

# ATLAS

MENTAL HEALTH ATLAS OF THE AMERICAS



**PAHO**



Pan American  
Health  
Organization



World Health  
Organization  
Americas



# Mental Health Atlas of the Americas

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## 2020

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Washington, D.C., 2023



Pan American  
Health  
Organization



World Health  
Organization  
REGIONAL OFFICE FOR THE Americas

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# PREFACE

The World Health Organization (WHO) Mental Health Atlas series represents the most complete and widely used source of information on the status of mental health worldwide. The objectives of this project include the collection, compilation, and dissemination of relevant information about mental health resources across all countries. This 2020 edition of the *Mental Health Atlas of the Americas*, based on data from 2018 to 2020, is an important compilation of information on mental health systems in the Member States of the Pan American Health Organization (PAHO). It contains a substantial portion of the reference data needed to measure progress toward the achievement of objectives and targets of the WHO's Comprehensive Mental Health Action Plan 2013–2030.<sup>1</sup>

The first case of COVID-19 in the Region of the Americas was identified on 21 January 2020, and most of the data submitted for this version of the Atlas were collected before the start of the pandemic. Although the data presented do not represent the impact of the pandemic on mental health actions and services in the Region, they do adequately describe the pre-pandemic situation and how it may have influenced the response capacity of countries. Thus, the interpretation of the data in this Atlas must be supplemented with other PAHO reports that have shown the impact of the pandemic on service delivery for mental, neurological, and substance use conditions in the Region of the Americas (see, for example, *The Impact of COVID-19 on Mental, Neurological and Substance Use Services in the Americas: Results of a Rapid Assessment, November 2020*;<sup>2</sup> *The Impact of COVID-19 on Mental, Neurological and Substance Use*

*Services in the Americas: Results of a Rapid Assessment, June 2021*;<sup>3</sup> and *Round Two of the National Survey on the Continuity of Essential Health Services during the COVID-19 Pandemic February - March 2021*<sup>4</sup>).

The COVID-19 pandemic has been a major threat to the physical and mental health and well-being of people in the Americas, a region that has been critically affected by this crisis. Adversities generated by the pandemic such as work instability, economic difficulties, isolation and reduced access to social support systems, and the loss of loved ones due to COVID-19 represent only some of the short- and long-term risk factors for mental health problems. In some cases, the pandemic has also exacerbated the symptoms of preexisting mental health conditions, which are associated with increased risk of premature death and long-term complications, among other consequences.

COVID-19 has highlighted some of the existing obstacles to mental health services in the Region prior to COVID-19, documented by earlier editions of the Atlas. Going forward, important challenges for countries of the Region will be to rebuild the capacity of pre-pandemic mental health services, respond to the increased demand for essential mental health and psychosocial support brought on by the direct and indirect consequences of COVID-19, and improve financing for mental health, in order not only to recover from this pandemic, but also to be better prepared for subsequent emergencies, such as those associated with climate change.

<sup>1</sup> World Health Organization. Comprehensive Mental Health Action Plan 2013-2030. Geneva: WHO; 2021. Available from: <https://www.who.int/publications/i/item/9789240031029>.

<sup>2</sup> Pan American Health Organization. The Impact of COVID-19 on Mental, Neurological and Substance Use Services in the Americas: Results of a Rapid Assessment, November 2020. Washington, D.C.: PAHO; 2020. Available from: <https://iris.paho.org/handle/10665.2/52999>.

<sup>3</sup> Pan American Health Organization. The Impact of COVID-19 on Mental, Neurological and Substance Use Services in the Americas: Results of a Rapid Assessment, June 2021. Washington, D.C.: PAHO; 2021. Available from: <https://iris.paho.org/handle/10665.2/54784>.

<sup>4</sup> Pan American Health Organization. Round Two of the National Survey on the Continuity of Essential Health Services during the COVID-19 Pandemic February - March 2021. Washington, D.C.: PAHO; 2021. Available from: <https://iris.paho.org/handle/10665.2/55060>.

# EXECUTIVE SUMMARY

- Thirty-nine countries and territories in the Region of the Americas (95% of the total) participated – at least partially – in the *Mental Health Atlas of the Americas 2020*.



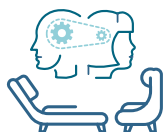
## Governance of the mental health system

- Thirty-four countries and territories (87% of the 39 that responded) have a mental health policