protection of personal liberty, fair trial, judicial protection (due process in psychiatric hospitals);
- Encourage agencies responsible for law enforcement, especially the judicial system and independent advocacy groups, to assume a decisive role in ensuring full respect for human rights at the national, provincial and local levels, as established in PAHO/WHO's Directing Council Resolution CD50.R8 on "Human rights and health" (15);
- Coordinate pertinent activities with associations of consumers and families and other civil society actors, who can play a very useful role in promoting action among lawmakers;
- Promote support within the intrasectoral and intersectoral mental health group or mechanism for updating legislation, translating it into regulations, and ensuring its effective implementation; and
- Ensure that legislation provides for the regulation on availability and rational use of medicines.

Indicators

- Existence of a comprehensive law dedicated to mental health, which incorporates up-to-date scientific and human rights standards, together with appropriate regulation; and
- Existence of an intrasectoral and intersectoral mental health group or mechanism to monitor the full implementation of the law.

4. Promote the establishment of mechanisms for monitoring the respect for human rights.

An international movement of protection and respect for human rights began at the end of World War II, as a result of the gross human rights violations that occurred at that time, gathering momentum thereafter. On due course, those rights were spelled out specifically in relation to people with disabilities due to mental disorders. With the return to democracy in Latin America in the final decades of the 20th century, human rights discourse became generalized in those societies, and concrete actions were undertaken by ombudsman's offices or similar entities and by NGOs. Importantly, the *Caracas Declaration* of 1990 linked the human rights focus to technical knowledge, to set in motion processes geared to the improvement of psychiatric care.

Nonetheless, to effectively reduce the risk of human rights violations in psychiatric institutions, specific actions are needed. These include, among others, providing training to mental health workers to sensitize them to human rights issues and creating transparent systems to monitor the level of respect for human rights in the public, semipublic, and private sectors.

Objectives

- To establish or improve the formal mechanism for surveillance and monitoring the respect for human rights of people with mental disabilities and substance use, through the institutions established within the judicial systems of each state. Those institutions should act as a permanent review body of all provisions for laws or sentences concerning those people;
- To forge intersectoral partnerships, especially between judicial institutions and NGOs, to promote awareness in all sectors of society about the human rights of people with mental disorders and substance use and their families, to prevent violations by commission or omisTo promote sensitization and increase knowledge about the human rights of people with mental disorders and substance use, especially among the staff of psychiatric institutions, as well as among service consumers and their families; and
- To develop mechanisms and procedures for monitoring human rights in psychiatric institutions, especially psychiatric hospitals and prisons.

Recommendations

- Include the promotion for the respect of the human rights of people with mental disorders and substance use as a permanent item in the agenda of the intra- and intersectoral consultation and coordination group or similar;
- Establish programs to increase awareness and understanding of human rights in mental health, targeted to the personnel of psychiatric institutions, especially mental hospitals and forensic services, and to consumers and their families;
- Develop national protocols for monitoring human rights that can be used in all institutions that provide mental health care; and
- Establish mechanisms and procedures for monitoring the respect for human rights in mental health services in the public, semipublic and private sectors. These should have the authority to impose sanctions or begin legal proceedings in response to violations.

Indicators

- Existence of an intersectoral group (or mechanism) that functions on a continuous basis and with governmental support, promoting awareness and monitoring of the respect for human rights;
- Mental health services have a registered system for monitoring the respect for human rights;
- Percentage of psychiatric hospitals that have received a human rights-focused inspection by an external auditing organization in the last 12 months; and
- Percentage of mental health institutions that have provided human rights training for their staff during the last five years (or any other period established by the country).

Box 2. Human Rights and Mental Health - An Intersectoral Effort.

One example of intersectoral effort is taking place in Argentina. The "Federal Board on Mental Health, Justice and Human Rights". It comprises members of the Human Rights Secretariat of the Ministry of Justice and of the Mental Health Program of the Ministry of Health. PAHO/ WHO provides technical support.

The Board brought together all stakeholders to pursue a multifaceted strategy to train jointly personnel of both agencies with regard to international standards and PAHO/WHO recommendations for the development of community-based services and to promote concrete actions to protect the rights of people confined to psychiatric hospitals.

Since its establishment, the Board has conducted various initiatives, e.g. regional training workshops and a workshop with national and international experts convened by the Supreme Court of Justice, the Association of Magistrates and the Lawyers Association. In addition, it continuously organizes training activities with the Institute for Judicial Studies of the Supreme Court of the Province of Buenos Aires and with provincial courts, and supports a degree course. Of late, the Board also promoted the adoption of the National Mental Health Law.

The principal lesson learned is that if stakeholders get together, update their knowledge, and share common understandings, responses to apparently insoluble problems do emerge.

Source: Pan American Health Organization. A su salud! Salud mental, derechos humanos y justicia. Buenos Aires: PAHO; 2007.

5. Strengthen multisectoral partnerships inside and outside the health sector.

PAHO/WHO's **Strategy and plan of action in mental health** states that: *"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."* It also suggests the *"creation of an intersectoral coordination structure or entity"* (Box 2).

Experience suggests that given the extensive and complex mental health agenda and its close relationship with health and other social areas, there is no chance of success if the mental health subsector tackles it independently. Therefore, what is required is the involvement of those responsible for providing political will and deciding about public investment, of health workers, consumers, families, NGOs and communities, and, occasionally, the collaboration between governments and international organizations.

Objectives

- To forge intra- and intersectoral partnerships to promote awareness among all social sectors and policymakers with regard to mental health and substance use;

- To create and/or strengthen structures and mechanisms of consultation and coordination for the development, implementation and monitoring of legislation, mental health policies, NMHP, and specific programs; and
- To support the work undertaken by organizations of consumers and/or of family members of people with mental disorders.

Recommendations

- Establish a group (or similar) for national-level consultation and coordination on the development, implementation, evaluation and monitoring of legislation, mental health policies, NMHP, and specific mental health programs. This body should have broad participation by stakeholders in the field of mental health (from inside and outside the health sector) and should establish regular working procedures;
- Establish a similar body for local-level consultation and coordination. This body should also define regular working procedures;
- Encourage and promote the creation and strengthening of consumers and family members organizations, ensuring their autonomy ("empowerment");
- Prioritize justified complaints of consumers in vulnerable situations;
- Promote specific multisectoral mechanisms of social inclusion, encouraging and developing personal autonomy and the inclusion of people with mental disabilities and substance use/ abuse in the open or protected work market;
- Develop multisectoral campaigns for mental health advocacy at all levels, from local to national; and
- Promote technical cooperation among countries in mental health issues, taking advantage of innovative experiences in the Region.

Indicators

- Existence of a group (or similar) of coordination and consultation on mental health (intra- and intersectoral), with an explicit work agenda and that functions on a continuing basis, and with evaluation mechanisms;
- Number of associations of consumers of mental health services and number of members;
- Number of family associations of people with mental disorders and number of members; and
- Participation by consumers and family members associations in the design and implementation of the National Mental Health Plan and specific programs.

V. CONCLUSIONS

Section 3 of this chapter summarized the principal findings obtained by the WHO-AIMS evaluation studies of mental health systems in selected countries of the Region, as well as the findings of *ad hoc* workshops. Those explorations, carried out by countries with support from PAHO/WHO, revealed the current state of policies, national plans, legislation and human rights monitoring in mental health. These data made it clear that appeals for action, issued on various occasions by the same PAHO and WHO Member States, must lead to implementation of the concrete and feasible proposals for action that are listed as recommendations in Section 4 of this document. The recommendations, directed to all interested sectors of government and civil society, are intended to facilitate the improvement of the current situation through the adoption of legislation, the creation of human rights monitoring mechanisms and the development of mental health policies and plans.

As already emphasized, in each country the national mental health policy, national mental health plan and legislation will need to be developed or modified in accordance with the reality of the respective country and its international and regional commitments. Furthermore, surveillance and training activities need to be carefully programmed to avoid human rights violations, whether by commission or omission.

Fortunately, each country currently has guidelines and technical supports developed by PAHO and WHO that facilitate the tasks ahead. This document has presented examples of possible actions that complement the **Strategy and plan of action on mental health**. As noted above, the recommended actions are not only the responsibility of national mental health experts but must necessarily involve a large set of actors; first and foremost among them are the consumers of mental health services and their families. It is the cooperative action by all stakeholders, together with a mobilized public, that can—and must—change the present situation, making it possible to better serve the mental health needs of the population in the Region.

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STRATEGIC AREA No. 2

MENTAL HEALTH PROMOTION AND PREVENTION OF PSYCHIATRIC DISORDERS WITH EMPHASIS ON CHILDREN AND ADOLESCENTS

I. INTRODUCTION

The provision of a proper answer to the high prevalence rates of mental disorders in the Region, coupled with the limited supply of services, constitutes one of the main objectives of the **Strategy and plan of action on mental health** (1), approved in October 2009 by the 49th Directing Council of the Pan American Health Organization (PAHO/WHO). Mental health promotion and the prevention of mental disorders are two intertwined areas of intervention that can help the countries meet such a challenge and, concomitantly, improve the well-being and quality of life of their populations (1, 2). It is for this reason that Strategic Area No. 2 proposes to "*include the component of mental health promotion and prevention of mental and substance use disorders in mental health plans, ensuring the implementation of special activities with children and adolescents*" (1).

Emerging research evidence and observations made during the course of interventions have demonstrated the effectiveness of promotion and prevention programs, more with reference to the latter than to the former (2). Drawing on those two sources of information, Strategic Area No. 2 provides a conceptual framework for guiding the development and/or implementation of these programs.

This chapter lays out several proposals for action. Some are specifically intended to provide interventions for primary prevention. There are others aimed at mental health promotion, while others use a mixed approach, given the tenuous boundaries between these two areas of action. Other areas such as secondary and tertiary prevention are also addressed in this chapter when such proposals can affect the mental well-being of the population.

II. CONCEPTUAL FRAMEWORK

Promotion and prevention in mental health care

Mental health promotion and the prevention of mental disorders are basic components of a public health approach within the framework of the right to health. It should be recognized that human rights principles (e.g. availability, access, acceptability, and quality) apply both to prevention and promotion as well as to curative care and rehabilitation. Over the years, the human rights systems of the United Nations and the Organization of American States have produced specific legal instruments (see Strategic Area No. 1) that can be used to protect the right to health of people at all levels. The actions considered here should include children and adolescents, who are often neglected in mental health plans and programs (3).

According to the World Health Organization (WHO), "*health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*" (4). This definition implies that these areas (physical, mental and social) are closely intertwined and should be reflected in interventions that seek a multidimensional effect. As an illustration, a program aimed at controlling stress (e.g. at work) can simultaneously contribute to modify the risk of a somatic disorder (e.g. hypertension) and to improve the social environment (2).

This comprehensive vision of health emphasizes the interrelationship between promotion/prevention and health recovery/rehabilitation, as well as the concept that mental health promotion is part of health promotion in general. It also makes clear that intra- and intersectoral collaboration is essential to address the health-disease process. Thus, programs geared to children and adolescents necessarily involve mental health and the maternal and child subsectors, as well as other sectors from outside health, such as education and social welfare.

As noted above, mental health promotion and primary prevention of mental disorders are related spheres, with no clear dividing line between them; as a result, interventions can overlap. Operationally, in order to decide whether an intervention fits within one area or the other, one must examine its goals and results (5). Mental health promotion seeks to foster positive mental health by improving people's resources and building on their strengths and abilities to cope with difficulties. In addition, it seeks to encourage the establishment of adequate living conditions and empower social actors to ensure that these conditions can be achieved. Mental health promotion initiatives can be planned at several levels. They can be directed to society as a whole, to specific communities (e.g. neighborhoods, schools, workplaces), or to people who are in special or vulnerable situations (e.g. children who live in poverty, in institutions or in the streets) (2).

> Primary prevention interventions for mental disorders must be supported by evidence-based data. These interventions can be grouped into three categories:
> 1) Universal, when the target of the intervention is society as a whole;
> 2) Selective, when the target is a specific population group; and
> 3) Indicated, when the target is an individual or family group at high risk of suffering from a mental disorder (6).

The process through which mental disorders start and develop has different stages and in each of those stages preventive action can be implemented. The earliest one is primary prevention, which is aimed at people who do not have problems or disorders or are at risk of developing them. It seeks to reduce their incidence. The next level of action is secondary prevention, which aims to prevent the progression of a disorder, limit its damage and restore health. It seeks to reduce the prevalence of a disorder. Finally, tertiary prevention focuses on physical, mental and social rehabilitation, to enable people to achieve the best possible quality of life. It seeks to reduce the disability caused by the disorder (6).

Risk factors and protective factors

A large part of the strategies to promote mental health and prevent psychological disorders depends on the identification of risk factors and protective factors *(7, 9, 10, 11)*. These can be classified

in terms of the individual, the family and the community, including economic and environmental contexts (2, 7, 9). Interventions to avoid or overcome specific risk factors, as well as those that strengthen protective factors will have a positive impact on all population groups. With respect to children and adolescents, such interventions will have a positive impact on their development, both immediate and long-term (e.g. actions to prevent child abuse, which can cause psychopathology not only at early age but also in adulthood).

Risk factors (e.g. environmental) interacting with elements of vulnerability (e.g. child´s temperament or difficulty to interact) can result in greater severity and longer duration of health problems. Protective factors, on the other hand, refer to conditions that bolster resistance to disorders and reduce their risk. Protective factors reduce the probability that a mental disorder will occur, either by lowering the person's exposure to risk factors or by mitigating their effects. Preventive actions, whose objective is to strengthen protective factors, overlap with mental health promotion, since the majority of these protective factors (e.g. adequate self-esteem, positive thinking, resilience, problem-solving skills, social skills and others) are considered positive aspects of mental health (7).

Risk factors

- *Individual*: genetic vulnerabilities; health problems (e.g. example, chronic diseases); neglect and maltreatment of children. Other individual risk factors can be the result of preexisting problems such as difficulties in school, interpersonal problems with friends or family members and substance use;
- *Family*: family conflicts or disintegration; family history of severe and persistent mental disorders; domestic violence and incest; parental absence, whether psychological or physical; low educational status of the family; social isolation; and family communication problems;
- *Community*: extreme poverty; unsafe neighborhood; exposure to assaults and violence; discrimination; belonging to a discriminated minority group; lack of access to health and education services; limited opportunities to study, work, or take part in extracurricular activities (e.g. cultural and recreational); and
- *Institutional*: systematic violations of fundamental rights of patients at treatment centers for addictions to alcohol and other drugs; disorganized schools and prisons, with marked climate of violence.

Protective factors

- *Individual*: good physical health; healthy habits; positive attitude and character; strong friendships; appropriate social skills; sense of hope and optimism; adequate self-esteem; ability to manage stress; adaptability; high intelligence; professional goals and existence of a life project (in some contexts);
- *Family*: satisfaction of basic needs, ensured by decent and stable employment; stability and cohesiveness; encouragement and reinforcement of positive activities and behavior; stable family life; recognition of achievement; support for positive goals; promotion of friendship, mutual assistance and tolerance; establishment of appropriate limits on behavior;

- *Community*: educational and professional opportunities; activities for children and adolescents (e.g. sports and educational activities); social support; support for families with special needs; legislation to protect young people; safe environment (absence of violence, drug use or pollution); opportunities for sustainable economic development (e.g. training and credit to help people in poverty start small businesses); and
- *Institutional*: organizations based on people's needs and offer good treatment; proactive environmental institutions; institutions that facilitate care for the disadvantaged (e.g. disabilities, ethnic minorities) and promote social responsibility for the mental health of the population.

The analysis of protective and risk factors linked to mental health is especially important in designing promotion and prevention interventions. Simultaneous interventions at several levels will increase the likelihood of success. For each action, planners should consider not only the group to which the action is targeted but also the environment in which this group lives (8, 11).

Mental health of children and adolescents

Contrary to common belief, mental disorders are usual during childhood and adolescence. In addition to specific disorders, though rarely limited to those two groups, many disorders diagnosed in adults can begin in early years. It should be noted that estimates of psychological morbidity in children and adolescents should be viewed with reservations since conditions are sometimes diagnosed during phases of individual development where it is difficult to differentiate clearly between phenomena that are part of normal development and those that are abnormal.

Psychopathology in childhood arises from complex interactions between specific individual characteristics (genetic, biological and psychological) and the environment surrounding the child (parents; siblings and extended family members; friends and neighborhood; school and community; and the broader social, economic, cultural, ethnic and gender context).

An analysis of the results of 10 epidemiological studies on mental disorders in children and adolescents conducted in Latin America and the Caribbean showed a prevalence rate of approximately 15% (12). Depressive disorder and suicidal behavior increased markedly in adolescence (13). It has been found that severe depression frequently begins in adolescence and gives rise to relatively high suicide rates in this age group (14).

According to available evidence, anxiety disorders (separation anxiety, phobias and post-traumatic stress disorder) are the most common mental disorders in children and adolescents. Although psychotic and eating disorders occur less frequently, they continue to arouse significant concern in the public health sector and society because of the severity of the psychopathological problem, the disability they generate (and the resultant family burden) and the associated risk of mortality.

Disruptive behavioral disorders (attention deficit hyperactivity disorder, conduct disorder, and oppositional defiant disorder) are common and of special concern to families and schools. These disorders are often treated with psychotropic drugs, which may not be fully justified in all cases (15).

Recently, an increase has been observed in the prevalence of pervasive developmental disorders (including autism and Asperger syndrome), partly due to higher levels of detection. Autism is characterized by deficits in social behavior and communication and severely limited activities (16, 18). Current data indicate that autism is probably caused by a combination of risk factors, both genetic and environmental. The symptoms of autism range from mild to severe, with considerable variation in the clinical picture. Many patients require lifelong care and have other medical problems. In the United States, the American Academy of Pediatrics has recommended compulsory autism screening for all children aged 18 to 24 months. Available data suggest that early behavioral intervention can lead to significant improvements in cognition and social communication and have an impact on long-term outcomes (18).

During childhood and adolescence, emotional and mental well-being influences health in very specific ways. Mentally healthy children and adolescents enjoy a better quality of life and function better at home, in school and in the community (19). Conversely, adverse experiences in early childhood, such as abandonment, maltreatment or abuse, are associated with a wide range of adverse results later in life, including greater risk of suffering from chronic diseases, engaging in suicidal behavior, higher utilization of health services and experiencing various mental disorders.

> The onset of mental illness in childhood or adolescence has negative effects on long-term development (20-24). There is currently widespread consensus that many mental disorders in adults are already present in earlier ages (25). These data underscore the importance of mental health promotion and the prevention of mental disorders in children and adolescents.

III. EVALUATION OF SOME ASPECTS OF MENTAL HEALTH PROMOTION AND PREVENTION OF PSYCHIATRIC DISORDERS

The assessment study of mental health systems using the World Health Organization Assessment Instrument for Mental Health Systems, known as WHO-AIMS (26), identified some problems related to promotion and prevention in different countries of the Region. Some of those findings are summarized below.

In six Central American countries plus the Dominican Republic, evaluators looked at the presence of school-based programs for mental health promotion and the prevention of psychiatric disorders. Nicaragua had programs in approximately 20% of elementary and secondary schools; in Guatemala, Honduras, Panama and the Dominican Republic the percentage found was between 21% and 50%; and in Costa Rica and El Salvador, it was between 51% and 80%.

Among the English-speaking Caribbean countries that evaluated their mental health systems, Belize reported that 51% to 80% of elementary and secondary schools had programs of this type; Jamaica, 21% to 50%; and Suriname, 1% to 20%. Dominica and Guyana reported no programs.

With regard to educational actions geared to the public, five of the seven countries in the Central America/Dominican Republic group reported that they had an agency in charge of implementing

such actions. The countries of the English-speaking Caribbean did not have specific agencies for that purpose, but they reported that actions targeting different population groups and sectors were carried out under the umbrella of the Ministry of Health.

Among the countries that conducted the WHO-AIMS evaluation in South America, Bolivia, Chile, Paraguay, Peru, and Uruguay identified only a minority of schools (1% to 20%) where promotion and primary prevention programs were implemented. Brazil reported that it had such programs but did not provide the percentage. In Ecuador, 21% to 50% of schools had such programs, but only at the secondary level.

Bolivia, Chile, Ecuador, Paraguay, and Uruguay carried out campaigns geared to the public through several institutions, but without central coordination, while Brazil and Peru carried them out with coordination by the Ministry of Health. The countries did not report whether the actions performed were subject to evaluation.

In short, with few exceptions, promotion and primary prevention activities were found to be limited in the countries evaluated, thus reducing the possibilities of decreasing the burden of disease and increasing psychological well-being. The gap between what is available in the area of promotion/ primary prevention and what is available in the curative area is wide. This gap needs to be reduced for the benefit of the population.

IV. Proposals for action

1. Establishment and strengthening of intrasectoral and intersectoral collaboration.

Intra- and intersectoral collaboration strengthens mental health actions and helps obtain results on priority issues where responsibility is shared among different sectors: governmental institutions, local authorities, community leaders, the media, professional organizations, religious institutions and civil society organizations in general. The objectives pursued are, among others, to generate new understandings, explore appropriate mechanisms for joint action, increase acceptance of actions by the public, evaluate interventions and improve the evidence database to support better decision-making (for the latter, see Strategic Area No. 5).

Forging partnerships and coordinating activities is a challenge and requires serious discussion and a clear understanding and acceptance of the distribution of functions and responsibilities among different sectors and actors (2, 7, 9).

Intra- and intersectoral partnerships and joint work can have an impact on the early risks associated with developmental problems during the prenatal period, in early infancy, and in childhood and adolescence. Such cooperation can facilitate the implementation of strategies to increase access to health care and other services for children, and it can help identify options for promoting healthy lifestyles and strengthening protective factors (2, 7, 9).

Objective

- To strengthen collaboration with stakeholders within and outside the health sector for mental health promotion and primary prevention of mental disorders and drug use related disorders.

Recommendation

- Establish a committee or working group with the participation of all relevant stakeholders within and outside the health sector, for the development of sustainable joint action program for mental health promotion and primary prevention of mental disorders and those related to substance use. This collaboration mechanism can be developed within the framework of the coordination group involved in the National Mental Health Plan. The working group should define the monitoring and evaluation component to ensure the effective and transparent implementation of planned actions.

Indicator

- Existence of a joint committee or working group, including representatives of all sectors involved, which can design and implement a program for mental health promotion and prevention of mental disorders and those related to substance use, based on scientific evidence or, failing this, on best practices.

2. Include a promotion and primary prevention component in the national mental health policy and plan, with emphasis on children and adolescents.

Programs for mental health promotion and the prevention of mental disorders seek to protect, improve, and maintain the psychosocial well-being of the population from the moment of conception through childhood, adulthood and old age. As noted earlier, those programs are aimed both at people who are currently healthy and those who are at risk of suffering mental and psychosocial health problems. They employ various interventions of a multidisciplinary, intrasectoral and intersectoral nature.

The **Strategy and plan of action on mental health** (1) recommends that national mental health plans include specific programs for mental health promotion and prevention of mental disorders, supported by evidence-based data.

As mentioned above, country reports from the evaluation conducted with the WHO-AIMS (27) revealed that investment in health promotion and primary prevention was minimal or nonexistent, at least with respect to the school systems, the component analyzed in greatest detail. It was also reported that, in general, in all countries the mental health budget was intended primarily for curative services and largely ignored for promotion and primary prevention programs.

It is necessary to emphasize the importance of including promotion and primary prevention components in mental health national plans, as well as for disasters preparedness, particularly in relation to children and adolescents (Box 1).

Box 1. Chile Grows with You

Chile Crece Contigo (Chile Grows with You) is a comprehensive social policy initiative of the government that takes an intersectoral and multidisciplinary approach to child protection. Through this program, children are covered from conception by appropriate and timely services that provide early stimulation and favor comprehensive development of the child. The purpose of the system is to provide equal opportunities from the earliest stages of life and to eliminate differential opportunities arising from socioeconomic disparities.

Children from needy families can attend free day-care centers and kindergartens. The system consists of: 1) an educational program for all citizens; 2) legislation and standards for the protection of motherhood and fatherhood; and 3) care for all children until the age of entry into the school system: better prenatal check-ups, humanized childbirth procedures and improved health check-ups, especially during the first two years of life (biopsychosocial support). Support also includes grants for families in vulnerable conditions. See: http://www.crececontigo.cl/.

Objectives

- To integrate a component of mental health promotion and primary prevention of psychiatric disorders in the national mental health policies and plans, with special emphasis on children and adolescents;
- To design early intervention programs to reduce or eliminate risk factors and increase protective factors, aimed especially at minors in vulnerable psychosocial situations, such as extreme poverty and marginalization; and
- To sensitize and collaborate with local communities in developing programs for primary prevention that respond to priority issues, such as violent conduct, substance use and suicidal behavior.

Recommendations

- Include mental health promotion and primary prevention in national mental health policies and plans and develop programs that emphasize children and adolescents, drawing on evidence-based data and supported with concrete budgetary allocations;
- Develop programs for promotion and prevention that: 1) are based on documented and successful experiences that promote healthy lifestyles, strengthen protective factors and the capacity for resilience and reduce risk factors; 2) clearly identify target groups; 3) ensure sustainability within the system by including and, when appropriate, training actors from different institutions that are motivated and whose mission is consistent with the objectives and methods of the program (e.g. users, families, schools, leaders, community organizations and professionals); and 4) include a monitoring and evaluation component (2, 7, 9);
- Support social protection programs geared to the most vulnerable groups in the community, such as programs aimed at reducing poverty and guaranteeing full employment;
- Strengthen the psychosocial component of primary health care (PHC), and include health promotion and primary prevention, based on priorities identified at the local level;

- Develop mental health protocols designed specifically for PHC, with action guides for promotion and primary prevention; and
- PHC actions should be supported by the specialized level through a regular process of supervision and consultation (also see Strategic Area No.3).

Indicators

- Existence of a specific section on mental health promotion and primary prevention in the national mental health policy and plan, that includes measures for monitoring and evaluation; and
- Proportion of PHC centers that have mental health protocols for primary care that include actions related to mental health promotion and prevention of mental disorders and those related to substance use. For its implementation the PHC staff should be trained and enjoy the support and supervision of the specialized level.

3. Develop programs for mental health promotion and primary prevention in specific settings.

Environments such as the school, the workplace and the judicial system, to cite only a few, are natural and key locations where there is potential for strengthening intersectoral cooperation and between institutions. They all offer the opportunity to work with well-defined population groups and to promote concrete interventions in the field of health promotion and primary prevention of mental disorders, including substance use (Box 2).

Box 2. Experience in Santiago Atitlán, Guatemala

The experience in this municipality, which has a predominantly indigenous population, is of special interest. A program for mental health promotion and prevention of mental disorders was incorporated within the portfolio of the Municipal Health Network, which created a special committee on mental health. The Network played an active role in the leadership and coordination of actions. Two indigenous women served as local promoters and were crucial in helping the population understand and accept the program. A key element in treatment adherence by people with severe mental disorders was family participation in the program.

Source: Report by the Ministry of Health and the PAHO/WHO Representation in Guatemala.

Comprehensive mental health care is important at every stage of life and should be implemented on the premise that biopsychosocial needs vary according to the context. Mental health care for children and adolescents should adopt a comprehensive approach that prioritizes mental health promotion and primary prevention, closely integrated with actions for treatment or cure, within the framework of the home, the school and the community (8, 28).

Maternal and child health services

Mothers continue to be the principal providers of primary care for children. Available evidence shows that the mother's mental health and her educational level have a direct impact on the well-

being of the child. For example, the children of women suffering from depression are at risk of delayed development and accidents, and the children of parents who react poorly to traumatic events are at risk for symptoms of post-traumatic stress (29). Infants born to mothers who abuse alcohol during pregnancy may have fetal alcohol syndrome. Consequently, it is important to closely attend to mothers before and after delivery with a view to improving their mental health and their capacity to raise and care for the child. It has been shown that home visits, particularly to young mothers at high social risk, by nurses and, to a lesser degree, by paraprofessionals, prolong the period of breastfeeding and reduce the use of corporal punishment on children, as well as the risk that they develop behavioral disorders in adolescence (37, 38).

Schools

Research has shown that lack of access to education, or limited education, constitutes a risk factor for various health disorders (physical and mental) and reduces employment opportunities. This situation sets in motion a vicious cycle of poor health and poverty (30, 31).

School is a fundamental component of children's lives (and kindergarten, if available), where they spend many hours of the day and months of the year (10). Therefore, school is also a privileged setting, and possibly the most appropriate place, to develop programs for mental health promotion and primary prevention. Besides, teachers and other school staff are well positioned to detect mental health problems among students, with the possibility of intervening and/or referring students to other services. However, in most countries of Latin America and the Caribbean, insufficient training of teachers in psychosocial issues is a real limitation. Another problem is the scarcity of specialized personnel (such as psychologists or trained nurses) devoted to mental health work in schools and other educational institutions. This situation could be better corrected when mental health services are based in the community (see Strategic Area No. 3).

The following are some examples of activities that can be included in health promotion school programs:

- Activities to increase self-esteem and encourage conflict resolution, socializing with peers, the observance of norms and the reduction or elimination of violent behavior and substance use;
- Secondary prevention interventions aimed at children and adolescents, include timely referral of students who show early symptoms of an emotional or behavioral disorder, initially to school personnel with special training, and if that fails to produce results, to a mental health professional, whenever available; and identification and referral of preschool and primary school students with academic problems for appropriate assessment (psychological and educational tests, speech evaluation). Needless to say, the earliest the identification and care of a problem (curative and rehabilitation), the better it will be solved and the lower the possibility of complications to appear; and
- Specific support to teachers and school workers in solving their own psychosocial conflicts and mental disorders. A good way to begin addressing problems of a psychosocial nature would be the development of the school code of conduct with active participation of parents, students, authorities, teachers, administrative and service staff.

Workplace

As mental disorders tend to arise at an early age they can cause a high burden, have a significant social impact and can entail high indirect costs due to reduction of labor productivity. In many industrialized countries, between 35% and 45% of labor absenteeism is caused by mental health problems. According to a study carried out in Canada, between 30% and 50% of disability benefits are due to mental health conditions (32).

Unemployment and job loss are well-researched health risk factors. Various studies have demonstrated that unemployed people are more likely to have symptoms of depression and alcohol abuse than people in full employment. People who lose their jobs have twice the probability of suffering depression as those who remain employed. Another significant finding is that "*even if an employee does not take sick leave, mental health problems can result in a substantial reduction in the usual level of activity and performance*" (29, 32). An important conclusion is that full and satisfactory employment is the best prescription for the good mental health of the adult, and, indirectly, of the whole family.

On the other hand, the workplace is a source of stress and serious conflicts for many adults. Programs for mental health promotion and prevention can address some of these difficulties, with favorable impact on individuals and their families. The work environment is ideal for carrying out such actions. Examples include programs to reduce alcohol use and those aimed at early detection and management of depression or at prevention of sexual harassment and its adverse psychological consequences (33). Many workplaces currently have health promotion programs, and they should all incorporate the mental health component in those initiatives.

It is important not to overlook that, while child labor is an activity regulated by law in different countries, it is a growing problem in developing countries18. As stated in the *Convention on the Rights of the Child*, children have *"the right to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development."* The working conditions they are exposed to, added to other related social determinants, may put this population's mental health at risk.

Community

Community development programs, particularly those directed to low-income populations and vulnerable groups are more effective when they have a dual approach. On the one hand, they focus on the individual trying to promote psychological, economic and social welfare, on the other, their purpose is to promote the environmental well-being of the community. This requires a participatory process that encourages both, well-founded decision-making by community members, based on the identification of solutions to priority local problems, and the implementation of joint activities. In recent years, urban and peri-urban unplanned growth has led to the emergence of social

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18   United Nations Children's Fund. Beyond child labour, affirming rights. New York: UNICEF; 2001. Available at: http://www.unicef.org/publications/index_4302.html

groups, mainly young, excluded and also excluding, with high risks to their mental health, such as suicidal behavior, substance use, violence and low levels of social tolerance. This process of urban disorganization has turned public spaces meant for recreation into highly dangerous areas.

The development of social networks could allow communities and urban and peri-urban groups to be better informed, assume responsibility for their lives, take on the construction of healthy public spaces and have greater opportunities to improve their situation. All this requires maximum support from local and national authorities and the private sector (2, 9).

Judicial system

The judicial system and the mental health services should coordinate actions to ensure that national mental health legislation, policies and plans include promotion and primary prevention as part of their agendas. The provision of basic information on individual and collective rights, national and international jurisprudence on human rights and the sanctions involved when failing to comply with it, could reduce the violation of human rights by omission (see Strategic Area No. 1).

Training programs for workers in the judicial system should cover the human rights standards established by international organizations (United Nations) and regional bodies (Inter-American Commission on Human Rights of the Organization of American States), as well as essential concepts with respect to mental disabilities, mental health and human development, especially in childhood and adolescence.

Objective

- To develop programs for mental health promotion and primary prevention together with all sectors involved, including, though not exclusively, maternal and child health services, the school system, workplaces, communities and the judicial system.

Recommendations

- Implement interventions for mental health promotion and prevention, based on intrasectoral and intersectoral collaboration, in selected settings such as schools (for children and adolescents) and universities; workplaces (for adults, but equally addressing the problem of child labor); maternal and child health services (for parents and children); the community (including religious organizations and neighborhood associations); and primary health care services;
- Formulate early intervention programs to promote the psychosocial development of the child through the support to parents and families; community actions for protection of children and adolescents; expansion of early childhood education opportunities (and for mothers); implementation of psychosocial programs in schools; and early diagnosis of mental disorders (1);
- Develop intervention programs for adolescents at risk of coming into conflict with the law; and
- Implement programs for promotion and primary prevention in maternal and child health services that include home visits to young, single mothers in situations of poverty during pregnancy and the first two-three years of the child's life.

Indicators

- Proportion of maternal and child health services with programs for mental health promotion and primary prevention, including home visits to young mothers during pregnancy and the first two-three years of the child's life;
- Proportion of schools with programs for mental health promotion (or health promotion that includes a psychosocial component) and prevention of mental and behavioral disorders;
- Proportion of workplaces with wellness programs that include a mental health component;
- Proportion of justice officials who have received training in mental health and substance use issues based on a human rights approach; and
- Proportion of municipalities that have established mental health promotion and primary prevention programs that include a psychosocial component, with special emphasis on children and adolescents.

4. Develop public education programs on mental health issues that include collaboration with the media.

In general, the information society possesses on mental health issues has increased over the years, since the time when people with mental disorders were routinely put away in insane asylums. Nonetheless, despite these changes, in many societies there is still widespread ignorance about mental health and mental disorders.

Public education campaigns can help reduce discrimination in relation to people with mental disorders and, to a certain extent, dispel myths and reduce stigma. They also help to reduce social and psychological barriers in the access to mental health services (33, 5). For maximum effectiveness and impact, it is important that these programs be tailored to particular settings, such as schools, workplaces or a specific community, where people share a common space and subculture and where it is possible to involve group leaders or representative actors (34) (Box 3).

Box 3. "La Colifata", a users' radio for all the community, Buenos Aires, Argentina.

"La Colifata" is a civil association that started in 1991 to broadcast from a psychiatric hospital. It was the first radio station of this type in the world. The broadcasters and protagonists are people in treatment and the community itself.

Its mission is to generate knowledge and to develop concrete intervention spaces to: diminish stigma by developing meeting opportunities between the community and the users; promote health actions in the community, relying on its proper resources, creativity, and collective participation; and promote the autonomy, the search for appropriate cognitive solutions and the exercise of civil rights.

More than 50 inpatients and some 30 visitors converge on *LT 22 Radio La Colifata* every Saturday. On this day there is live radio broadcast on FM 100.1 and on line, carried out directly from the "Hospital Borda" compound in Buenos Aires. They are also connected to social networks via the Internet.

To achieve the expected results initiatives should be implemented in collaboration with other stakeholders, particularly users and their families. The dissemination of information includes traditional media and those based on the Internet (e.g. social networks, multimedia, electronic journals and others).

Special consideration should be given to the role of media and the need to sensitize them regarding mental health problems, since mental disorders are frequently associated with violence in the media, perpetuating negative myths (34, 35). A continuous working partnership with the media will help establish appropriate channels for reporting, explaining and "changing stereotypes and misconceptions about mental disorders" (34). It is also necessary to monitor these efforts and assess their impact.

Objectives

- To improve knowledge, attitudes and practices (mental health literacy) of the population on mental health issues and eradicate discrimination related to mental disorders;
- To strengthen working partnerships with the media to modify their biased perspective and improve the content of messages on mental health. Particularly, avoid sensationalism with regard to suicides and other violent behaviors, including those related to people with mental disorders;
- To promote respect for the codes of ethics by the media and social communicators; and
- To help children and adolescents make a critical and appropriate interpretation of the messages conveyed by the media.

Recommendations

- Design and implement educational campaigns differentiated according to target groups and particular settings;
- Establish a formal mechanism for systematic and practical cooperation with the media on issues related to mental health and substance use; and
- Include websites and other means of communication used by children and adolescents among the media instruments to increase their mental health literacy.

Indicators

- Number of educational campaigns on mental health carried out per year; target groups, number of sessions and number of participants;
- Number of meetings with representatives of the media to review mental health issues and facilitate the delivery of mental health information to the general population; and
- Number of social networks that include mental health issues.

5. Develop and implement a program to combat stigmatization, discrimination and social exclusion of people with mental disorders.

Many factors affect the capacity of people with mental disorders to be accepted and included in the community. Among them:

- Problems related to the symptoms and signs of mental illness itself and the nature of the disability;
- The knowledge, attitudes and behavior of the community, of close family members and of health services personnel, as noted earlier; and
- The availability and quality of mental health care in the community.

Frequently, stigmatization and discrimination influence the beliefs, attitudes and practices of the community with respect to people with mental disorders and disabilities as well as their families. Stigmatization of mental disorders is deeply rooted in many social, cultural and professional contexts (including the health sector). For example, in some cultures people believe that mental illness is contagious or that it occurs because the person has offended an evil spirit. Developed countries are not free from myths and misconceptions, for example, committing acts of violence is often attributed to people with severe mental disorders (36). In many countries, people with mental disorders lose their citizenship rights, such as the rights to vote or to stand for election. They also face restrictions to receive education, to obtain a decent job and to have access to acceptable housing.

Objective

- To reduce stigmatization, eliminate discrimination associated with mental disorders and increase social inclusion of people with mental disorders.

Recommendations

- Design and implement programs, through a coordinated effort involving associations of users and families, as well as institutions working in the promotion and protection of human rights, aimed at reducing and eradicating stigmatization and discrimination against persons affected with mental illness or disability. These programs should be directed to different target groups (e.g. schools, universities, health professionals in general and mental health professionals in particular, users of mental health services and their families, judges, central and local authorities, and others);
- Promote the inclusion of children with special needs in regular schools as the best strategy for access to proper education. This will help reduce self-stigma as well as other people's stigma in relation to these children;
- Use all available methods to combat stigmatization: educate the public to increase their knowledge about mental health; promote behavior changes in work settings that discriminate against people with mental disorders; give opportunities to people with mental disorders to establish direct contact with other people (e.g. speaking in schools and universities, with employers and with the press) so that they can advocate for their human rights, whether or not listed in existing legislation, and for the right to be different;
- Ensure that mental health services provide support to users and family members in their fight against stigma and discrimination in the community (36); and
- Support civil society organizations whose mission is to advocate for the human rights of people affected by mental disease or disability, including associations of users and family members.

Indicators

- Number and type of annual activities against stigmatization and discrimination planned, carried out and evaluated together with all sectors involved; y
- Number of organizations working in the protection of human rights of people with mental health problems.

V. FINAL CONSIDERATIONS

Activities for mental health promotion and prevention of mental disorders are being integrated into the mental health agenda. However, the pace of implementation remains slow, even though sufficient evidence-based data are available and political will to act is emerging.

This chapter has presented some recommendations for action that could help change this situation. Many do not require special financing but rather a redistribution of the budget allocated to mental health. In addition, funds could be raised from other sectors that are also involved in activities related to mental health.

One can hope that political will, combined with the knowledge currently available, will accelerate the implementation of actions for mental health promotion and prevention of psychiatric disorders and thereby increase the well-being of the population and reduce the burden of disease.

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STRATEGIC AREA No. 3

MENTAL HEALTH CARE DELIVERED THROUGH PRIMARY HEALTH SERVICES

I. INTRODUCTION

The *Caracas Declaration* adopted in 1990 marks a turning point in the mental health field in the Region of the Americas (1), inasmuch as it promoted a change in the model for the delivery of mental health care. Two decades later, the proposed model continues to be relevant. The *Caracas Declaration* was subsequently endorsed by all the countries of the Region, through resolutions passed by the Directing Council of the Pan American Health Organization/World Health Organization (PAHO/WHO) in 1997 (2), 2001 (3), and 2009 (4). Essentially, the Declaration was a response to the significant deficiencies of the traditional institutional model in the delivery of mental health care and the need to replace it with a community-based model. The World Health Organization, for its part, issued the *World Health Report 2001*, entitled *Mental health: new understanding, new hope* (5), which gave renewed impetus to the efforts of the countries to modify their public mental health policies with a view to strengthening community-based health care systems.

PAHO/WHO, through the Directing Council Resolution CD 49.R17 of October 2009 (4), charts the course to follow for definitively developing quality community-based mental health care. The Resolution concludes that "*universal, equitable access to mental health care* is achieved by "*strengthening mental health services within the framework of primary health care-based systems and integrated delivery networks.*" It also urges Member States to continue with the activities that tend "*to eliminate the old psychiatric hospital-centered model.*"

Strategic Area No. 3 charts the course to promote the delivery of mental health services through primary health care and through the development of alternative forms of care, as illustrated in Figure 1 below. These alternatives include formal as well as informal or traditional community-based options.

Box 1. Mental health care in the health system.

> **LEVELS**
> - Primary Health Care (traditional and formal health care).
> - Specialized care: outpatient, hospitalization (partial and total) and rehabilitation (protected residences, work and leisure time).
> **FUNCTIONAL NETWORK**
> Health facilities of different levels form a functional network where users move in and out according to their needs. Occasionally, professionals move from one service to another, thus ensuring continuity of care.
> **TERRITORY**
> Health care services are responsible for promotion, primary prevention, curative care and rehabilitation within a given geographical area.

Admittedly, the implementation of the community-based model in the Region is still inadequate although PAHO Member States have forged a consensus to advance this evidence-based model over the past 20 years. As a result, there is still an enormous gap between the needs of the population and the resources needed to meet them. The **Strategy and plan of action on mental health**, adopted by PAHO/WHO in 2009, provides the framework for developing the community-based model in the Region, grounded in the principles of equity, access and care quality. These principles apply to all people regardless of age, gender, socioeconomic status, ethnicity, religious affiliation, culture or any other differential characteristic.

II. BACKGROUND AND GENERAL FRAME OF REFERENCE

The primary health care strategy promoted in the *Declaration of Alma-Ata* in 1978 (7) and renewed 19 years later by PAHO/WHO (8), is a key point of reference for developing mental health care in the Region. A mental health care system that includes primary health care enables the population to have easy access to services and, if properly supported by specialized personnel (see Strategic Area No.4), it can provide good quality care and have good response capacity. Importantly, it has been estimated that some 90% of users with mental disorders can be appropriately treated at the primary care level (9).

With respect to the total disease burden in Latin America and the Caribbean, the percentage of mental and neurological disorders increased from 8.8% in 1990 to 22.2% in 2002 (10). Also, the existing treatment gap for mental health disorders should be considered, i.e. the difference between the real prevalence rate and the percentage of the population diagnosed and treated. For example, over one-third of the people with non-affective psychosis and 70% of those with alcohol-related problems do not receive any type of mental health care (10). It should be noted that in most countries the treatment gap is partly explained by the concentration of mental health resources in psychiatric hospitals.

Integrating mental health care into primary health care is clearly the most viable and efficient way to bridge this gap and to reduce the burden (11, 12). In 2008, the World Health Organization launched a global initiative, the *"Mental health Gap Action Programme: scaling up care for mental, neurological, and substance use disorders"* or mhGAP (13). Relying on disease burden criteria as well as on the availability of potential means of care and the expected treatment responses, mhGAP focuses on eight priority conditions: depression, psychosis, bipolar disorder, epilepsy, developmental and behavioral disorders, dementia, alcohol use and drug use disorders, self-harm and suicide, and other significant emotional or medically unexplained complaints. WHO has already started disseminating the mhGAP Intervention Guide through its website (13).

The mhGAP:
- Offers a comprehensive model of care;
- Can be adapted to conditions at the country level and is viable for developing countries health systems;
- Includes interventions for the priority conditions listed above and provides evidence-based protocols for clinical decision-making;
- Provides guidelines for the delivery of care, training and supervision;
- Uses a symptom and syndromic approach for clinical care;
- Uses intervention packages designed to be administered by non-specialist health professionals; and
- Requires the support and supervision of mental health professionals.

III. CURRENT SITUATION OF THE MENTAL HEALTH SERVICES

The study of the mental health systems conducted in some countries of the Region using the World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) (14) identified the current situation with regard to the integration of mental health services at the primary care level, mental health staff training, specialized community-based mental health services and forensic psychiatry. The information now available, which is briefly summarized below, justifies the need for changes. More in-depth information is available in the PAHO and WHO websites, which include the reports of countries that have completed the WHO-AIMS assessment (14).

WHO-AIMS data highlights

Integration of mental health services into primary health care

With the exception of very few countries, the integration of mental health services into primary health care has been limited and inadequate. Most PHC centers lack standardized evidence-based protocols for their personnel for the detection and treatment of psychiatric problems. The *WHO essential package for mental health policy, plan and services* can help to bridge this gap (6).

Mental health training for PHC personnel

As mentioned before, efforts to achieve broader coverage by the mental health services must include the active participation of PHC personnel. Yet, the WHO-AIMS assessment study identified a very troubling situation, resulting from the very low levels of training currently provided in this area in undergraduate and graduate/postgraduate programs or within health services. It is expected, the mhGAP *Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings*, which can be used in the training of PHC personnel, will help to modify the current situation and boost the PHC response capacity (13) (see also Strategic Area No. 4).

Hospital-based care for mental disorders

The WHO-AIMS study identified considerable asymmetry in the admission of people with mental disorders to psychiatric hospitals compared with the general hospitals. While general hospitals are launching new in-patient mental health care services and strengthening existing ones, in many countries psychiatric hospitals still retain their centrality with respect to the care and hospitalization of people with mental disorders. This fact is reflected in a series of indicators, such as hospital admissions and the allocation of human and financial resources.

Involuntary treatments

Another problem identified was the lack of information on and regulation of involuntary commitments, as well as the common use of physical restraints and isolation with inpatients in hospital facilities. Therefore, there is room to suspect that the current situation of the mental health services may result in or facilitate violations of the human rights of inpatients, specially, in psychiatric hospitals.

Forensic units

The assessment of mental health systems shows the insufficiency and generally precarious situation of forensic services.

Box 2. From WHO-AIMS data to action: bilateral collaboration as a facilitator of changes in the mental health system in Bolivia.

Bolivia used the WHO-AIMS to obtain relevant information about its mental health system, so as to facilitate sensitization and promote action among the national, departmental and local health authorities. For a population of almost 10 million inhabitants, the WHO-AIMS study identified 39 mental health services: nine psychiatric hospitals and 30 outpatient services. Those 39 services only represent 1.4% of the total number of public health services in the country.

In light of these worrisome results, a community mental health collaboration project was set up between the Department of La Paz, Bolivia, and the Province of Río Negro, Argentina, to accelerate the rate of changes that the WHO-AIMS identified as necessary within the framework of the *Caracas Declaration*. PAHO/WHO provided technical and financial support. Some of the achievements of this project include the integration of mental health variables in the national health information system, the development of a comprehensive primary care pilot model and the formulation of a departmental public policy (No. 377/10) designed to implement mental health as a cross-cutting issue in institutional activities.

This departmental-based experience should now be extended nation-wide and its results evaluated.

IV. Proposals for action

1. Integrate or strengthen the mental health component in primary health care.

A PHC-based health system is "*a core set of functional and structural elements that guarantee universal coverage and access to services that are acceptable to the population and that are equity-enhancing. It provides comprehensive, integrated, and appropriate care over time, emphasizes health promotion and prevention, and assures first contact care. Families and communities are its basis for planning and action* (8)."

It is abundantly clear from the definition above that integrating the mental health component into primary health care is an optimal strategy for guaranteeing access to care for people with mental health disorders and, as a result, for bridging the enormous treatment gap (10). Indeed, it is highly unlikely that both goals can be achieved if care is only provided via specialized health services, and even less likely if such services are centralized in traditional psychiatric hospitals.

Studies have shown that 80-90% of people with mental health problems seek help at the primary care level. However, only 50% of this population is diagnosed at the PHC level, depending on the type and focus of the interview (14), and only 5 -15% reaches the specialized care level (13). These findings

provide a new reason to support PHC as a means of bridging the treatment gap. As noted earlier, the existence of intervention protocols will help in this regard. As soon as the WHO mhGAP Intervention Guide is available in all countries, it must be adapted to local conditions. Each country must define the scope of its implementation (whether nationally, by specific regions, or as pilot programs in the initial phase) and set a timetable for the extension of the initiative until national coverage is achieved.

To ensure PHC effectiveness, the following minimum conditions must be met:

- Training for first level health care workers;
- Sustained provision of essential psychoactive drugs;
- Consideration of the specific psychosocial needs at each stage of the life cycle; and
- Consideration of the specific sociocultural features and gender makeup of the population.

Objective

- To ensure that PCH services have an efficient response capacity to address mental health problems, with an intercultural and gender approach in all age ranges and the collaboration and constant supervision of the specialized care level.

Recommendations

- To ensure that the mental health policy and plans clearly endorse the integration of the mental health component into PHC as the basic strategy for meeting existing needs, including the allocation of the necessary resources to guarantee that this component is fully operational;
- Organize formal services and collaborate with informal services to ensure that each level of the pyramid (see Figure 1) operates effectively;

Figure 1. Service organization: optimal mix of primary health centered services.

Source: Rodríguez J, Malvárez S, González R, Levav I, eds. Salud mental en la comunidad, 2.ª edición. Organización Panamericana de la Salud. Serie Paltex No.49. Washington, DC: OPS; 2009.

- Set up and maintain a system that ensures the flow of care from the community to the most specialized level and vice versa (referral and back-referral);
- Guarantee a sustained supply of essential psychoactive drugs; and
- Adopt/adapt the WHO mhGAP intervention packages and guide to specific country conditions (13), and train PCH personnel in the use of these tools. This will enable the PHC personnel to identify and manage (or refer) priority mental health problems in a timely manner (see Strategic Area No. 4).

Indicators

- The country's national health policy and plan explicitly refer to the integration of the mental health component into PHC;
- Percentage of PHC centers that provide care for priority mental health problems under protocols formally adopted by the health sector;
- Percentage of PHC centers that have a sustained supply of essential psychoactive drugs;
- Percentage of PHC centers interacting with formal specialized services;
- Percentage of PHC centers interacting with informal or traditional health services; and
- Percentage of the mental health budget allocated to PHC.

2. Establish or strengthen specialized outpatient care nationwide.

The complexity of specialized outpatient mental health care can vary, depending on the development level of the country's health system. To be efficient and facilitate adequate continuity of care, these services should work closely with other levels of care, such as primary health care, psychiatric services in general hospitals, and informal community-based mental health services (16). Moreover, such services should guarantee care for all segments of the population, taking age, gender, socioeconomic level, and ethnic/cultural affiliation into account to prevent the most vulnerable groups or those in special situations from being marginalized in the delivery of services (Box 3).

Specialized outpatient mental health services should be close to the community and be assigned the responsibility for providing care to a particular population (geographical area of responsibility that can include one or more PHC centers) and participate at all levels of prevention (primary, secondary and tertiary).

Multidisciplinary teams should offer comprehensive care for mental health problems. The multidisciplinary approach implies that such teams are made up of professionals with backgrounds in the health, behavioral and social sciences, as well as paraprofessionals. In situations where human resources are scarce, the professional boundaries may be blurred in order to meet the needs of users, their families and the community.

Box 3. An Intercultural Experience in Chile

In 1996, the Ministry of Health developed a technical instrument, *Health and Indigenous Populations*, implemented through the National Health and Indigenous Populations Program and the Indigenous Communities Integral Development Program (*Programa Orígenes*, in Spanish). In turn, the Mental Health and Psychiatry National Plan established the need for implementing specific strategies to support the development of those communities by enhancing their cultural identity, increasing their degree of internal social cohesion and with the rest of the national community, and strengthening the ancestral wisdom of their lifestyle and traditional medicine.

With the health reform, "interculturalism" was incorporated within the legal framework through article 16 of the Health Authority Law. This article establishes that it is the duty of the Ministry of Health to formulate policies that enable the integration of an intercultural approach in the health programs of communities with high concentration of indigenous populations, encouraging collaboration and complementarity between the health care provided by the formal health system and the one provided by indigenous medicine. This strategy allows the indigenous people to obtain comprehensive and timely resolution of their health needs, in their health context.

To date, one of the major achievements is the inclusion of intercultural facilitators and cultural "advisers" in the health facilities located in areas densely populated by indigenous populations. This, together with the allocation of physical spaces adjacent to health centers, where traditional medicine is practiced, has facilitated the integration of both types of medicine and the referral and counter-referral processes that take place between the health care network and the indigenous medical system. Examples of this integration are: the Ruca Lawén Comprehensive Health Care Center, incorporated in Lake Ranco's municipal surgery, run by the "*nañas*" (*mapuche* doctors); and the "Hospital de Nueva Imperial" in Temuco, with an impressive mapuche health center, the Manquehue Hospital. This hospital has inpatient facilities, numerous consulting rooms for specialists, and for the *machis* and their assistants. It is managed by a local indigenous association.

Some specific experiences in intercultural mental health care are:

- The *mapuche* mental health and natural medicine workshops, carried out by the Comprehensive Mental Health Program and the Malalhue Health Center Program for Indigenous Populations, which offers women mental health promotion and prevention activities, incorporating ancestral knowledge coming from the natural *mapuche* medicine. At these group meetings participants are sensitized with respect to violence against women, child abuse and mood disorders, together with the promotion of self-care practices and the learning of natural treatments as moderators of the nervous system.
- The *Wiñoy Monguen* program (Learning to Live), in Ralko's Family Health Center, located in High Bio-Bio, organizes self-help workshops to recover cultural and identity processes of the *pehuenche* women admitted to the Intercultural Mental Health Program and has contributed to the partial and/or total remission of depressive and/or anxiety symptoms.

Box 4. Two key resources in the psychiatric reform in Brazil.

With the promulgation of law 10,216 in 2001, every Brazilian citizen with a mental disorder has the right to be served in open community care services. As a result, the number of beds in psychiatric hospitals is gradually declining, being replaced by a novel system, comprising the CAPS (Psychosocial Health Care Centers), the SRTs (Therapeutic Residences Services), primary health care and other community-based services.

Psychosocial Health Care Centers (CAPS)

The CAPS constitute a novel mental health care resource available in the cities. Relying on open doors services, with daily clinical care and activities for people with severe mental disorders, unnecessary hospitalizations and social isolation in psychiatric hospitals are being prevented. The CAPS are linked with primary care, the emergency system, and other institutions to ultimately strengthen the social ties of users in their neighborhoods. Since the end of the year 2010, CAPS are present in 1118 cities of Brazil, with 1,620 units, thus giving coverage to 60% of the population. This compares favorably with 2001, when the Psychiatric Reform Law was promulgated. In that year the country had 295 services covering 21% of the population.

Number of CAPS from 2001 to 2010
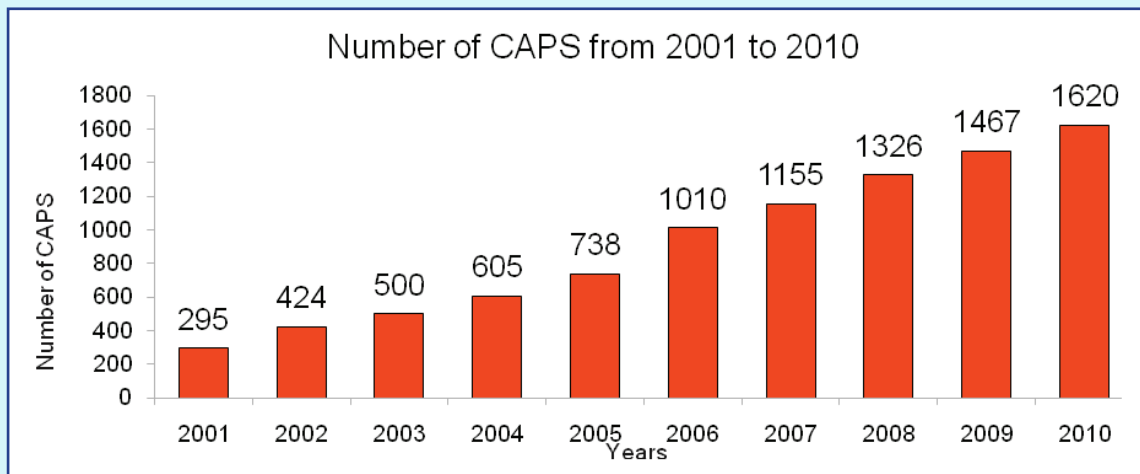
Therapeutic Residence Services (SRT)

The SRTs are houses located in an urban space, established in order to serve the housing needs of people affected by severe mental disorders that are discharged from psychiatric hospitals. The number of users of each residence can vary from one to eight. The SRTs provides professional support for the individual needs of each resident, who are linked to a Psychosocial Health Care Center (CAPS) or to another service in the mental health care network. The number of SRTs has increased from 85 in 2002 to 570 in 2010, consistent with the rate of reduction of psychiatric beds.

Objectives

- To establish outpatient mental health services by geographical area (with defined areas of responsibility) throughout the country, with the ability to integrate or interact with the PHC services and the community, as well as with the other specialized health network components and community rehabilitation resources.

Recommendations

- Policies and plans should clearly establish the adoption of the community-based model of mental health care throughout the country as the most appropriate strategy for meeting the psychosocial demands and needs of the population;
- Allocate the necessary resources to ensure that this component of the health system is fully operational, which can be accomplished by redistributing existing resources and/or assigning new budget lines;
- Reorient psychiatric care so that it is provided in specialized outpatient mental health services by formal and informal agents of the community (Box 4);
- Organize a specialized mental health services network with defined geographical areas of responsibility. A variety of different service modalities and components can be adopted based on the characteristics of the national health system and the available resources;
- Establish fluent and sustained communication between community-based outpatient mental health services and PHC health teams/centers. Specialized teams should visit PHC centers and offer support, guidance and supervision to PHC health workers;
- Develop care services protocols; and
- Establish regulations for referral and back-referrals.

Indicators

- The national health policy and plan explicitly refer to the restructuring of mental health services to ensure that the different needs of the population are largely met in the community;
- Percentage of provinces/departments/regions in the country with specialized outpatient services that provide comprehensive mental health care and operate in a coordinated and sustained manner with the other components of the health services network;
- Percentage of specialized community-based mental health workers trained in a program with standards that have been officially approved by the ministry of health (see Strategic Area No. 4); and
- Percentage of mental health outpatient facilities that have their own referral and back-referral protocols.

3. Integrate a mental health component into general hospital services.

The integration of a mental health component in general hospital services is in keeping with the strategy of making mental health an integral part of the general health system, as well as the specific objective of decentralizing services. This integration helps to reduce the stigma and other negative consequences of commitment to psychiatric hospitals (Box 5).

The decentralization of services also enables people with mental health disorders to receive care in their own communities, allowing patients to maintain the bond with their families, take advantage of existing social support resources, and strengthen community rehabilitation activities. It also facilitates the access of people with mental disorders to comprehensive health care, to other medical specialties and to health technologies available in general hospitals.

Box 5. Integration of mental health care services in Panama's general hospitals.

The following were key processes in the development of the mental health component in Panama's health services and in its integration to the general hospitals :

- Reintegration of people into the community after long hospital stays, which has made it possible to gradually lower the psychiatric hospital bed occupancy rate;
- Opening of wards for psychiatric patients in national general reference hospitals (e.g. Complejo Hospitalario de la Caja del Seguro Social/CSS –Social Security and the Hospital Santo Tomás);
- Opening of psychiatric beds in regional general hospitals as part of internal medicine services or as independent wards, depending on the development level and specific conditions in each province/region. In some cases, the same specialized mental health team provides services at the general hospital on an outpatient basis, thus guaranteeing continuity of care;
- Training of specialized human resources (psychiatrists and mental health nurses) in the new primary care-centered model;
- Gradual deployment of specialized personnel in PHC facilities in all health regions in the country, as well as general practitioners, pediatricians, and gynecologists;
- The National Mental Health Program has carried out health promotion activities and for prevention of mental disorders and has established links with other health programs. Admission to psychiatric hospitals is discouraged. It has also developed activities aimed at reducing the stigma surrounding mental illness and to broaden the concept of mental health, thus creating a more favorable image among the general public; and
- The progressive development of a budget for medicines, which includes psychoactive drugs, thereby facilitating the purchase by the public sector of antipsychotics as well as traditional and next-generation antidepressants. This facilitates patients' access to the required medication (including during crisis), reduces the need for hospitalization and shortens hospital stays.

The community has accepted the organization of the service network developed over the last two decades, especially, the mental health services integration into the general hospitals.

In general hospitals, the mental health component includes: emergency care, the development of psychiatric consultation and referral programs, and the hospitalization of people with mental disorders, either in specialized wards or other (e.g. internal medicine).

Objective

- To develop mental health services in general hospitals, ensuring the integration of this component into the service network and its relationship to other levels of care.

Recommendations

- Ensure that the mental health policy clearly states that the country adopts brief hospitalization (full or partial) of people with mental disorders to general hospitals, with appropriate resolution capacity. The mental health plan should propose appropriate actions for the development and implementation of this care service modality;
- Ensure the allocation of the necessary financial and human resources for this component to be fully operational. This can be accomplished by redistributing existing resources and assigning new budget lines and personnel;
- Clearly establish and strengthen referral and back-referral mechanisms between the mental health services offered in general hospitals and specialized outpatient services, as well as with the PHC network; and
- Train the staff in the mental health units of the general hospitals.

Indicators

- The national health policy and plan explicitly refer to the restructuring of mental health services to ensure that the hospitalization needs of people with mental disorders are largely met in general hospitals;
- Percentage of general hospitals offering mental health services, in-patient psychiatric services, liaison psychiatry and emergency care; and
- Percentage of psychiatric beds in general hospitals of the total hospital beds and total psychiatric beds of the country/province/region.

4. Develop community-based rehabilitation programs to promote deinstitutionalization and social inclusion.

Deinstitutionalization does not mean simply reducing the number of patients admitted to psychiatric hospitals. On the contrary, it is an active and multisectoral program for the rehabilitation and social inclusion of that population (Box 6).

Box 6. Deinstitutionalization in Brazil: The "Back Home" Program

This program was established in 2003, through the Federal Law No. 10.708/03, as part of a psychosocial rehabilitation policy for long-term inpatients in psychiatric hospitals. This program, which proved to be useful in the process of deinstitutionalization, guarantees a payment of R$320.00 monthly (nearly US$190, in January 2011) to people with a long history of psychiatric hospitalization, who can use the funds directly by means of a bank card. The deposit in the recipient's bank account has a strategic role in re/gaining their civil rights. In 2010, 3,635 people were beneficiaries of the program. This number will triple in the coming years, being estimated that it will reach 12 thousand people.

"Back Home" Program. Number of beneficiaries.
(Programa de Volta para Casa) (2003-2010)
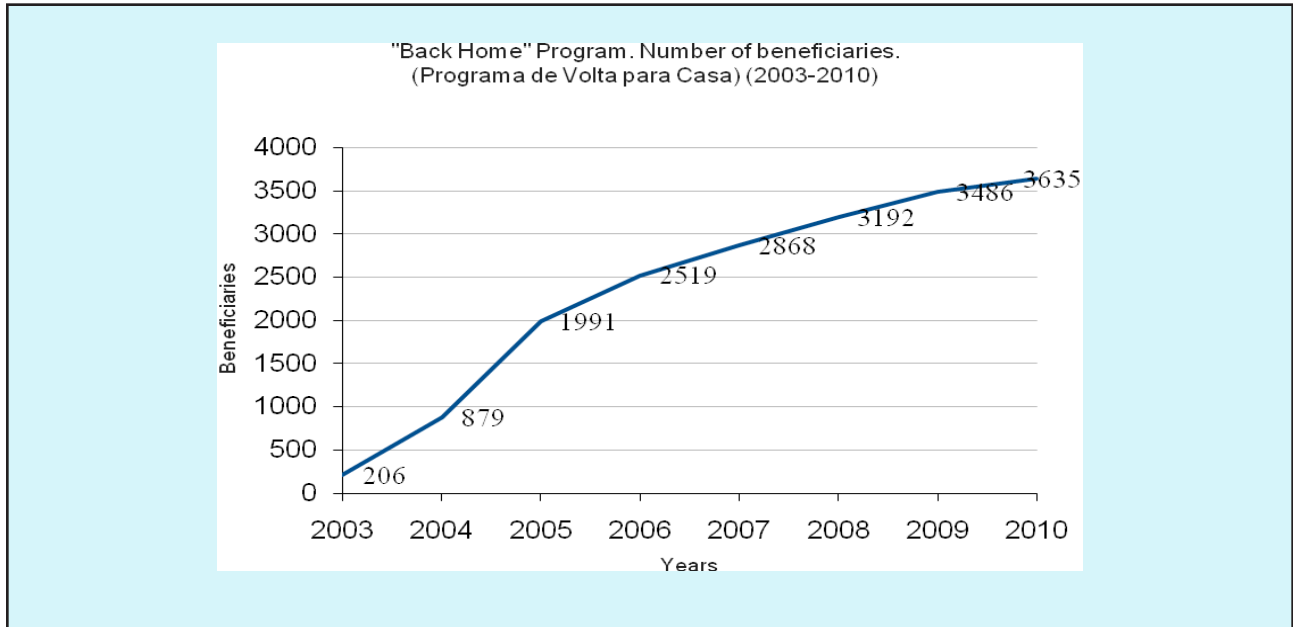
Deinstitutionalization requires the development of community rehabilitation components ranging from therapeutic facilities (e.g. day hospitals) to residences that provide ongoing care (e.g. assisted-living facilities) and sheltered residential facilities (e.g. halfway houses). It involves processes such as job placement (e.g. social enterprises and cooperatives) and social reintegration (e.g. social clubs and users associations). It also includes a psycho-educational program that enables the participation and active support of families.

Deinstitutionalization is closely related to the ongoing reform that is gradually replacing traditional psychiatric hospitals (i.e. insane asylums) for community-based care. National mental health policy and plans should address the problem posed by the process of downsizing or closing the psychiatric hospitals or their transition to newer modalities of services. It will be impossible to move forward with the community-based model of mental health care or to build an efficient health care system as long as obsolete structures such as asylums persist, with their poor quality of care and frequent human rights violations.

The model focused on the psychiatric hospital hinders the development of mental health care networks, does not satisfy the needs of the community and favors people´s uprooting and institutionalization.

Each country should establish the timetables and modalities for reform and the closure of psychiatric hospitals according to its particular situation at the national or local levels. Thus, steady progress can be made in replacing those archaic institutions with a network of alternative services such as the ones described in this chapter (Box 7).

Box 7. An insane asylum joins psychiatric care reform in Iquitos, Peru

The rehabilitation center for people with mental disorders of Iquitos (Centro de Rehabilitación del Enfermo Mental - CREMI), in Peru, has been functioning since March 1991 as both an alternative for people with psychiatric disorders admitted to the "Hospital de Apoyo" and for those that were neglected by society and their families. Initially it had 20 beds, but by the end of 2009 the number rose to 89, as a result of greater demand and the lack of outpatient facilities. The CREMI thus became a mere shelter for people with psychiatric history subjected to an unjustified deprivation of liberty, despite the efforts of its staff.

In the year 2000 the first attempt of reform was carried out, which included a study to seek alternatives for hospitalization and **the prohibition of the use of chains as a means of physical containment.** In the year 2005, in light of the denunciations of human rights violations as per the Defensorial Report No. 102, the "safety cells" mentioned in this document were demolished.

Since March 2009, with the support of PAHO/WHO consultants, further psychiatric care reform actions have been carried out, namely: integration of the mental health network within the existing health services network, including community care; transfer of short stay inpatients to general hospitals; and provision of adequate residential accommodation for people that can be discharged, e.g. in sheltered and halfway homes.

With the removal of bars from the collective bedrooms (August 2010) by the regional authorities and the "Asociación Bola Roja" of medical clowns, a new milestone in the reform process was reached. Part of the 2011 agenda is the installation of *Safe Homes* to complete the discharge of the remaining inpatients in the best possible conditions.

In situations where the lack of resources prevents the replacement of psychiatric hospitals in the short- or medium-term due to the risk of compromising services, it is essential planning for reform of the hospital setting with regard to the social environment, the physical plant, its structure and functioning (e.g. monitoring of human rights and care quality). Regardless of the current circumstances, deinstitutionalization is a necessary and priority process. Ideally, institutionalization of new people should be avoided. In the event that a psychiatric hospital continues to receive patients for short- or mid-stay hospitalizations, it should prevent the uprooting of the newly admitted patients and should not hamper the development of services in other areas.

Hospital reform will always encounter resistance to change, both externally and from within. For various reasons, psychiatric hospital staff can become a major obstacle. Change will only be possible if it is made on a rational basis and with solid techniques, nurtured by a code of values, where the protection of human rights is an essential component. Accordingly, garnering the support and political will of government authorities, professionals, the psychiatric hospital staff, NGOs and public in general, is essential for the success of this process.

Objective

- To develop the health care services within the framework of a program for psychosocial rehabilitation and social inclusion as a means of facilitating deinstitutionalization and the reform of psychiatric hospitals, and to assure adequate care to people with severe and longstanding mental health disorders.

Recommendations

- Ensure that mental health policy includes deinstitutionalization as an essential strategy for restructuring mental health care;
- Ensure that the national mental health plan develops a broad and comprehensive program for psychosocial rehabilitation. This program should be multisectoral and community-based, with special emphasis on people with severe and longstanding mental health disorders, many of whom may face unfavorable social and economic conditions. It should assure the respect for human rights and establish a firm connection with the community mental health care network and other relevant stakeholders (see "Partnerships" in Strategic Area No.1);
- Ensure that institutionalized patients in psychiatric hospitals have an individualized plan that provides for their rehabilitation and social reintegration, as well as support for their family members; and
- Develop a psychiatric hospital reform plan with specific short-, medium-, and long-term goals.

Indicators

- Existence of a comprehensive, multisectoral deinstitutionalization program in place;
- Percentage of long-stay hospitalized patients (of six months or more) who have been relocated to facilities near their families or to other appropriate rehabilitation facilities;
- Percentage reduction in long-term psychiatric hospital beds per year;
- Number/rate of slots for patients at mental health day facilities by region/ department/state; and
- Number/rate of housing slots in sheltered or community residential facilities.

5. Provide mental health care for children and adolescents in PHC and specialized mental health facilities.

One of the weakest and less visible areas of community-based mental health services is services for children and adolescents (also addressed in another chapter of this document). This situation is largely due to a lack of trained human resources. However, there are other important obstacles to providing effective care, including the mistaken notion that mental disorders early in life will disappear on their own; that mental disorders of this age group have a limited impact; that such disorders will not leave a psychopathological mark; or that there are no effective interventions for child disorders.

None of these notions are valid. A high degree of continuity has been observed between mental disorders in children and adolescents and those in the adult population, but early interventions can prevent or reduce the risk of long-term disability. In fact, effective care reduces the disease burden

of mental disorders and lowers the associated costs to health systems and communities (17, 18) (see Strategic Area No. 2).

Moreover, collaboration both among and within the affected public sectors (especially social welfare and education) is essential for providing effective curative interventions and rehabilitation services for children and adolescents (see Strategic Area No.2). Adopting the most common diagnostic and treatment protocols for childhood mental disorders will facilitate interventions in PHC services. These protocols are included in the mhGAP's package of core interventions (13).

Objectives

- To include the child and adolescent component within mental health care at the PHC level;
- To develop mental health care programs for children and adolescents in the specialized mental health network of community-based services;
- To include a child and adolescent mental health component in hospital pediatric services;
- To develop specialized child and adolescent mental health services, including brief hospitalizations in general hospitals, in pediatric wards or in specific child psychiatry wards (according to resources and needs); and
- Plan health promotion and prevention programs to promote a healthy childhood (see Strategic Area No. 2).

Recommendations

- Establish training programs for PHC personnel on detection and early intervention in childhood and adolescent mental disorders, in collaboration with the educational and social welfare sectors. Such training programs can utilize the mhGAP package of interventions (13) and should be coordinated by specialized community-based mental health services;
- Develop specialized mental health services for children and adolescents based on the characteristics of the country's health system and available resources. These services should be distributed equitably by geographical region so as to ensure an appropriate referral and back-referral system with specialized mental health services;
- Promote the training of specialized personnel in childhood and adolescent mental health issues (Strategic Area No. 4); and
- Establish an intra- and intersectoral group to develop, consult, coordinate and monitor childhood and adolescent mental health interventions. Participation of the educational sector is especially important in this regard (Strategic Areas No. 1 and No. 2).

Indicators

- Number of outpatient services specialized in mental health care for children and adolescents;
- Number of specialized services in child and adolescent mental health care in general or pediatric hospitals
- Percentage of PHC staff trained in protocols for the treatment of childhood mental disorders, especially those using the mhGAP intervention package; and

- Existence of an intra- and intersectoral group that plans, coordinates and monitors child and adolescent mental health activities at all levels.

6. Establish or strengthen forensic psychiatry services.

Forensic psychiatry is the branch of psychiatry that deals with civil and criminal legal issues related to mental disorders.

In civil law, forensic psychiatrists are responsible for legal matters such as determining whether an individual is mentally competent to sign a contract or will; deciding whether a parent is sufficiently competent to continue discharging his/her parental obligations following a divorce; or, in the case of mental illness, establishing which of the spouses can have a marriage annulled or has grounds for divorce.

In criminal law, forensic psychiatrists are part of the legal team that makes decisions as to whether or not a person is competent to stand trial. This decision is made on the basis of a psychiatric evaluation prior to the start of legal proceedings. In all legal systems, a trial cannot proceed if the individual in question is found to be mentally incompetent (*non compos mentis*). In many countries, legal proceedings are suspended and the individual is ordered to submit to treatment or hospitalization. Legal proceedings cannot resume until a medical opinion is issued stipulating that the individual has recovered his or her mental faculties.

Moreover, at any time during legal proceedings, one of the parties (the defendant or the district attorney) may decide to file a motion to declare the accused not guilty. The "not guilty" motion can refer to one or more of three elements that can affect the individual's mental capacity:

1) The cognitive ability of a defendant at the time of the crime to recognize or understand the severity or error of the criminal behavior;
2) The ability of the defendant to understand all the emotional elements that can play a definitive role at the time of the crime; and/or
3) The will power or volitional capacity to control the behavior as defined in the law.

If it could be demonstrated that the defendant suffers from a mental disorder that affects one of these three mental capacities, the justice system would be in a position to find the defendant not guilty of the crime due to insanity. A determination of not guilty in a criminal proceeding terminates the trial, but if the participation of the defendant in a criminal action is proved, he/she is remanded to a hospital for treatment for a period that generally corresponds to that of the probable sentence and as long as the conditions continue, which in general correspond to the criteria of necessity for hospital treatment and dangerousness.

Depending on the laws in each country, the defendant becomes a patient entirely under the jurisdiction of the mental health system or enters a forensic subsystem under the jurisdiction of a system parallel to the courts. At this point, the defendant cannot be released until such time as the complete recovery of his/her mental faculties can be demonstrated.

The forensic system operates at an intermediate level between psychiatry and the law and collaborates with both the judiciary and the health sector. The goal is to provide the individual with effective psychiatric treatment and support his rehabilitation and reintegration into society. Many problems are observed in Latin America and the Caribbean, owing to the weak coordination between justice and the health sector, the shortage of specific regulations, and the lack of appropriate services and trained personnel for forensic functions.

Objectives

- To establish and/or strengthen forensic psychiatry services; and
- To forge a close and sustained partnership between the judiciary and the health system.

Recommendations

- Establish a forensic services network to appropriately address the country's needs in this field, in accordance with national and international legislation, the characteristics of the national health system, the available resources and in agreement with the judiciary;
- Establish collaboration between the health and justice sectors to regulate and define the different aspects established by law; and
- Ensure that all correctional institutions provide part- or full-time mental health services.

Indicators

- Number of psychiatric forensic services;
- Number of psychiatric beds available for forensic services;
- Existence of an agreement between the health and justice sectors; and
- Percentage of correctional institutions providing mental health services for inmates.

7. Ensure the protection of human rights of inpatients.

The protection of the human rights of people with mental disorders being treated at health facilities, especially in forensic units, psychiatric hospitals and long-term care facilities for people with severe mental conditions was addressed, in general, in Strategic Area No. 1. This chapter refers to two particularly important aspects that should be monitored: involuntary commitment to institutions and measures involving physical restraint or isolation.

Objectives

- To ensure the human rights protection of people with mental disorders receiving treatment at health facilities, especially people in psychiatric hospitals, forensic services and long-term care facilities.

Recommendations

- Regulate and develop protocols for involuntary commitment, including any pertinent monitoring activities, in accordance with existing legislation (mental health law or other), which should meet international standards; and
- Regulate and develop protocols for physical restraint and isolation measures applied to people with mental disorders admitted to hospital-based services, forensic units or residential facilities, including pertinent monitoring activities (Strategic Area No. 1).

Indicators

- Percentage of general or mental hospitals that have regulations and protocols for involuntary commitment;
- Percentage of people with mental disorders involuntarily admitted to hospital-based services;
- Percentage of institutions admitting people with mental disorders that have regulations and protocols for physical restraint and isolation measures; and
- Percentage of inpatients at psychiatric services subject to physical restraint or isolation during their stay.

8. Provide care to people with problems related to the use of alcohol and other psychoactive substances.

Alcohol use has become one of the most serious health risk factors worldwide. According to WHO data (19), alcohol accounts for 9.7% of the disease burden in the Americas—resulting in the loss of some 13.1 million disability-adjusted life years (DALYs)—and 4.8% of all deaths in the Region. In short, alcohol use is the leading health risk factor in the Americas (20) and the third leading risk factor worldwide (19). For this reason, in May 2010, the World Health Assembly adopted the *Global strategy to reduce the harmful use of alcohol* (WHA 63.13).

The *Global Strategy* establishes 10 evidence-based strategic areas for action at the national and subnational levels. It offers several options for addressing the disease burden attributable to the harmful use of alcohol, noting that at the collective level, public policies are the most cost-effective means of reducing the disease burden attributable to alcohol use, including controls on the sale, promotion, pricing, and availability of alcoholic beverages.

Illicit drug use also has adverse consequences for health in the Americas; however, the available information on its impact on mortality and morbidity is still rather limited in most Latin American and Caribbean countries. Marijuana, cocaine, and volatile solvents are used most often, followed by opioids, especially heroin (21). The use of injecting drugs varies from country to country; however, it is a common problem that demands immediate attention, especially as it relates to the transmission and prevention of HIV/AIDS. In September 2010, the Directing Council of PAHO approved the *Strategy on substance use and public health* (CD50/18), which lays emphasis on treatment and comprehensive care for drug users.

The delivery of PHC-centered services is essential to curbing the harmful use of alcohol and other substances. Screening services and brief interventions can cover most of the at-risk population and expand links with more specialized treatment options in a cost-effective manner. In order to ensure their effectiveness, such services should be an integral part of the health system and linkages with NGOs and social service networks should be promoted. Finally, given the inherent risks of alcohol use for women of childbearing age who plan to become pregnant, and to the fetus during pregnancy, prenatal and gynecological services should routinely include questions about the use of alcohol and other drugs. Furthermore, these services should offer brief counseling sessions on the risks of alcohol and drug use, as well as treatment for chemical dependency and other related mental or physical health problems. In all cases, it is essential that a neutral, nonjudgmental approach be utilized; otherwise, women may avoid contact with health professionals, thus jeopardizing the healthy development of their babies or even their own health.

Objectives

- To formulate and implement public policies to curb the harmful use of alcohol and other psychoactive substances; and
- To establish alcohol and drug treatment programs within general and specialized health services so as to reduce use harmful effects.

Recommendations

- Promote the formulation and implementation of public policies on problems related to the use of alcohol and other substances, which are reflected in the national mental health plan;
- Institutionalize screening and brief intervention programs for harmful use of alcohol as part of the essential services at the primary level of care, especially for pregnant women, with a view to guaranteeing basic care for the entire population;
- Link primary care services with specialized community-based services, social services and self-help groups, with a view to developing an integrated system in which people who need monitoring or greater care have speedy access to the services they need.
- Regulate in-patient services and establish that they should be used only in very severe cases, after careful evaluation and medical/psychiatric certification;
- Train primary health care teams in how to screen patients using standardized questionnaires (e.g. the WHO *Alcohol Use Disorders Identification Test* - AUDIT) (22), and in the brief intervention interview technique (BI)[19];
- Train primary health care teams in the identification, management and referral of people with chemical dependencies to formal and informal health care services (e.g. Alcoholics Anonymous). According to the prevalence of other psychoactive substances in the general population, the World Health Organization ASSIST questionnaire (*Alcohol, Smoking and*

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19   The *brief intervention* is a short motivational interview technique (generally a single session lasting only 5 to 15 minutes) to promote the need for change in patients and to help them set goals for lower use and risk. Brief interventions are not appropriate for drug- or alcohol-dependent people, but for those with hazardous consumption, who can change their habits to avoid dependency and the associated health risks of harmful substance use. The brief intervention can be utilized by trained professionals who are not mental health experts, for example, nurses, health agents, primary health care professionals and family doctors, among others.

Substance Involvement Screening Test) can be used (23), as well as brief interventions for hazardous substance use (24);

- Train mental health teams in the effective treatment of substance dependency and the harmful use of alcohol and other drugs;
- Guarantee universal access to drug therapies for opioid dependencies (e.g. methadone and buprenorphine), and provide specialized training to professionals on how to determine the appropriate dosage;
- Guarantee drug users access to HIV/AIDS treatment. According to the situation in each country, implement programs to distribute syringes/needles and provide condoms, among other measures, to prevent the transmission of HIV and other blood-borne infections among injection-drug users; and
- Provide community-based social and health services for the most vulnerable groups through programs such as mobile health units, search and direct contact services to offer users care and support, and 24-hour support services.

Indicators

- Existence of a national policy to reduce the harmful use of alcohol and other drugs that includes a plan of action, developed in a participatory manner, with budget, basic indicators and measurable goals;
- Existence of a focal point or reference at the ministry of health for drug and alcohol use health issues;
- Existence of standards at PHC for screening hazardous alcohol and other drugs use and for brief interventions, as well as information about the WHO mhGAP Intervention Guide with regard to alcohol and substance use;
- Percentage of the at-risk population in primary care that receives the brief intervention or is referred for specialized treatment;
- Existence of standards for distributing needles and syringes to users of injecting drugs;
- Existence of standards for voluntary HIV/AIDS testing and counseling, and access to HIV/AIDS treatment for drug and alcohol users;
- Number of services with the ability to distribute sterile needles and syringes for drug users in the community (i.e. in places where injecting drug use has been detected and associated with the transmission of HIV/AIDS and other blood-borne infections;
- Availability of drugs to treat opioid dependency (e.g. methadone and buprenorphine);
- Existence of standards for diagnosing and treating alcohol and other chemical dependencies and their associated comorbidity;
- Existence of undergraduate, graduate/postgraduate, and continuing education curricula covering topics related to the use of alcohol and other drugs;
- Percentage of PHC health professionals trained in the detection, care, and treatment of disorders caused by the use of alcohol and other substances; and
- Percentage reduction in the treatment gap for disorders caused by the use of alcohol and other substances.

V. Conclusions

The PAHO/WHO **Strategy and plan of action on mental health** provides an appropriate framework for developing a community-based services model in close collaboration with the primary health care level. The WHO *Mental health Gap Action Program* (mhGAP) is an optimal intervention tool to improve PHC health services and bridge treatment gaps.

The structure of mental health services in a community-based model implies that teams are responsible for specific geographic areas and a given population, and are integrated into the general health system. Community-based mental health teams should be multidisciplinary and located as near as possible to the PHC centers. Primary health care personnel require ongoing support and supervision to ensure that mental health problems are properly detected and treated.

With a view to reducing stigma and other adverse consequences, it is essential that hospitalization for psychiatric disorders take place primarily in general hospitals. Furthermore, the development of community-based rehabilitation units and programs may favor a strong deinstitutionalization process and promote community-based treatment of severe mental disorders. The development of a service network should consider human rights protection, especially of those people affected by severe psychiatric disorders.

To ensure the sustainability of these processes, some specific conditions are required, including the availability of and access to essential psychotropic drugs in outpatient and community-based health services, as well as health information systems that have the most sensitive and priority data on mental health.

Given the enormous burden to the health system caused by the misuse of alcohol and other substances, there is a need for national strategies to curb these activities. These strategies include the adoption of public policies, based on a consensus among different sectors, which will provide the platform for the aforementioned actions.

Recommended readings

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STRATEGIC AREA No. 4

HUMAN RESOURCES DEVELOPMENT

I. INTRODUCTION

In the majority of the countries in the Region, particularly in Latin America and the Caribbean (LAC), mental health systems face significant challenges in the delivery of mental health care that is consistent with the needs and characteristics of the population and that makes rational use of the available resources. In answer to these challenges, human resources (HHRR) play a key role, for example, in changing the paradigm of care, from mental institutions to community-based care. Importantly, this paradigm has been endorsed by all Member States of the Pan American Health Organization / World Health Organization (PAHO/WHO).

Apart from those, which are shared with other areas, the HHRR area confronts some specific challenges:

- Ensuring their adequate supply and geographical distribution;
- Providing positive practice environments, decent and stimulating working conditions, mechanisms of support and labor motivation to ensure the commitment of workers;
- Developing cadres of health and mental health workers with knowledge and skills to promote mental health, prevent psychiatric disorders, offer curative care in the community, and implement psychosocial rehabilitation programs. In addition, current HHRR should address the multiple psychosocial problems prevalent in their communities, as well as those that are newly emerging; and
- Ensuring that the community-based care model is translated into a routine practice in services and programs.

HHRR in mental health are characterized by trends and problems that are similar to those of the rest of the health sector. In 2005, twenty nine countries of the Americas gathered at a conference in Toronto, Canada, to analyze the situation of the human resources for health in the Region. Various problems were identified, such as the absence of policies in this field; the inadequate composition and inequitable distribution of the resources; the migration of health workers; and poor working conditions. In addition, it identified the lack of relevance in education, reflected in the separation between training, continuing education and health service priorities. As a result of the deliberations, the conference issued the "*Toronto Call to Action,*" identifying five critical objectives:

1) Define long-term policies and plans to prepare the workforce for future changes in the health systems, counting with their active participation including during the periodic revisions of policy and programs;
2) Place the right people in the right areas and positions, to achieve an equitable distribution in quantity and competence of health workers in the different regions in order to meet the specific health needs of the population;

3) Promote national and international initiatives for countries to retain their health workers and avoid staffing gaps;

4) Generate labor relationships between the workers and the health organizations that promote healthy work environments and foster commitment to the institutional mission to guarantee quality care for all the population; and

5) Develop mechanisms of collaboration between training institutions and health services to adapt the education of professionals and technicians to the framework of a health care model that is universal, equitable and of quality.

The debate generated in the Region as from the conference in Toronto led to the adoption of a technical document and a resolution by the Pan American Sanitary Conference of PAHO/WHO in 2007 on *Regional goals for human resources for health 2007-2015*. Resolution CSP27/10 offers both an appropriate framework for the analysis of the present situation and future projections as well as a set of orientations for the development of HHRR (1). This is the general context in which falls the development of human resources in mental health, which also has the specific political and technical support of PAHO/WHO 1997, 2001 and 2009 resolutions related to mental health (2, 3, 4).

Recall here that Resolution CD49.R17 reiterated the appeal to the Member States to *"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."* The Resolution constitutes a clear recognition that to achieve improvement requires the active participation of HHRR, encouraged by their commitment to change and properly trained to carry it out (6).

Furthermore, the document **Strategy and plan of action on mental health** (7)*, adopted through this resolution, recognizes that *"mental health programs depend, to a large extent, on properly trained human resources"* and warns that *"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."*

Both, the Resolution and the **Strategy,** make a clear call to those responsible for the development of HHRR in the countries to be creative when designing training programs, and to relinquish outdated patterns in terms of objectives, location and strict adherence to the traditional boundaries between professions. It is also a call to improve teaching methods and curriculum contents. This is a complex challenge, given that care provider institutions and educational establishments operate at a distance from each other, with little or no coordination (see item 5 of the *Toronto Call to Action*).

This disconnection between training and services has often led the ministries of health to provide training in basic elements that were not provided at the right time by undergraduate educational programs, consuming sizable proportions of their limited financial resources. At the same time, the scientific evidence for action has become weaker, as universities rarely include subjects that benefit the development of services in their research programs (7, 8, 9). That is why the **Strategy and plan of action on mental health** (7) stresses the need for *"strengthening partnerships with academic institutions to achieve the stated goals."*

Finally, the human rights component should permeate HHRR development processes and contents. As described in Strategic Area No. 1, there are international conventions, treaties and protocols that establish human rights principles related to the field of mental health, to which the countries are signatories.

The diversity of human resources

Community mental health care has led to a recognition that, in addition to specialists (e.g. psychiatrists, psychologists, nurses, social workers, occupational therapists, and educational psychologists), there are other agents that people turn to in personal or family crises (e.g. religious and community leaders, traditional healers and others), who operate within a pyramid-shaped care network. The basis of this pyramid is self-care and integrates various mental health care levels and agents, with differential intervention capacity (see Strategic Area No. 3).

The complementation between the population´s own resources and those of the health services in a community-based model has been described in a recent PAHO/WHO manual (10). Both groups, professionals and community agents, should be considered as fitting targets for HHRR development, in keeping with their respective functions and task profiles. As to the evaluation of the community agents' interventions, see the article by Bolton et al, among many others (11).

The proper composition of all HHRR and their equitable distribution are key elements in meeting the expressed and latent care needs at all levels and among all population groups. Adequate training for mental health service managers is also central, who, in their leading role, promote the necessary conditions for achieving improvements in the quality of care and the establishment of service networks. For example, PAHO/WHO, through the Virtual Public Health Campus, offers a training program for managers of mental health services in some Central American countries to support the design and implementation of mental health policies and plans. (See: http://devserver.paho.org/virtualcampus/drupal/)

> The importance of the HHRR component and the complexity of its development demands greater involvement of all stakeholders. This means that the strengthening and development of human resources in mental health requires a shared responsibility between the educational sector, with its network of academic and teaching institutions, and the health service providers. It is reasonable to expect that following a proper development, the HHRR will assume their leading role in the reduction of barriers and difficulties that currently limit adequate mental health care.

II. BACKGROUND AND FRAME OF REFERENCE

Rational development of HHRR should, at a minimum, revolve around five key areas. These should be considered by planners, service managers, training institutions of professionals, technical personnel, and other mental health workers to ensure a process that is integrated and consistent with national mental health policies and plans.

Key areas for the rational development of human resources

1. The health status of the population and its specific needs.[20]

HHRR should operate taking into account the sanitary and mental health situation at the national and local levels. Importantly, access to knowledge about the situation of mental health is facilitated by the existence of community studies on mental disorders and service evaluations, which have been conducted in several countries of the Americas (12, 13). This epidemiological situation, which reflects the disparities in the mental health status of the population (stemming from differential access to production and consumption goods that operates as a powerful social determinant), should be taken into account in the development of the HHRR. This is a *sine qua non* condition to become effective agents of change.

2. Consistency between HHRR development and national policies and plans, as well as with PAHO/WHO resolutions and international human rights conventions.

If mental health professionals lacked appropriate training in both theory and practice (fueled by values such as equity, which serve as the underpinnings for national policies and for PAHO/WHO resolutions), and if their training had taken place in the mental hospital environment, mental health workers would find it difficult to function within the framework of community-based mental health services. This obvious inconsistency between the locations where human resources are trained and the settings in which they provide services is a frequent contradiction.

An essential element to consider as well is the coherence between the international declarations and conventions adopted by the country and the practice. For example, for the *Convention on the Rights of Persons with Disabilities (2007)* to be a tangible reality in everyday actions, health workers must not only know of its existence but study it, internalize it, advocate for its implementation and act according to its guidelines and spirit (Box 1).

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20   PAHO/WHO periodically publishes a complete up-to-date report on the general health situation in the countries of the Americas.

Box 1. Convergence of policies and services with HHRR development in Argentina.

The linchpin of this experience that began in the mid-1980s was the articulation between mental health policies and services and the training of managers and leaders seeking the transformation of the traditional psychiatric services.

The experience linked PAHO/WHO technical cooperation with Argentine national and provincial mental health authorities and with the School of Public Health of the National University of Cordoba. Five courses were completed within the framework of this initiative, three on mental health policies, plans and services, and two on research. The courses were extended subsequently to other provinces, and within three years there was a network of numerous committed and motivated mental health agents provinces could rely on. This academic activity made it possible to harmonize concepts, align technical orientations, and move towards deinstitutionalization.

The courses (training component) encouraged the development of a series of national and provincial activities related to mental health planning and regulation (policy component). They also promoted national mental health seminars (information and research component) as well as processes of change in mental health services (technical and implementation component), with an impact that has spread over the years and continues today.

Source: Malvárez, S. Construcción de un nuevo paradigma de salud mental: la experiencia argentina. In: La Enfermería en las Américas. Nursing in the Americas. Enfermagem nas Américas. Pan American Health Organization. Washington, DC: PAHO; 1999.

3. Integrated networks of community-based mental health care

Professionals, technical personnel and community mental health workers should have the scientific knowledge and skills that will enable them to work within teams and networks in the total range of action: the promotion of mental health, the prevention of psychiatric disorders, the early identification of risks and problems, curative interventions and psychosocial rehabilitation (14, 15).

This knowledge should include interventions in disasters and emergencies (16, 17, 18, 19) because of the serious potential they have for affecting the neediest populations and causing immediate adverse psychosocial reactions, with possible impact in the medium and long-term.

4. Heterogeneous composition of HHRR in mental health

Given the magnitude and diversity of the populations' mental health needs, and bearing in mind that specialized human resources and services are limited, that the treatment gap is wide, that population attitudes are not always favorable with regard to mental health, and that there are community members potentially able and strategically positioned to meet some of those needs, human resources in mental health should be viewed as a heterogeneous group with convergent purposes. As stated before, adopting the network model for mental health care services proposed by PAHO (10), and modified by WHO (20), implies deploying financial, material, organizational and health worker resources, by level, in a manner resembling a pyramid (see Strategic Area No. 3, Figure 1).

Consequently, training and continuing education should be facilitated to them, so that partnerships, as harmonious as these different assumptive worlds permit, can be forged. Religious leaders, traditional healers, teachers, police officers, hairstylists, youth club leaders and other community agents are included in that group (18) (Box 2).

Box 2. An example of a potential partner: hairstylists as community agents.

Depressive disorders have high prevalence rates but their treatment gap is large. To strengthen community resources that could be used to reduce this gap, PAHO/WHO conducted a study in Panama on the knowledge and attitudes of hairstylists (N=268) in beauty parlors (N=107) about depression, taking advantage of the fact that the customers seek their services rather often and stay there for 1 to 3 hours every time.

It was observed that, although most hairstylists talked with their clients about their problems, their knowledge about depression was limited and their attitude toward treatment in the health services was ambivalent. It was concluded that training could make them partners and a valuable resource for community action to reduce the untreated prevalence of the disorder. Almost 90% of the interviewees expressed an interest in obtaining more information about depression (i).

There are also other examples. A recent study in the United States found that this group was an important source of informal social support for older adults and that they were capable of recognizing the symptoms of depression, dementia, and self-neglect (ii).

In short, despite existing cultural differences, if an offer of collaboration were appropriately negotiated so that salon personnel increased their knowledge and developed more positive attitudes, mental health professionals could gain strategically positioned agents in the community.

i. Moreno P, et al. El empleado del salón de belleza como agente comunitario en el control de los trastornos depresivos. Acta Psiquiátrica y Psicológica de América Latina 2003;48:1-4,47-56.

ii. Anderson K.A, et al. Hairstylists' relationships and helping behaviors with older adult clients. Journal of Applied Gerontology 2009, July 2. Published online.

5. The mental health component in the training and continuing education of health workers.

In general, undergraduate mental health training in technical and professional health programs is scarce or limited in scope. This situation repeats itself in graduate education and in-service training. It is therefore necessary to expand and strengthen the mental health component in those educational processes (see below).

III. THE STATE OF HUMAN RESOURCES FOR MENTAL HEALTH

The evaluation of mental health systems carried out in several Latin American and Caribbean countries using the World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) (5) identified some common problems. Among other results, it showed that there is a clear disproportion between the burden of mental illness and psychosocial problems (around 22%)

and the time devoted to mental health in the undergraduate curriculum. Added to this, is the fact that the universities are not graduating mental health professionals and technical personnel in numbers consistent with the needs of the countries.

WHO-AIMS also revealed an inequitable distribution of psychiatrists in the countries studied, be it in terms of territory or by type of workplace. They are located in psychiatric hospitals in greater proportion than at general hospitals, outpatient services or community mental health care centers. Another finding, for example, was the limited number of mental health nurses in most of the countries, in contrast with the relatively high number of psychologists, especially in some South American countries.

WHO-AIMS identified unequal opportunities for in-service training. As a rule, training programs benefit psychiatrists more than other mental health workers. Coverage levels for training programs in mental health, for both specialized and primary care personnel are very low. For example, in Central America, only 7.7% of primary health care (PHC) physicians received at least two days of training in mental health in the year preceding the study.

From the current situation analysis, there is a clear need for mental health workers to be trained in a comprehensive manner. This would allow them to achieve a broader role and perform multiple functions in the context of mental health teams so as to partly overcome the traditional boundaries between professions. The issue of rigid professional boundaries, especially in community care, merits special analysis and decision-making in each country.

Another regional study conducted by PAHO/WHO to be published under the title *Enseñanza de la enfermería en salud mental en los países de América Latina* [Teaching of mental health nursing in the countries of Latin America], analyzed the structure and contents of education and found that it follows a predominantly psychiatric model with community-oriented elements and prevention. Another significant finding was the diversity of contents that address the three levels of prevention (primary prevention, early diagnosis and timely treatment, and rehabilitation). Paradoxically, practices continued to be centered on the traditional psychiatric hospitals.

Lastly, a study conducted in 2007 by PAHO/WHO and completed by the National University of Córdoba in Argentina (Escalante M et al. Personal communication) used the database of the Latin American Association of Schools of Public Health to identify the existence of mental health master's degree programs. Of a total of 109 educational institutions, only seven offered specialized master's degrees in mental health. The study also revealed that only 15.8% of the 95 master's degree programs in public health had mental health contents. Among the remaining programs (e.g. master's degrees in health services administration), 39% offered these contents. This situation is particularly troubling as the graduates with master's degrees are the future leaders and managers that will run programs and services, be responsible for decision-making and define the strategic vision of mental health plans.

IV. PROPOSALS FOR ACTION

The general objective described in the document **Strategy and plan of action on mental health** (7) and Resolution CD49.R17, 2009 (4) establishes that it is a duty to: *"Train health workers, improving their mental health skills, ensuring they are consistent with their function in the health system."*

The activities at the national level suggested in this document are the following:

- Ensure an up-to-date database of human resources in mental health, which will serve as the basis for planning;
- Formulate systematic training plans for health workers, with curricula based on the development of appropriate competencies;
- Ensure that training programs include human rights issues;
- Ensure in-service supervision to support the training process;
- Formulate expanded training plans that include informal service providers, community agents and workers from other sectors related to mental health (e.g. police officers, judges and teachers);
- Evaluate the professional profiles for nurses, and plan differential modalities for undergraduate and graduate education to enable these professionals to be involved in specific mental health functions. Nurses are a vital resource in all countries;
- Ensure equitable access to technical and scientific information available; and
- Collaborate with the universities and training programs to include or improve community-based mental health contents in undergraduate and graduate curricula.

The above mentioned activities, taken from the **Strategy and plan of action**, are, extended, complemented and specified through six action proposals. These are preceded by a set of general recommendations.

General recommendations

The proposals for action suggested below include a set of common elements and conditions that are essential for maintaining conceptual and practical unity between the development of HHRR and the construction of integrated service networks. These recommendations are:

- Promote multisectoral participation, specially including the health and educational sectors, as well as other relevant sectors of civil society;
- Ensure an interdisciplinary approach in HHRR learning and development processes;
- Promote an active participation of mental health workers, as well as of users and their families, in the design and implementation of the training programs;
- Regard population studies on mental health status and social determinants as the basis for the training programs, together with the policy for developing community-based mental health services, particularly with reference to the process of deinstitutionalization;
- Encourage the diversification of practice settings in the training, such as specialized and general health services and those engaged in primary prevention and psychosocial rehabilitation;
- Integrate ethical, human rights, intercultural and gender components in all training programs;

- Design and implement comprehensive educational models that include the development of critical thinking and the ability to function at work in conditions of conflict, tension and uncertainty;
- Incorporate new information and communication technologies into the training processes, develop online learning, and promote the production and dissemination of educational resources; and
- Promote cooperation between countries to facilitate the exchange of knowledge, best practices and experiences, within the framework of mutual collaboration fostered by Pan-Americanism.

Proposals for action

1. Formulate and implement a comprehensive development program for human resources for mental health.

The problems related to human resources development are complex and directly affect service delivery at different levels. A necessary basis for planning in this field is to have a well formulated situation analysis. Fortunately, as a result of studies conducted at the regional and national levels, the majority of the countries have at least some basic data on the state of HHRR in mental health (in terms of quantity, distribution, and qualification level).

As already stated, mental health human resources are heterogeneous and include professionals, technical personnel and other agents outside the health sector. Indeed, a comprehensive program for the development of human resources should take into account the role, skills and knowledge of mental health and psychosocial issues required for general health workers. HHRR development also requires political will to prioritize it and to ensure continued funding for its effective and sustained implementation.

Educational and training programs in mental health do not operate in isolation but interact with other components of the complex field of human resources. Among those are: personnel allocation and distribution, incentive systems, retention mechanisms and health careers, regulatory and service operation processes, and professional organizations. The articulation of all those components with the country's health, educational and labor policies should also be considered to assure a proper HHRR development.

Objective
- To design a program for the development of human resources in mental health that offers an integrated response to current and future needs on the subject, has adequate funding, and its objectives and guidelines are included in the national mental health policy and plan.

Recommendations

- Establish an intersectoral coordinating group or mechanism for all parties involved in the training of HHRR in mental health (e.g. ministries of health, education and labor; universities; professional and users associations);
- Formulate and implement a comprehensive and periodically updated program for training and capacity-building, to respond equitably to mental health needs of the population, taking into account current epidemiological findings and projections for the future, health services

situation assessments, the recommendations of the **Strategy and plan of action on mental health** (7) and Resolution CD49.R17/2009 (4). The program should be tailored for the national, local or institutional levels. The definition of times and goals, with a period not exceeding five years, is also recommended; and

- Adopt the *Regional goals for human resources for health* (1) as a guide for the development of actions.

Indicator

- Existence of a national program for the development of HHRR in mental health congruent with the *Regional goals for human resources for health* (1), that is agreed by all the parties involved, has adequate funding, and properly reflects the actions included in the national mental health plan.

2. Train mental health professionals and technical personnel in management positions in services and/or programs and all those responsible for implementing actions.

Activities aimed at meeting the mental health needs of the population require complex technical and administrative management techniques, guided by scientific knowledge from several disciplines (e.g. epidemiology, anthropology, sociology, health economics and political science). But, as it is the case in public health, training based exclusively on clinical contents and skills is neither sufficient nor appropriate for performing managerial functions or leading the implementation of the full spectrum of actions necessary in community mental health. This need has resulted in the progressive (but still insufficient) development of master's programs and post-graduate courses in mental health in various educational institutions of the Region.

Objective

- To plan the mental health staff development so that they can hold competently management and leadership positions in the implementation of the national mental health policy and plan (or provincial/state level, as appropriate).

Recommendations

- Open graduate programs in mental health, or in public health with a specialization in mental health, in as many universities and educational establishments as determined by national needs and capacity;
- Ensure the involvement of all stakeholders, especially, the ministries of health, service providers and educational institutions, acting in a sustained and coordinated manner;
- Courses should prioritize mental health professionals and technical personnel who hold, or can hold in the future, leadership positions in planning and management (including of hospital and community services and programs), in education and research;
- These programs should provide knowledge about: deinstitutionalization and the community mental health model; epidemiology and mental health research methods; human rights; relevant aspects

of the social sciences, statistics, planning and administration of programs and services, including financing, computer skills and English, to facilitate access to the scientific literature (19); and

- Identify and analyze the post-graduate programs in public health and health services administration available in the country and, if needed, to promote the integration of mental health components in their curricula.

Indicators

- Number of specific master's programs and/or graduate courses in mental health with a public health focus; and
- Number of graduate courses in public health with a mental health component incorporated (in universities or other educational institutions in the country).

3. Train specialized human resources that could operate within the mental health services network.

The mental health care community model is based on both, scientific evidence and a human rights approach, and it requires complex skills and technical tools to carry out activities for promotion, prevention, treatment and psychosocial rehabilitation, as well as for changing patterns of thought and action in mental health. There are multiple activities to be performed, which include planning, the delivery of direct and indirect care, information, monitoring, evaluation and research. All this requires the development of specialized human resources, among other tasks, to be in charge of highly complex mental health actions, whether individual or collective, and to provide consultation, support and training of PHC and general hospitals staff.

It is up to each country, province, state, or region to set up the training programs most suited to the needs of the respective population, given the resources available (both existing resources and those mobilized specifically to meet this objective), in line with the national mental health policies and plans. Countries now have available accessible literature and technical documentation for training specialized personnel (10). Training programs should use dynamic and innovative educational methods and strategies.

Box 3. A successful training experience with the mental health services nursing staff in Belize.

Given the country's lack of psychiatrists, Belize took the initiative of providing specialized mental health training to nursing staff and assigned them responsibilities in all aspects of community-based mental health care. Belize currently has 3.3 specialized nurses for every 100,000 inhabitants. This strategy is responsible for establishing a permanent and well-received presence within community-based mental health services, thus facilitating access to these services and helping promote linkage with primary care.

In addition to providing outpatient curative clinical services, nurses participate in preventive activities in mental health, assist in crisis situations, advise the courts, administer care to people with suicidal behaviors, and offer psychological counseling both before and after HIV testing. These nurses are also trained and authorized to prescribe a limited number of psychotropic drugs. They consult regularly with the country's only psychiatrist and participate in workshops and continuing education sessions to update themselves on the latest techniques in the management of mental health problems.

The presence of community-based services was a contributing factor in the closure of the country's psychiatric hospital in 2008. The national health network includes eight public and five private hospitals, as well as 37 health centers. With the closure of the psychiatric hospital, patients requiring hospitalization are now admitted to the country's general hospitals. This allows families to participate directly in the patient's care and enables patients to be treated in their own communities.

By facilitating accessible, low-cost community services, Belize has demonstrated that it is possible to significantly expand care to patients with mental health problems. Thus, nurses can be trained effectively to provide mental health care to the vast majority of people with psychosocial problems. Currently, only a small fraction of patients need to be referred to the psychiatrist.

The key to this training process lies in the necessary intersectoral articulation, in which service providers, educational institutions and professional associations come together to set criteria and priorities and identify mental health specialization needs in medicine, nursing, psychology, social work, and other specialties (Box3).

Objective

- To implement programs for the development of specialized human resources so that they can perform actions in the mental health services network from a community perspective, including in emergencies arising from disasters.

Recommendations

- Health care providers (ministries of health, social security, municipalities, NGOs), with the support of educational institutions and professional organizations, should plan and provide

training for all specialized staff so that they can perform the multiple activities characteristic of the community mental health model, based on agreed on priorities and available resources;

- Specialized staff training should be developed in an interdisciplinary context to create a collaborative culture among professionals and thus enrich needs assessments and intervention modalities;
- Mental health personnel should be trained to perform a dual role: as providers of specialized services, by implementing mental health programs at different levels; and as multipliers, by developing training programs for PHC workers, including supervision and support for the health workers in those services, and training and support for community agents, when partnerships are established; and
- Specialized personnel should be trained to be competent in monitoring actions and program impact evaluation.

Indicators

- Existence of a training program for specialized mental health workers, with content, times, evaluation requirements and other defined standards (according to the team members' different professional profiles); and
- Percentage of mental health personnel (in all specialized disciplines) who work in community mental health programs and have had a complete course in community mental health, meeting the standards set by the country, and whose results have been evaluated.

4. Increase the mental health response capacity of health workers at the first level of care and in the hospital service network.

Increasing mental health care coverage and reducing the overwhelming treatment gap that currently exists depends on the increase of the capacity to respond to mental and psychosocial health problems in first-level care services and general hospitals. For this, it is essential to include primary health care workers in training programs. These programs should:

- Develop the ability to identify and address the most common mental health problems at different ages, including comorbidity with physical illnesses;
- Promote positive attitudes free of stigma and imbued with respect for people affected and their families; and
- Launch initiatives aimed at promoting mental health and prevent mental disorders.

It is also necessary to train health personnel in general hospitals on the psychosocial aspects of care for people with physical illness and mental disorders, who are treated in emergency rooms or as inpatients.

The building and strengthening of the health workers' response capacity starts during basic training. Therefore, the integration of mental health contents into the undergraduate curricula of careers such as medicine, psychology, nursing, social work and occupational therapy is required (Box 4).

Box 4: Basic content for training health workers of the care services network.

Common contents for all staff
- Concepts of community mental health and mental health determinants;
- Promotion of inclusion and solidarity with regard to different people;
- Identification of risk situations for mental health problems: extreme poverty and marginality; crises generated by loss (bereavement, divorce, unemployment); chronic diseases; domestic violence; sexual abuse and family dysfunction; or any other negative event in life, such as school failure among adolescents and young adults;
- Establishment of a significant relationship with users and family members, taking into account sociocultural and gender differences;
- Development of skills for communicating with users and their families, health workers, members of the community and specialized mental health personnel; and for communication among the service network staff;
- Intervention in situations of individual or family crisis and in emergencies and disasters;
- Initial intervention in the care of people with signs of addiction, violence, stress, depression, emotional problems related to physical conditions, mental health problems of children and elderly people, and the management of psychosocial problems of everyday life;
- Promotion and protection of mental health and prevention of emotional problems and psychological suffering;
- Information on the community mental health services network and referral system;
- Monitoring, retention methods, support, rehabilitation and social reintegration of people with mental disorders under treatment.

Contents for physicians at the first level of care and in non-specialized hospital services
- Timely detection and management of priority conditions established by WHO mhGAP *Mental health Gap Action Programme* (20), namely: depression; psychosis; bipolar disorder, epilepsy, developmental and behavioral disorders, dementia, alcohol use and drug use disorders, self-harm and suicide, and other significant emotional or medically unexplained complaints.

Contents for nursing personnel at the first level of care and in non-specialized hospital services
- Detection and clinical and community management of mental disorders, according to the priorities set by the mhGAP (especially if there is no physician at the first level of care);
- Skills required for home care and community management of people with mental disorders, especially the most severe and chronic;
- Capability to plan and carry out actions for mental health promotion and primary prevention; and
- Ability to provide monitoring, curative care, rehabilitation and social reintegration to people with mental health problems who have been discharged from psychiatric hospitals, and their families.

Objectives

- To develop HHRR training programs for personnel in the community services network and in general hospitals, so that they become competent to carry out activities in mental health promotion, prevention, curative care and rehabilitation, and in the psychosocial aspects of physical illness (Box 4); and
- To promote the integration of community mental health values, contents and practices into the undergraduate curricula in medicine, nursing, psychology, occupational therapy and

social work. These should allow the identification and analysis of mental health problems in the community and the design and implementation of programs and basic interventions of promotion, prevention, health recovery and rehabilitation.

Recommendations

- Establish training of trainers programs (for mental health professionals) in educational techniques, information and communication technologies applied to learning, and familiarize them with the contents of PAHO and WHO publications for mental health services and programs (e.g. the **Strategy and plan of action** and the mhGAP, among others);
- Familiarize trainers with the principles of continuing education and e-learning (Web- based distance learning) and with the community mental health model so that they can then train non-specialized personnel in the services network, especially in PHC. They should be aware of community interventions of proven effectiveness and their potential to assist users;
- Establish intersectoral "service-education" partnerships to promote the integration of community mental health values, contents, and practices into the undergraduate curricula in nursing, medicine, psychology, social work, and occupational therapy; and
- Develop teacher-training courses on the mental health community model that include the identification of and management of mental health disorders, as well as prevention and promotion. This should help improve the learning contents and practices of basic training.

Indicators

- Existence of a training program in mental health available to personnel in the first health care level and general hospitals, with a clear definition of contents, times, evaluation requirements, and other standards (according to the different profiles of responsibilities of the team members);
- Percentage of human resources at the first level of care and in general hospitals who have received a mental health course that meets the standards set by the country, the results of which have been evaluated. This course should include the management of priority conditions based on the WHO mhGAP intervention package;
- Percentage of schools of health sciences that have integrated mental health into the undergraduate curricula (e.g. medicine, nursing, social work, occupational therapy and psychology) and have developed teacher-training community mental health programs; and
- Percentage of curriculum time devoted to mental health contents (e.g. psychology, behavioral sciences, mental health and psychiatry) in medicine, nursing, social work, occupational therapy and psychology.

5. Training of key community leaders and agents in the psychosocial aspects of health.

There are agents in the community who, because of their specific roles and activities, are involved in work related to mental health in a broad and comprehensive manner (health promotion, primary prevention, and curative care and rehabilitation of mental and psychosocial problems). Those tasks are as varied as the functions of these agents are: teachers identify behavioral disorders in their students; religious leaders provide spiritual support for persons in crisis (e.g. divorce, bereavement);

lay leaders can serve as advocates for services and community education; hairstylists can refer clients suffering from depression, for example, to a health worker; work supervisors can identify and refer workers who abuse alcohol; police officers are called on to act in critical situations in public areas; and similarly with regard to other agents (e.g. lawyers, policemen and firemen). An additional advantage is that these agents are located in positions accessible to potential users and are free from the stigma that still surrounds specialized mental health services.

There are other people in the community, such as traditional healers, who are an intimate part of the social and cultural life of the population, even in urban settings. The functions of such groups should be examined objectively and without prejudice to establish a good working relationship for the benefit of the community. Both the benefits of their activities and the potential risks and adverse effects, including human rights violations, should be recognized.

Finally, social communicators are another important influential group who, properly oriented, can help disseminate mental health issues and community mental health information and practices (see Strategic Area No. 2).

> It should be pointed out that the list of community agents starts with the individual himself, whether a user of specialized services or not, who practices self-care and takes part in mutual support activities. However, for self-care to be effective, appropriate and reliable information should be made available to all (21).
>
> Individuals, their families and community-based care providers have a huge potential for help so long as they possess proper capacities and tools. They can, and should, play an important role in identifying and referring people and families with problems, in monitoring and rehabilitation, and, particularly, in social reintegration actions. They have the right and responsibility to actively participate in the design and implementation of mental health policies and plans.

Objective

- To develop training programs especially aimed at community agents outside the health sector. These programs should be developed in a participatory manner, with monitoring and impact assessment, including in disasters.

Recommendations

- Identify health community agents and explore their knowledge, attitudes, and practices to forge partnerships with those who are considered fit, in order to increase their capacity to detect mental health problems and to refer people in need to the formal health services timely; and to support them in the effective implementation of their activities up to the limit of their operational capacity (10);
- Inform families and community members about different aspects of mental health care through specific programs (e.g. educational campaigns) and the media. These activities aim at increasing the level of self-care and mutual support and at informing on general and

specific mental health problems, such as matters related to substance use or to crises and disasters; and

- Provide mental health information to the media so that they cooperate with the dissemination of appropriate contents, best practices and service availability, and refrain from sensationalism or improper handling of information.

Indicators

- Number of community programs designed to increase self-care and mutual support in mental health;
- Number of programs for community health agents and number of agents (province/ state, district, municipality) that have received mental health training (in keeping with the standards set by the country); and
- Number of training/information activities for journalists and media workers and number of participants.

6. Training of psychiatric hospital staff in the processes of deinstitutionalization.

Many of the countries in the Region still have a large number of psychiatric hospitals and people that have been hospitalized for long periods, thus perpetuating stigma, abandonment and long-term disability. The staff working in these institutions (e.g. physicians, nurses, psychologists, social workers, occupational therapists, service personnel, and managers) constitutes a critical group who, if properly trained and motivated, can become agents of change and the drivers of reform and deinstitutionalization, rather than an obstacle to both.

> Most of the regional experiences in reform and deinstitutionalization have focused on sensitization, motivation and training of the mental hospital personnel.

Sensitization and training activities for the mental health hospital personnel offers them the possibility of recovering a sense of dignity, creative capacity, institutional commitment, competence for rehabilitation, and a positive outlook for the future of the field, all of these often missing in the traditional psychiatric hospital life.

Objective

- To design and implement in-service continuing education programs in psychiatric hospitals using an appropriate, dynamic and motivational teaching model.

Recommendations

- Directly link the training of all the different groups of the hospital staff with regard to the psychiatric reform and deinstitutionalization; and
- The programs should include, among others, the history and analysis of the outdated mental institutions as "total institutions;" the replacement of this model with integrated,

community-based mental health service networks; strategies for social diagnosis to program the discharge of inpatients in an adequate way; techniques for rehabilitation and social reintegration within the context of the family, the community and work.

Indicators

- Number of continuing education programs in mental health available to the staff of traditional psychiatric hospitals, with definition of contents, times, evaluation requirements, and other standards; and
- Percentage of psychiatric hospitals with continuing education programs aimed at promoting reform and deinstitutionalization.

V. Conclusions

The development of human resources is a vital strategic component to improve the mental health status of the population. According to different studies performed, the current situation of HHRR suffers from major limitations, but it is possible to correct them. Needless to say, the process of change should be carefully programmed by all the parties involved. All this requires a creative and conscious joint effort.

Obviously, it will be almost unattainable to provide quality care that is respectful of the human rights of people with mental disorders and their families, if countries do not prioritize the strengthening of human resources by raising their level of competence and social commitment.

The development of human resources poses more than a few difficulties. The issue is to relinquish outdated frameworks that rely on a corps of specialized personnel solely. Such a framework of action prevents the development of a model of care adapted to the distinct needs of different population groups and extends the current gap. As an example, for certain disorders, such as alcohol use, there are more people who do not have access to care (nearly 70%) than those who actually receive care from the health sector (22).

Since there are many and diverse community agents (10, 11), efforts to provide mental health training should reach them all, beginning with self-care and mutual support. Furthermore, program design should be in accordance with the functions, characteristics, autonomy and opportunities for action of these agents.

Probably nothing can have a greater adverse impact on HHRR development programs than the failure to harmonize training and educational scenarios with service delivery settings. It is unlikely that appropriate training for future health agents can be provided in undergraduate programs if teaching activities are not located in the community. Moreover, graduate programs (e.g. psychiatry residencies) cannot be based on psychiatric hospitals either.

Mental health action in the community demands a body of knowledge that is differentiated by the level of complexity, depending on where the agent is situated in the care pyramid. The resolutions

of PAHO/WHO Directing Council would merely be dead words and the needs of large population groups would remain unmet if mental health actions were not based on scientific evidence and imbued with the principles and values spelled out in the **Strategy and plan of action** and other international resolutions and conventions adopted by the governments of the Hemisphere.

Finally, though no less important, actions to promote the development of human resources should be carefully evaluated to verify whether or not the proposed targets have been met (23-26). In conclusion, training involves monitoring, support and supervision in the field.

Minimum teaching material and key readings for training programs

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STRATEGIC AREA No. 5

STRENGTHENING CAPACITY TO PRODUCE, ANALYZE AND USE INFORMATION ON MENTAL HEALTH

I. INTRODUCTION

The Directing Council of the Pan American Health Organization/World Health Organization (PAHO/WHO), aware that in many countries information on mental health is limited or nonexistent and the deficit in sound decision-making that this implies, adopted Resolution CD49.R17 in October 2009 (1). Among other things, it urges Member States "*to bridge the existing mental health information gap by improving the production, analysis and use of information, as well as research, with an intercultural and gender approach.*"

The **Strategy and plan of action on mental health** (2), which served as a basis for the Directing Council's deliberations, recommends: "*Strengthen[ing] the National Health Information System to improve collection and regular analysis of a core set of mental health data.*" Strategic Area No. 5 in that document establishes the following three operational objectives:

Objective 5.1: To comprehensively assess mental health systems in the countries by establishing a baseline and monitoring the situation.

Objective 5.2: To improve the mental health component in National Information Systems, ensuring regular collection and analysis of core mental health data.

Objective 5.3: To strengthen research on mental health within the parameters of each country's needs and available resources.

This chapter discusses several components of information and research, with a view to guiding and facilitating the implementation of the **Regional Strategy**, based on each country's specific conditions.

> Health Information Systems (HIS) collect and process relevant sector's data, to then analyze them and turn them into information. This information, disseminated and analyzed by all stakeholders, provides a sound basis for decision-making while making it possible to identify problems and needs, prioritize, assess trends, and to evaluate the impact of policies, plans, programs, and interventions (3). A central objective of HIS is to make practical use of the information in the processes required for improving health work.

The concept of "system" involves a connection between all the components, whose structure, organization, and operations are geared to a particular purpose. This also applies to HIS, because the different components responsible for the collection, processing and analysis of data, the dissemination of information and decision-making are interconnected and communicated.

Evidence can come from both quantitative and qualitative research and/or from the HIS. This interplay of information is particularly useful in policy and program design (5). HIS should have the

capacity to provide evidence-based information. This helps improve the efficiency of the investment in health and enforce social justice principles, such as equity (6).

HIS are useful for all stakeholders: for those who design and implement national and/or local policies and programs, for those who direct health systems at different levels and for those who directly manage health services and teams. HIS are also useful for the community and for public opinion in general since they provide information about the state of collective health as well as on the impact that the various implemented - or not implemented - policies have on it. In this regard, HIS help enforce the "right to information" established by international conventions, to which countries are signatories. Note that each stakeholder involved and each level of action has different needs, which means that these systems should be molded to fit particular requirements.

The following are the areas that should be included in a HIS (4):

- Health determinants (social, economic, environmental, behavioral, and biological), and the context within which the health system operates;
- Health legislation, policies, plans, and programs, as well as health system resources (infrastructure, equipment, human and financial resources and information systems);
- Health system performance (availability, access, quality, and use of services); and
- Population health outcomes (mortality, morbidity, disability, well-being, and quality of life).

At the local management level, the HIS should give health teams and all potential users rapid access to information, with the resulting improvement in the effectiveness of services and their interventions, in addition to democratizing decision-making. It has also been observed that an HIS can enhance coordination among facilities and support processes for improving quality of care (7).

II. Background and Frame of Reference

Public health information systems

For HIS to operate as they currently do, it was necessary to develop at least three components:

- A system for the definition and classification of diseases;
- A set of statistical methods of analysis for bio-social events; and
- An organized health care system that uses this information.

The first information systems, developed in the late 19th century and first half of the 20th century, concentrated on infectious diseases surveillance. Subsequently, with the expansion of the field of population health under the direction of the World Health Organization, information was added on chronic noncommunicable diseases, trauma and accidents, occupational health, physical environmental factors, unhealthy behaviors, and, in recent decades, elements of health system structure and process. Furthermore, improvements were made in definitions and classifications as well as in the methods of analysis. More recently, computer technology was also incorporated (8).

HIS are used for (9):

- Quantitative estimates of health problems;
- Documentation of the distribution and spread of health/disease events;
- Portrayal of the natural history of disease;
- Detection of epidemics, facilitating epidemiologic and laboratory research;
- Monitoring of population health determinants;
- Evaluation of disease control and prevention measures;
- Monitoring health services performance;
- Empirically testing working hypotheses; and
- Producing input for health planning.

Many developing countries have underutilized HIS because, among other things, data quality is poor, they function intermittently or they are not part of decision-making processes (10). An important additional problem is that professionals lack a culture/habit of making regular efficient use of the available information.

Periodic evaluations are fundamental to ensuring the usefulness and efficiency of the HIS. Nevertheless, they are rarely done. Below is a summary of the basic elements that should be included in the evaluation (11):

- Importance for population health diagnosis: determine to what extent the events or data that the system captures are the most important for describing population health and its determinants;
- Objectives and usefulness: determine whether the objectives of the system and the data collected continue to be valid in the current epidemiological scenario, if they are used for decision-making, who uses them, and what actions are executed;
- System operation: describe the HIS's target population, the components involved, the way they are organized and function, and the implementation of the three basic activities (data collection and processing, information analysis and production and dissemination of results);
- Quantitative attributes control: determine the extent to which the system is processing information correctly and in a timely manner, evaluating sensitivity, specificity, and predictive values, as well as the representativeness of the information and whether it is delivered punctually; and
- Operating costs of the system: estimate the direct operating costs and cost-benefit of the system.

There are also some particularly important ethical aspects that should be considered by those who design and operate an HIS:

- It should be determined whether the HIS and its products benefit the health of the population, compared with the potential risks and/or harm they could cause to individuals or the population at large. This analysis should be explicit and transparent to any member of the community and should be evidence-based;
- Careful handling of people's data should be guaranteed. This can involve the request for informed consent, together with respect for an individual's freedom not to provide data if he does not want to without any negative consequence. The confidentiality of all personal information in records and computerized systems should also be guaranteed;
- Potential conflicts of interest by system administrators or some users should be considered. These conflicts can arise from the improper use of information on individuals, as well as from the exclusion of information when there is intent to conceal a situation. Consideration should also be given to potential conflicts of interest associated with specific investigations using information on individuals from HIS; therefore, the use of the same protocols that ethics committees use to evaluate research proposals is recommended; and
- It must be ensured that the information produced is public and easily accessible to anyone. This holds true for both reports and specific investigations.

Mental health information systems

HIS for mental health (MHIS) have general characteristics in common with the systems used in public health. Nevertheless, they also have some distinctive problems or limitations:

- It can be difficult to determine the presence of a mental disorder in an individual. To avoid diagnostic reliability problems, it is recommended that strict use be made of international standardized classification systems and their diagnostic criteria (Chapter 5 of the World Health Organization's International Classification of Diseases ICD-10); For research, it is preferable to use structured interviews for collecting information and diagnosing disorders;
- The lack of priority that mental health problems tend to have in some countries' health policies;
- The stigmatization and social discrimination suffered by people with mental health problems make the need for carefully reviewing ethical aspects; and
- The existence of multiple institutions working in the mental health area entails a challenge: their coordination for the creation of an MHIS that responds to the necessities of all relevant parts.

Unlike other areas of public health, the type of care and services model in mental health has been the object of ongoing discussion. Over the past half century, there have been reforms in psychiatric care that have included the progressive closure of large psychiatric hospitals and the creation of alternative ambulatory services based on a community model (see Strategic Areas No. 1 and 3). This has brought with it an expansion in the kind of problems addressed; greater complexity in interventions (with special emphasis on those of a psychosocial nature); the integration and coordination of health care systems; the development of programs that seek to improve the response capability of primary care; greater interest in promotion and prevention strategies; and concern

about preventing stigma and discrimination as well as safeguarding the human rights of people with mental disorders and their families. MHIS should include data and indicators that make it possible to measure the progress made by this community model. Each country, in turn, should design an indicator system that best reflects its policy and plan of action on the matter.

Finally, it is recommended that MHIS be grounded in and built on public health models, increasing the possibility that the information produced will be used in decision-making (12, 13, 14, 15).

Status of information and research

The assessment study of mental health systems done by PAHO/WHO in most of the Latin American and Caribbean countries (using the World Health Organization Assessment Instrument for Mental Health Systems, known by its acronym WHO-AIMS) (16) identified the status of mental health policies, plans, and services in general and included items about information. Another study conducted by the *Global Forum for Health Research*, linked to the World Health Organization (17), explored research output through a survey of investigators from Latin America and the English Caribbean identified by various means.

The results on information systems, obtained from WHO-AIMS, and on research, from the second study (16), revealed the limited development or complete absence in virtually all the countries of an MHIS and research, especially on mental health services. It should be pointed out, however, that countries such as Brazil, Chile, and Mexico have promoted policies that have resulted in concrete benefits in both spheres of action.

In conclusion, most countries have two responsibilities:

- To develop an information system that will provide a firm foundation for decision-making; and
- To investigate how mental health services operate to verify their effectiveness, their commitment to the principle of equity, and, in general, to justify the investment in them.

III. PROPOSALS FOR ACTION: TOWARDS A MODEL FOR MENTAL HEALTH INFORMATION SYSTEMS

As noted above, the MHIS should be a subsystem or fully integrated component of the HIS. The model proposed below is only a frame of reference to be applied in different ways and with different degrees of complexity depending on the cultural context, the socioeconomic conditions and the level of development of community mental health services in each country. Table 1 describes the basic elements of an MHIS model that could be applied in low- and middle-income countries.

Table 1. Main aspects of an information system.

Input & Resources	Processes	Outcomes
• Coordination and leadership • Policies and laws • Human resources • Budget • Infrastructure	• Data collection • Processing • Analysis • Dissemination	• Information used for decision-making

MHIS Input and resources

Coordination and leadership

Action is required by the operational personnel responsible for MHIS (18) in order to maintain working relationships with the different actors involved in the collection, analysis, and use of the information from the health sector and other sectors and to lead technical and administrative aspects. The national mental health coordinating program or agency in the ministries of health should establish a clear and effective working relationship with the HIS.

It is recommended that an advisory group be created in which the different stakeholders in the mental health system are represented and which reflects the different disciplines and needs of MHIS users. The advisory group can be specific to the MHIS or the mental health policy and plan in general, and its members should include the following parties at a minimum:

- Mental health service managers and teams;
- Primary health care teams; and
- Mental health service users and their relatives.

Policies, laws, and regulations

The MHIS has the basic function of measuring the degree to which the goals and targets of mental health policies and plans have been met (19).

The legal backing for mental health policies varies from country to country. The measures specified in legal regulations facilitate data acquisition from public, semipublic, and private mental health services, and from other sectors. Legislation is also useful for establishing the ethical and legal parameters for data collection and transfer, and the dissemination and use of information (3).

Human Resources

The MHIS requires teams with technical competence. For example, at the national level, it would be convenient to have at least one mental health professional with training in public health to oversee information quality, guide its analysis, and safeguard its use. At the local level, mental health teams must be trained in data collection methods, as well as data analysis and use for their daily work. Since the MHIS should be part of the HIS, the staff that runs the latter should be sufficiently knowledgeable about the specific characteristics of mental health data.

Budget

The MHIS needs financial resources to carry out its activities. In order to justify the request for these resources, it is advisable to estimate the cost-benefit of having an appropriate information system, taking into account the contribution that the system can make to the improvement of the

mental health services network and the possible reduction in unnecessary spending owing to a lack of information for sound decision-making.
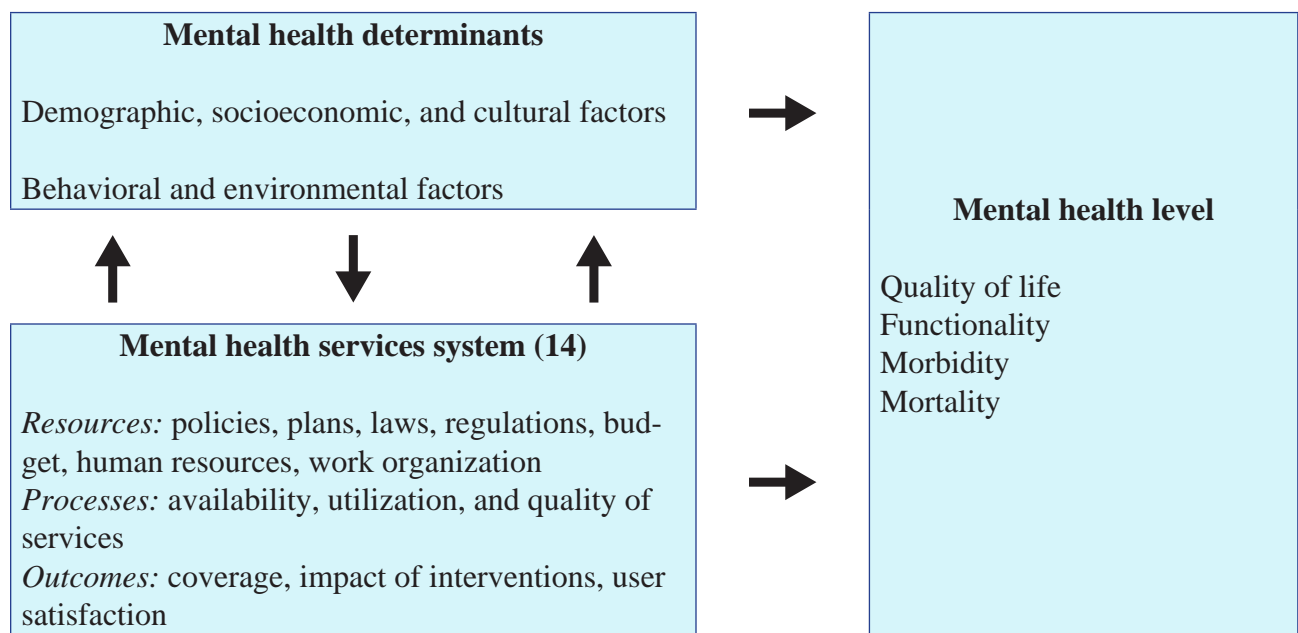
Infrastructure

It goes without saying that the investment in infrastructure will be more feasible and efficient when the MHIS is part of an HIS. In low-income countries, at the local level, having pencil and paper and a system for communication with the central levels (regular mail, fax, e-mail) is enough. However, a computer system that stores and processes the data is indispensable for the national and regional levels.

Processes

Data collection

At the central levels, a basic set of regularly used indicators should be defined for monitoring and evaluating the mental health policy or plan, taking its goals and targets into account. At the peripheral levels, intermediate indicators can be added that permit monitoring and evaluation of local goals and targets. The frequency for measuring the variables associated to the indicator will depend both on the ease of obtaining the data and on the possibility that the condition being measured will change. The indicator set should cover the different areas that need to be measured for decision-making, including the principal mental health determinants and the mental health status of the population (Figure 1).

Figure 1. Principal measurement domains in a mental health information system (MHIS).*

Mental health determinants

Demographic, socioeconomic, and cultural factors

Behavioral and environmental factors

Mental health level

Quality of life
Functionality
Morbidity
Mortality

Mental health services system (14)

Resources: policies, plans, laws, regulations, budget, human resources, work organization
Processes: availability, utilization, and quality of services
Outcomes: coverage, impact of interventions, user satisfaction

* Adapted from: World Health Organization. Health Metrics Network. Framework and standards for country health information systems. Geneva: WHO; 2008.

Data for developing the indicators can be obtained from different sources, both those that provide data on the general population (censuses, civil registries, household surveys, etc.), and those that provide data collected in institutions. These data include, among others, three types of records: individual records, service records and resource records (3). The following are the principal data sources that can be used:

- Censuses: data on population size, geographical distribution, and demographic and socioeconomic characteristics;
- Civil registries: data on life events (births, deaths);
- Population surveys: the most common are household surveys, which produce information on prevalence rates for mental disorders and use of services (20). However, these studies can be very expensive. Surveys of the school-age and workforce populations and of people seeking care in general health services can serve as a proxy for the true prevalence rates at a lower cost;
- Service records: these records show the frequency and characteristics of both clients and the different types of contacts between them and members of the health team (e.g. individual consultation, group intervention, home visit, telephone consultation, on-line consultation, etc.). The data are useful for monitoring, evaluation, and planning, for health facilities as well as the regional or national level. They are also useful to the clinical team for planning future interventions, monitoring treatment outcomes, and providing long-term monitoring of people with chronic disorders;
- Records of mental health resources: ideally, data on public, semipublic, and private resources can be obtained from these records (e.g. number and distribution of facilities and human resources, budgets, and spending, disaggregated to the extent possible);
- The World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS) (16): this instrument is one of the central recommendations of PAHO's **Strategy and plan of action on mental health** for assessing mental health systems in countries (2). This document offers some practical ideas on how to use the instrument, which should be administered at the national level, ideally, every five years; Nevertheless, given the enormous usefulness of the information it provides, much of the data should be collected more frequently at the different levels of the mental health system to ensure up-to-date information for decision-making during the intervals between the AIMS studies; and
- Research Studies: these make it possible to obtain more in-depth data on some of the critical aspects. In low-income countries, research often makes up for deficiencies in the above-mentioned data sources. The **Strategy and plan of action on mental health** also point out the importance of strengthening mental health research geared to each country's needs (2).

When deciding which indicators to use and the data source, it is necessary to weigh the advantages and limitations of the different sources and the cost of using one or the other. There may be several data sources for each area of measurement (Table 2).

Table 2. Relationship between domains that should be measured and potential data sources[*].

	Mental health determinants	Mental health services system			Mental health status
		Resources	**Processes**	**Outcomes**	
Censuses	X			X	X
Civil registries	X				X
Population surveys	X		X	X	X
Individual records	X	X	X	X	X
Service records		X	X	X	
Resource records		X			
Research	X	X	X	X	X

* Adapted from: World Health Organization. Health Metrics Network. Framework and standards for country health information systems. Geneva: WHO; 2008.

Data Processing

Data collected at the peripheral levels of a mental health services system (teams, facilities, districts) should be able to flow quickly to the central levels (province, region, country). Data from sources external to the health system, in turn, should meet the needs of each level in the system (Figure 2). At the same time, each level should systematically store its data to ensure that the information is quickly available when necessary for decision-making.

Figure 2. Data flow in the mental health services system.
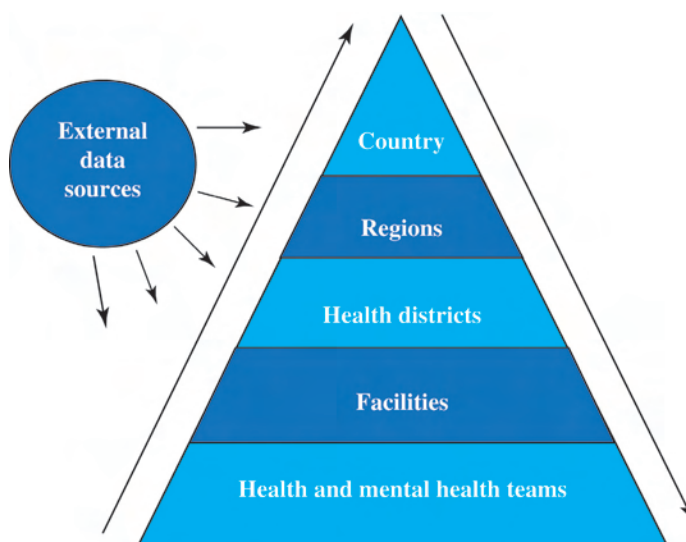
Data flow	Mental health services system levels (internal data)	Flow of analyzed information

As already stated, protecting the confidentiality of information is essential, especially at the peripheral levels, where data are related directly to individuals who are using mental health services. Therefore, at the local level it is necessary to remove all identifying information from confidential data and respect national standards for the protection of personal data and research on human subjects. It should be recalled that at the local level in lesser-developed countries, information will continue to be stored in hard copy for a long time to come, but it should be kept secure.

Another aspect to ensure is preservation of data quality. The smaller the amount of data collected, the easier it will be to perform actions to ensure their reliability and consistency. As mentioned earlier, there must be clear definitions for the different items that are recorded and collected, as well as training of the technical personnel and professionals involved and the supervision of their work. Data should be reviewed to eliminate errors and, insofar as possible, different sources should be compared to correct inconsistencies. Periodic quality control is highly recommended.

The final stage in processing includes aggregation of the data, adjustment of information from multiple sources to permit its use as a whole, and the presentation of understandable, easy-to-read reports.

Data analysis

Raw data must be turned into information if it is to be useful for decision-making. This involves the use of indicators. Consequently, each level of the system should periodically conduct an analysis specifically related to its context. As a result, the most centralized levels should provide feedback to the peripheral levels with the analyzed information (Figure 2). This would enable each level to have a diagnosis of its situation and a comparison with other teams, facilities, or districts, and with national or regional averages. It is necessary to analyze both, recent indicators, which make it possible to characterize the current situation, and indicator series over time, which show trends. It is also interesting to compare the indicator levels with national, regional, and local, or even international standards or targets.

Dissemination

The results of the analysis at each level should be presented in at least two annual reports, a mid-year and a final one, which would enable a greater number of people (stakeholders) to be informed about MHIS operations and their outcomes. It is important that these reports not be distributed exclusively among technical personnel and health professionals; they should also be shared with the users of mental health services and representatives of other sectors and NGOs. That way, everyone will have the necessary information for contributing to decision making aimed at the improvement of the system. The reports should use language that is appropriate for the main recipients, and the information system should be user-friendly.

Outcomes

As mentioned repeatedly, the ultimate goal of an MHIS is for the information to be used in decision-making (21). This implies that the information system should take into account the needs of the various stakeholders and the type of decisions that each of them must make (Table 3).

Table 3. Examples of MHIS users, their information needs, and potential decision-making processes*.

MHIS users	Examples of mental health information needs	Examples of potential decision-making processes
People with mental disorders	• Availability and quality of services • Treatment options • Confidentiality of records	• Where to consult • Which treatment to choose or consent to • What information to provide to clinical teams
Family members and friends	• Availability and quality of services • Treatment options	• Where to seek support • How to best support the sick family member
User organizations and human rights NGOs	• Service gaps • Respect for users' human rights by services	• What service improvements should be advocated for • What rights need protecting
Clinical teams (primary and specialized care)	• Availability and quality of specialized services • Quality of care • Treatment outcomes • Available resources • Cost-benefit of interventions	• How to improve quality • Which treatments to use • What working conditions need to be improved • How to improve coordination between primary health care and specialized services
Mental health managers in facilities or districts	• Productivity and efficiency of services • Available resources • Needs of the population • Cost-effectiveness of interventions	• What incentives to provide • What gaps need closing • Which interventions need to be modified or changed altogether
National or regional policies and management	• Level of achievement of goals and standards • Population needs • Regional differences	• Which strategies to use to improve achievement • Which problems to prioritize • Where and how much to invest • What support do regions need
Other sectors	• Availability and quality of services • Effectiveness of interventions	• How to coordinate with mental health services • What types of problems can be referred
Researchers of mental health services	• Available mental health data • Needs of the different information system users	• What critical policy and service matters are research priorities

* These examples are not necessarily recommendations, since information needs and decision-making processes vary from country to country and region to region.

The implementation of decisions should produce an impact on both services and mental health determinants and, ultimately, on the population's mental health status. This impact should be monitored and evaluated using a series of indicators, which will again generate data for the MHIS. This begins another cycle that goes from data to decisions and impact (Figure 3).

Figure 3. Transforming data into information and evidence*.
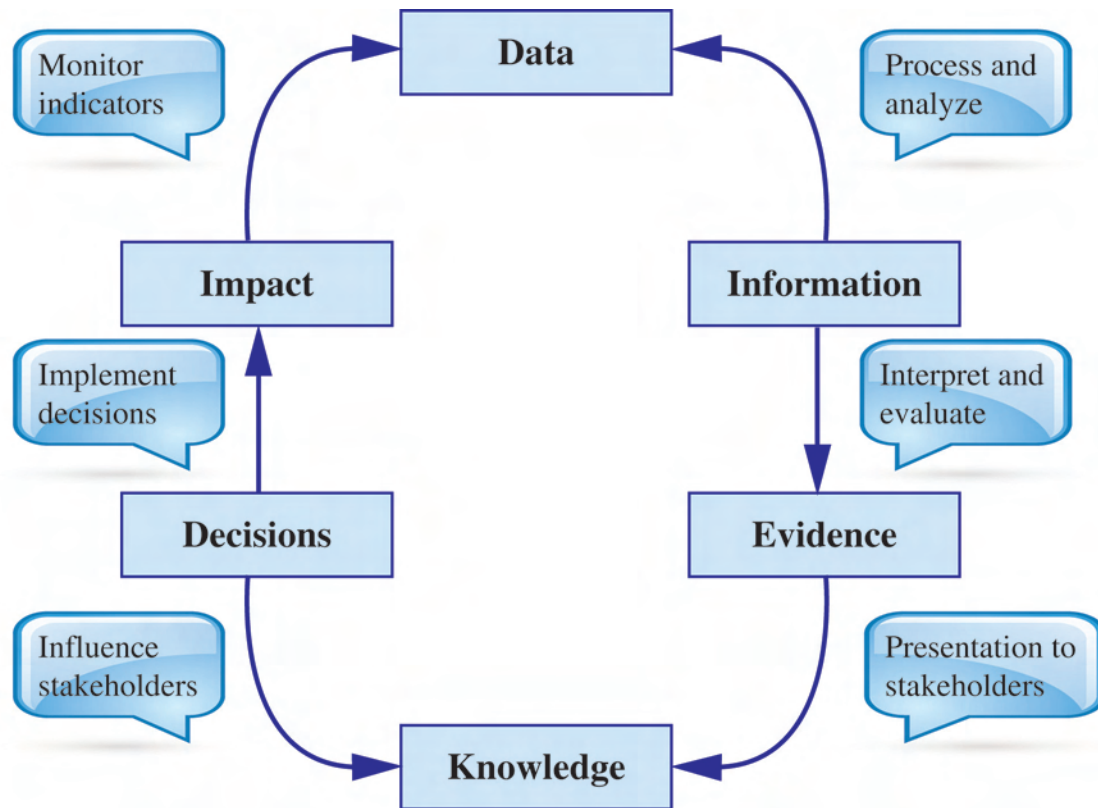
* Adapted from: World Health Organization. Health Metrics Network. Framework and standards for country health information systems. Geneva: WHO; 2008.

IV. Principal Mental Health Indicators

Indicators are a specific output of the HIS. They are used as the main instrument for evaluating the health status of the population and the performance of services and programs.

Selecting indicators requires in-depth analysis and agreement among their potential users (18). In addition to evaluating the usefulness of an indicator for measuring the goals and targets of a national and/or local plan or program, the analysis should evaluate its cost and quality, which will depend on the degree of compliance with a series of requirements (22). These are:

- Validity: measures what it intends to measure;
- Reliability: measurement by different people or at different times yields the same results;
- Sensitivity: registers the changes that it is intended to evaluate;
- Feasibility: capable of being measured with obtainable data;
- Relevance: provides information considered relevant for potential data users; and
- Cost: provides information that justifies the investment in resources.

It is recommended that a basic set of mental health indicators be identified; some simple to measure and others more complex and specific. It is also desirable to progressively add different indicators to include all the measurement domains listed in Figure 1.

Indicator selection should focus on the following aspects: indicators should be sensitive to change over time and among different populations and regions (23); they should facilitate the evaluation of mental health services; they should allow the measurement of mental health promotion and prevention activities at all levels of care (23); they should be culturally pertinent; and they should respond to various perspectives: mental health service users, family members, professionals, and the community. Although when selecting indicators consideration will be given to the data that can be obtained, it should be the indicators themselves that determine the relatively agreed-on set of basic data to be collected, and not the converse (18).

Implementation can be done in two stages. During the first stage, indicators that can be measured with the data already collected and available could be selected. For the second stage, indicators that would require greater development and the production of new information could be added. Some of the data should be collected regularly or systematically, especially at the individual level and in mental health services (e.g. number of users served, routine outcome evaluation, satisfaction). National-level data can be collected periodically (e.g. semiannually or annually).

There are three reasons why it is impossible to make a universal list of all MHIS indicators. In the first place, since the indicators are used to evaluate the implementation of mental health policies, plans, and programs, each country needs to select the indicators it considers most suited to its goals and targets. Secondly, the information available in each country differs both in what is evaluated and in the metrics used. Finally, the ability to measure the indicators will depend on the human resources and materials that the country allocates to the task.

Even though a valid list of indicators for all countries cannot be drawn up, it is possible to recommend some basic indicators that could be included in most of the MHIS. A minimum set of core indicators for the Region have been selected in Tables 4, 5 and 6. However, according to the reality of each country, other complementary indicators that respond to specific necessities could also be considered.

The following criteria were used to compile the system of basic indicators:

- Appropriate properties (validity, reliability, sensitivity);
- Coverage of three principal domains of an MHIS (determinants, mental health status, and services);
- Coverage of resources, processes, and outcomes;
- Measurement of general, rather than specific, aspects;
- Inclusion of the perspective of both professionals and service users; and
- Inclusion of a greater number of easy-to-obtain indicators, and a low number of indicators whose measurement requires expensive studies.

Indicators of mental health determinants for an MHIS

The data sources for indicators of specific mental health determinants generally come from population surveys, which are not within the reach of most low- or middle-income countries because of the technology and resources they require. It is suggested that only some indicators of this type be chosen (Table 4), for which a simple, low-cost measurement instrument and methodology could be developed, ideally for a sample of the general population, or at least of the population seeking care in primary health care centers. Table 4 shows a proposal for basic indicators of general health determinants that are also important for mental health and can usually be obtained from data produced by other sectors.

Table 4. Basic indicators of mental health determinants in the population*.

Domain	Sub-domain	Indicator	Unit of Measure	Source/Level	Level of Disaggregation
Social and cultural environment	Social support	Perception of social support	Scoring on perceived social support questionnaire	Population research or studies	Sex, age, ethnicity, rurality and socioeconomic level
Social and cultural environment	Literacy	Literacy rate	Per 100 adults	National statistics	Gender, geographic area, ethnicity, rurality and socioeconomic level
Social and cultural environment	Schooling	Average years of study	Number of years of study per adult	National statistics	Gender, geographic area, ethnicity, rurality and socioeconomic level
Social and cultural environment	Alcohol consumption	Average annual consumption of pure alcohol	*Annual* per capita alcohol consumption, in *liters*, for individuals aged ≥15 years	National statistics	Geographic macro-areas
Social and cultural environment	Violence against women and children	Rate of women aged ≥15 years and children who suffered physical/sexual abuse in the last year	*Number of women* aged ≥15 years who suffered physical/sexual abuse (per 100 women); similarly in identified children	Population research or studies	Age, ethnicity, rurality and socioeconomic level
Socio-economic environment	Income	Poverty rate	Per 100 population	National statistics	Sex, age, ethnicity, rurality and geographic area
Socio-economic environment	Employment	Unemployment rate	Per 100 adults seeking work	National statistics	Sex, age, ethnicity, rurality, socioeconomic level, and geographic area
Protection of first stage of life	Prenatal care	Rate of prenatal care coverage	Per 100 pregnant women	HIS	Age, socioeconomic level, and geographic area
Protection of first stage of life	Delivery care	Rate of care coverage by health workers	Per 100 parturient	HIS	Age, socioeconomic level, and geographic area

* Adapted from: Lavikainen J, Fryers T, Lehtinen V, eds. Improving mental health information in Europe. Proposal of the MINDFUL Project. Stakes and European Union. Helsinki; 2006.

Indicators of mental health status for an MHIS

Mortality indicators have usually been used to measure population health status. However, on their own, they have a low correlation with mental health status. Furthermore, indicators of quality of life, functionality, and morbidity, which have a greater correlation with mental health status, are difficult to obtain because they require complex, costly population surveys.

As a proxy for the prevalence of nonspecific mental disorders, we propose the administration of an instrument whose application is simple and feasible in any country of the Region, such as the 12 items Goldberg General Health Questionnaire (GHQ-12) or a similar tool. To measure the level of well-being, we suggest the use of a brief quality of life scale (e.g. WHOQOL-BREF). Both instruments could be administered together with the perceived social support questionnaire proposed in Table 4, every certain number of years--ideally in a sample of the general population or, at least, in the population seeking care at primary health care centers. Table 5 contains a list of possible indicators for the mental health status domain.

Table 5. Basic indicators for the mental health status of the population*.

Domain	Sub-domain	Indicator	Unit of measure	Source / Level	Level of disaggregation
Specific causes of mortality	Suicide	Annual suicide rate	Per 100,000 population	Civil registry/ HIS	Gender, sex, age, ethnicity and rurality
Specific causes of mortality	Drug use related deaths	Annual drug mortality rate	Per 100,000 population	Civil registry / HIS	Sex , age and ethnicity
Specific causes of mortality	Alcohol consumption related deaths	Annual death rate from liver cirrhosis and alcohol-related accidents	Per 100,000 population	Civil registry / HIS	Sex, age, ethnicity and rurality
Morbidity	Common mental health problems	Rate of people with psychological distress in the past month	Per 100 population	Population survey	Sex, age, socioeconomic level
Quality of life	Quality of life	Score on quality of life scale	Average score	Population survey	Sex, age, ethnicity, rurality and socioeconomic level

* Adapted from: Lavikainen J, Fryers T, Lehtinen V, eds. Improving mental health information in Europe. Proposal of the MINDFUL Project. Stakes and European Union. Helsinki, Finland; 2006.

In countries already regularly using the annual suicide rate indicator, adding the rate of suicide attempts in sentinel sites might also be considered. In addition, those countries that periodically perform population studies on problematic substance use could also include rates of alcohol and/or illicit drugs abuse and dependence and some of its consequences among the mental health status indicators.

Indicators of the mental health services system for an MHIS

These indicators are the ones most frequently used in an MHIS, especially resource and process indicators, due to the relative ease of obtaining data and their low cost. These data normally come from health facility service records.

The mental health services domains and indicators presented in this section (Table 6) include some of the proposals from different experiences with MHIS, such as WHO-AIMS (16), the MINDFUL Project (23), the PAHO Health Analysis and Statistics Unit (25), *Key Performance Indicators/Australian Government* (24, 26), and *Health Canada Indicators for Mental Health* (27).

In some cases, generic indicators are proposed. In others, measurement by type of facility is proposed, e.g. ambulatory services, day treatment centers, psychiatric hospitals, in-patient units in general hospitals, and community residences.

Table 6. Basic indicators for the public and social security mental health services system.

Domain	Sub-domain	Indicator	Measure	Source / Level	Level of Disaggregation
Human resources (Resources)	Psychiatrists	Rate of psychiatrists in the country	Per 100,000 population	Resource records	Geographic areas and rurality
Human resources (Resources)	Clinical psychologists	Rate of clinical psychologists	Per 100,000 population	Resource records	Geographic areas
Human resources (Resources)	Nurses in mental health	Rate of nurses in mental health	Per 100,000 population	Resource records	Geographic areas and rurality
Human resources (Resources)	Social workers in mental health	Rate of social workers in mental health	Per 100,000 population	Resource records	Geographic areas and rurality
Human resources (Resources)	Occupational therapists in mental health	Rate of occupational therapists in mental health	Per 100,000 population	Resource records	Geographic areas and rurality
Human resources (Resources)	General practitioners in primary health care (PHC) trained in mental health (at least 16 hours in the past 5 years)	Rate of general practitioners in PHC trained in mental health	Per 100,000 population	Resource records	Geographic areas, ethnicity and rurality
Human resources (Resources)	Other PHC professionals trained in mental health (at least 16 hours in the past 5 years)	Rate of other PHC professionals trained in mental health	Per 100,000 population	Resource records	Geographic areas, ethnicity and rurality
Human resources (Resources)	PHC technicians trained in mental health (at least 16 hours in the past 5 years)	Rate of PHC technicians trained in mental health	Per 100,000 population	Resource records	Geographic areas, ethnicity and rurality

(Continued)

	Table 6. (Continued)				
Domain	**Sub-domain**	**Indicator**	**Measure**	**Source / Level**	**Level of Disaggregation**
Material resources (Resources)	Mental health funding	Percentage of annual health budget allocated to mental health	Percent of annual health expenditure	Finance unit of the ministry of health and of social security	Geographic areas, population with different socioeconomic level, ethnicity and rurality
Material resources (Resources)	Dispensing of free psychotropic drugs (at least one for depression, psychosis and epilepsy)	Percentage of population with access to free, basic, psychotropic drugs	Percent of population	Finance unit of the ministry of health and of social security	Geographic areas, population with different socioeconomic level, ethnicity and rurality
Material resources (Resources)	Psychiatric hospital funding	Percentage of mental health expenditure for psychiatric hospitals	Percent of mental health budget	Finance unit of the ministry of health	Psychiatric hospitals
Program resources (Resources)	Mental health in primary care	Percentage of primary health care centers with personnel trained in mental health	Percent	Resource and training records	Areas and type of center
Infrastructure (Resources)	Ambulatory mental health care (specialized level)	Number and rate of ambulatory mental health centers	Per 100,000 population	Resource records	Areas and type of center
Infrastructure (Resources)	Mental health day programs	Number and rate of slots in mental health day programs	Per 100,000 population	Resource records	Areas and type of program
Infrastructure (Resources)	Community residences for the mental disabled	Number and rate of beds in community residences	Per 100,000 population	Resource records	Areas
Infrastructure (Resources)	Psychiatric hospitalization	Number and rate of psychiatric beds	Per 100,000 population	Resource records	Areas, general and psychiatric hospitals, for acute and chronic disorders
Service use (Access)	Ambulatory patients with mental disorder	Annual number of ambulatory patients with mental disorder	Per 100,000 population	Facility service records	Sex, age, ethnicity, rurality, areas, primary and specialty care, diagnosis
Service use (Access)	Mental health ambulatory contacts	Number of mental health ambulatory contacts. Annual average number of contacts per user	Rate of mental health ambulatory contacts per user	Facility service records	Sex, age, ethnicity, rurality, areas, primary and specialty care

Table 6. (Continued)

Domain	Sub-domain	Indicator	Measure	Source / Level	Level of Disaggregation
Service use (Access)	Users seen in mental health day programs (hospital, center, etc.)	Annual number of users seen in mental health day programs	Per 100,000 population	Facility service records	Sex, age, ethnicity, rurality, areas, diagnosis, type of program
Service use (Process)	Length of stay in mental health day programs	Average length of stay in mental health day programs	Number of days stay per user	Facility service records	Areas, diagnosis, type of program
Service use (Access)	Inpatients in psychiatric beds	Annual rate of inpatients in psychiatric beds	Per 100,000 population	Facility service records	Sex, age, areas, diagnosis, general and psychiatric hospitals, for acute and chronic disorders.
Service use (Process)	Length of stay in psychiatric beds	Average length of stay in psychiatric beds	Average number of days of stay per user	Facility service records	Areas, diagnosis, general and psychiatric hospitals, for acute and chronic disorders
Quality of care (process)	Interaction of primary care physicians with mental health professionals	Percentage of primary care physicians who systematically interact with mental health professionals	Percent	Facility service records	Areas, socioeconomic level, ethnicity and rurality
Quality of care (process)	Ambulatory psychiatric visit duration	Average psychiatric ambulatory visit duration	Average number of minutes per consultation	Periodic survey of facilities	Areas and type of facility
Quality of care (process)	Community care (home, school, employment, etc.)	Percentage of ambulatory mental health centers with community care programs	Percent	Periodic survey of facilities	Areas and type of facility
Quality of care (process)	Voluntary psychiatric hospitalization	Percentage of voluntary hospitalization in relation to total psychiatric hospitalization	Percent	Facility service records	Areas, general and psychiatric hospitals, beds for acute and chronic disorders
Access (Process)	Waiting list for first psychiatric ambulatory visit	Average waiting period for first psychiatric ambulatory visit	Average wait in number of days per user	Periodic survey of facilities	Areas and type of facility

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(Continued)

Table 6. (Continued)					
Domain	**Sub-domain**	**Indicator**	**Measure**	**Source / Level**	**Level of Disaggregation**
Impact (Outcome)	People with depression that are discharged with improved health	Annual percentage of people with depression that are discharged with improved health	Percent of people diagnosed with depression	Facility service records	Sex, age, rurality, areas, socioeconomic level
Coverage of treatment gap (Outcome)	People with schizophrenia diagnosis in continuous treatment	Percentage of people with schizophrenia receiving continuous treatment	Percent of people diagnosed with schizophrenia	Facility service records	Areas and type of facility
Impact (Outcome)	People with schizophrenia who do paid work	Percentage of people with schizophrenia who do paid work	Percent of people diagnosed with schizophrenia	Facility service records	Areas, type of facility, socioeconomic level, ethnicity, rurality
Coverage of rehabilitation gap (Outcome)	People with mental disabilities receiving community rehabilitation	Rate of people with mental disabilities receiving community rehabilitation	Per 100,000 population	Facility service records	Sex, age, rurality, areas, socioeconomic level
Impact (Outcome)	Community confinement	Percentage of psychiatric hospital readmissions under 30 days	Percent compared to total psychiatric admissions	Facility service records	Areas, general and psychiatric hospitals
Satisfaction (Outcome)	Users	Percentage of users satisfied with services	Number of users above cutoff point on scale per 100 users	Periodic survey of facilities	Areas and type of facility

Other domains of interest for evaluating actions with an MHIS not included in this chapter because they require hard-to-measure indicators, have still not been developed, or their validity still needs to be studied, include: continuity of care (over time, among facilities, among professionals); effectiveness (outcomes of interventions); cost-effectiveness (cost compared to expected or attained outcome); access (with geographic and funding subdomains); adaptation and quality (use of treatment protocols and guidelines).

V. Ensuring that information is used for action

The essential reason for a mental health information system is to serve as a tool for action at all levels (18). Although the general recommendation is to develop the MHIS at the national level, this is particularly difficult in very large countries with a decentralized federal administration. If the decision is to initiate the MHIS at the national level, most peripheral levels must be consulted and

involved. On the contrary, if the country's conditions only make it possible to initiate the MHIS locally, it is always advisable to attempt to expand it to other localities and regions, and, as soon as possible, to the national level.

The system's users must know what type of information will be available and how frequently, how that information can serve their particular needs, and how it can help them with decision-making (Table 3). Box 1 gives an example of using available information as the basis for making decisions on improving the mental health services network in Chile.

Box 1. An example of action stemming from national-level information.

In 2005, Chile evaluated its national mental health services system using WHO-AIMS. One of the main conclusions was that, despite the progress made in integrating mental health into primary care and the implementation of psychosocial rehabilitation programs, there was a relative weakness in secondary ambulatory care. Among the models of specialty ambulatory care in the country, the development of community mental health centers was favored, among other reasons, because such centers were much easier to link to primary health care centers and community organizations and activities. From 2006 to 2009, the Ministry of Health issued new regulations for these centers and increased their budget to encourage their development. During that time, the number of community mental health centers rose from 38 to 63, increasing coverage in the country's health areas from 38% to 69%, and increasing the ratio between these centers and traditional psychiatric clinics from 0.7 to 1.1 (28).

The dissemination of information is another essential strategy to promote MHIS use. It helps create an enabling environment for the introduction of changes both in information systems and in services and programs. Promoting interest in information leads to support from health services and gives credibility to the people who manage the information system. In some countries this is known as the "democratization of information".

Dissemination should take place at the level of planning and management decision-makers and at the level of those in charge of obtaining data from clinical services. Effective dissemination requires prioritizing relevant information for each level and ensuring that the language and type of presentation are accessible.

The different stages in the development of an MHIS should emphasize the following aspects:

- Quality of the information produced;
- Progressive development of the information system, which will make it possible for potential users to gradually familiarize themselves with it and appreciate the importance of the information being produced. At the outset, it should try to collect minimum basic information. When too much data is presented, it is difficult to use for decision-making, especially if one is not familiar with the information;
- Consultation with all parties involved, because if they participate in developing the system, it is more likely that the information will really be used;

- Differentiation between routine and non-routine data to have more information on a specific problem;
- Integration of the MHIS into the HIS from the planning stage, and linking it to information systems in other sectors. This coincides with the principle of mainstreaming mental health services into general health services. When the MHIS is included in the framework of the HIS, the existing infrastructure can be used for data collection, processing, analysis, and use;
- Training staff from all the levels of the system, including those from the managerial level, on data collection and the use of the information produced; and
- MHIS are dynamic systems that evolve, among other reasons, according to the context in which they are, to advances in terms of promotion, primary prevention, diagnosis and management of mental health problems and to the level of development of the countries and their health systems.

Some special recommendations for mental health information systems in developing countries that can help increase their use have recently been issued. Two of these recommendations are:

- The adoption, adaptation and validation of preferably self-administered instruments that are appropriate for different levels in the health care system; and
- The adoption of innovative and unconventional approaches through the mobilization of community members, traditional healers, and health workers, in addition to general and family practitioners for data collection (29).

It has also been proposed that, in addition to their administrative and research uses, mental health information systems offer innovative applications related to diagnosis and treatment, in order that they can make practical sense to the clinical team, which will be motivated to collect data, analyze it, and use the information (30).

VI. Recommendations for implementing or strengthening an MHIS

Having discussed an MHIS model, the possible indicators to use, and some suggestions to ensure that the information is used for action, now it is necessary to review practical elements that contribute to implementing or strengthening the MHIS.

The MHIS should be a priority in mental health policies and plans. However, this task presents complexities resulting from the organizational model for delivering services and care, as well as the many determinants of mental health. Mental health data often come from many different sources, which hamper the work.

Taking the first step in the implementation of an MHIS requires a strong political and institutional commitment, which must be manifested not only as explicitly expressed willingness, but also through the provision of sufficient resources to guarantee its implementation and sustainability.

For implementing the MHIS, the World Health Organization (14) proposes a circular four-step cycle that is flexible to country needs (Table 7). In order to address the shortcomings of mental health system assessment processes and as a complement to the WHO proposal, a series of practical aspects should be considered, broken down into three areas:

1. Development, implementation, and functioning of the system

- Most countries in the Region of the Americas have limited, scattered information. To overcome this hurdle, in addition to the political will, the progressive involvement of all stakeholders should be added, including clinicians, managers, technical personnel, and users and family members;
- Training the personnel that provide information to the system is a critical point in the process; and
- It is necessary to establish data quality controls that make it possible to ensure the validity of the system.

2. Information collected and sharing outcomes

- Information should be delivered to different levels depending on their needs;
- The routine statistics should be defined, clearly identifying the requirements of MHIS users and the periodicity with which they need the information; and
- On-line access should be allowed, with predetermined criteria for access, facilitating use at different levels and for different purposes.

3. Challenges that should be considered in the development of an MHIS

- The relationship between the interventions and outcomes in people with mental disorders, which requires identifying outcome measures and establishing procedures for their periodic measurement; and
- Ties with researchers and centers that facilitate the use of data and the production of new research based on the information from the system.

If all the resources necessary to implement the steps and tasks listed in Table 7 are not available, you can at least start collecting data in some health facilities representative of the various levels of the mental health services system, which act as sentinel.

Table 7. Steps in designing and implementing a national mental health information system (MHIS)*.

Step 1. Needs assessment: What information do we need?

Task 1: Form a team to design and implement the MHIS (see Section 3);
Task 2: Review current policy and planning objectives and targets, so that the MHIS reflects them;
Task 3: Consult with all relevant stakeholders. This should be done during all steps in the cycle; and
Task 4: Identify indicators to measure policy and planning objectives (see Section 3). The following issues should be considered: validity, reliability, cost, relevance, specificity, sensitivity, balance among the different areas covered by the indicators and frequency of data collection.

Step 2. Situation analysis: What information do we have?

Task 1: Review the current situation: what information is collected and how it is processed, analyzed, used, and disseminated; and
Task 2: Conduct a "walk-through" analysis. This requires visiting the facilities to confirm how information is collected and flows.

Step 3. Implementation: How can we get the information we need?

Task 1: Identify the essential MHIS subsystems and indicators. Using the information collected in steps 1 and 2, determine which indicators to add and which to eliminate;
Task 2: Establish the basic data set, with its sources, frequency of collection, processing and analysis, users, goal, and upper and lower thresholds that trigger an action;
Task 3: Map information flow;
Task 4: Establish the frequency of data collection. This depends on feasibility and the speed of change in the data, as well as the ability to take action based on the data;
Task 5: Identify the roles and responsibilities of each stakeholder at each stage of the MHIS;
Task 6: Design and distribute MHIS manuals of procedure and data collection forms;
Task 7: Train staff;
Task 8: Address barriers to getting the needed information, such as staff opposition, ensuring staff participation in designing the MHIS and incentives during implementation. Another barrier is inadequate technology, bearing in mind that if there are insufficient resources, pencil and paper can be used at the local level and computerized systems at higher levels;
Task 9: Establish quality controls in all stages of the MHIS process and provide feedback on the data with the information necessary for each stakeholder;
Task 10: Conduct a pilot project before large-scale implementation to test the feasibility of an MHIS and iron out difficulties; and
Task 11: Roll out the MHIS.

Step 4. Evaluation: How well is the MHIS working?

Task 1: Establish criteria for evaluating the MHIS. For example, validity, reliability, sensitivity, accuracy, completeness of data, timeliness of the information, importance, usefulness, simplicity of administration, acceptability, feasibility, flexibility;
Task 2: Establish a framework for evaluating the MHIS, including the definition of the aspects to be evaluated and the methods involved;
Task 3: Compare with baseline data; and
Task 4: Establish a timetable. Determine frequency of the evaluations.

* Adapted from: World Health Organization. Mental health information systems. Geneva: WHO; 2005. Available at: http://www.who.int/mental_health/policy/mnh_info_sys.pdf

Comprehensive assessment of mental health systems

The World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS) (16) is the tool that WHO makes available to countries for assessment of their mental health systems with the object of improving these systems with the information compiled. As said before, its periodic administration (e.g. every five years) would make it possible to complement the information that service records provide and to go deeply into areas where these records do not provide sufficient data.

In the WHO-AIMS, data sources may be from national, district, or local levels. The use of one or the other will depend on the availability and quality of the existing information. The AIMS is mainly geared to collecting information at the national level, although it suggests that in large countries, the survey can be focused on smaller areas, which would mean that most national items would be aggregate data. Nevertheless, the importance of disaggregated data for the development and planning of local action plans should not be forgotten.

To begin, a data collection plan and timetable need to be developed that describe how data is to be collected and when, and that identify the potential sources and key people in the different institutions, agencies, and facilities that should be contacted. This point alludes to a central issue that investigators must face when interacting with institutions in the search for information: "Who is the focal point?" This person is not necessarily the one who has authority associated with a position but the one who has his finger on the information needed. The accurate identification of this/these informant/s will be important when addressing any data collection process based on institutional records. One of the results of this phase of the process will be the development of a data collection plan and the timetable.

The wide range of denominations occurring in the design and implementation of mental health services makes this a relevant subject when assessing any system and emphasizes the importance of definitions and descriptions of terms.

The different levels of institutional development in countries and their consequent organizational culture can result in major differences in data reliability. As a result, it is suggested that when exact data is not available, the items should be completed using the best possible estimate. Data sources that can help in making an estimate include focus groups, consultations with experts, consultations with secondary data sources, surveys, and the formation of a key informant committee. Since there are many and varied data sources, it is suggested that during the data collection process, a list be drawn up of all sources available at the different levels, since this will facilitate new assessments and future comparisons.

The dissemination of results, via a descriptive report on national and/or regional indicators, should be based on planning that at a minimum ensures successful dissemination that will contribute to the adoption of mental health policies and plans.

With regard to its content, WHO-AIMS includes six domains of exploration: Policy and Legislative Framework; Mental Health Services; Mental Health in Primary Health Care; Human Resources; Public Education and Links with Other Sectors; and Monitoring and Research.

Its administration in dozens of low- and middle-income countries, including those in the Americas, has demonstrated the validity of this quantitative, systematic assessment. The results confirmed the gap that exists in the response to mental health problems, which is higher in certain population groups, such as children and adolescents, and reaffirmed that mental health resources are scarce, inequitably distributed, and inefficiently used (31).

Visit the PAHO and WHO websites to see the basic WHO-AIMS documents and country reports on completed assessments: http://new.paho.org/, and http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html

Recommendations

- Conduct a comprehensive assessment of the mental health system in the country using the WHO-AIMS, which will serve as a baseline for follow-up and monitoring of changes;
- Conduct a reassessment, using the same instrument, every five years; and
- Introduce several AIMS indicators into regular MHIS processes.

Strengthening Research

There is plenty of evidence on the mental health research gap in low- and middle-income countries, including those in Latin America and the Caribbean (31). In this regard, strengthening and supporting research increases and documents the visibility of the mental illness burden in the countries. In addition to the need for financial resources, there is the need for investigators; however, in almost all the countries they are both still very limited. This results in a dearth of publications and of information based on scientific evidence.

Furthermore, having academic publications available does not necessarily help meet the needs of the corps of professionals who require new and more effective resources for their daily work. In Latin America and the Caribbean, this constraint is associated, *inter alia*, with how hard it is to gain access to these publications and to the language in which they are written, since most influential scientific journals are published in English.

It should also be underscored that there is often an almost complete separation or divorce between academic and/or research institutions and service providers. This means that research is not geared to many of the essential problems that the health sector faces, and that research findings are not used in daily practice or in solving people's mental health problems.

Finally, remember that research can contribute data needed for some of the minimum indicators proposed in the previous section (e.g. perceived social support, quality of life and morbidity); and with the future development of new indicators to measure complex areas (e.g. results of the interventions of mental health services). A key objective for all countries should be to develop a policy of sustained stimulus for research.

Recommendations

- Support the development of research so that it generates up-to-date scientific information that enables all parts to make use of new knowledge in their regular activities;
- Establish a permanent collaboration between academia (universities and study centers) and national health systems. This enhances the mutual action and makes it possible to produce new information to meet local and national needs;
- Stimulate epidemiological studies of mental disorders especially in vulnerable populations, such as ethnic minorities or people affected by disasters, migration, and violence; and
- Promote studies of the cost-effectiveness of interventions, a still pending challenge. Also untapped is the contribution of other areas in the social sciences, such as anthropology, sociology, and health economics.

Mental health research indicators

- Amount and proportion of budget allocated to mental health research;
- Number of research grants awarded annually;
- Number of annual publications in scientific journals; and
- Number of annual scientific meetings sponsored by and with active participation of all stakeholders in the mental health field.

VII. Conclusions

Mental health not only faces a gap in the response of services to people's needs but also in the ability to produce, analyze, and use information necessary for decision-making, which reduces the effectiveness and efficiency of mental health services.

The history of public health in the world shows how the appropriate use of information produced by HIS has significantly contributed to the prevention and control of a number of health problems. Mental health should learn from the history of HIS, including the more recent progress in the conceptualization of models and the development of good practices in various countries.

Strengthening MHIS, steadily increasing their ability to deliver necessary information for good decision-making, can help improve the performance of services in mental health promotion, protection, and recovery.

The most important aspects that should be considered when developing an MHIS:

- The MHIS is essential for every mental health policy, plan, or program and should be a component of the HIS;
- MHIS operations should range from data collection, processing, and analysis, up to information dissemination and use, and decision-making;
- The MHIS is a process that requires human resources and materials to support its operations and that leads to the generation of products;
- Indicators play a key role, and at least a basic set of them should be adopted to describe the different domains in a mental health system;
- The MHIS should produce consolidated general information that provides an overview of the situation, which is most useful at national policy and planning level; and disaggregated information, which is most useful at the local and clinical level;
- Most of the data collected by an MHIS come from sources internal to the mental health services, usually service records. However, the MHIS should always consider including data sources with episodic records and information generated by other sectors;
- WHO-AIMS is an essential instrument for the MHIS that delivers episodic information and complements information from mental health service records. The fact that the AIMS uses a relatively simple methodology for obtaining the best available information, tapping expert opinion when other, more accurate, data sources are not available, makes it feasible for any country in the Region of the Americas, regardless of its income level;
- Applied research on mental health policies and services is also an essential component that complements other sources in an MHIS. However, since its use involves greater technical and financial resources, it should be reserved for obtaining the type of information necessary for making critical decision-making that is not provided by other information sources; and
- Given the underdevelopment of MHIS in the Region of the Americas, it is necessary to instill a culture of assessment in the management of mental health services, which should encourage learning about the production, analysis, and use of the information necessary for decision-making. This learning can be supported and facilitated through technical cooperation from PAHO and among the countries themselves.

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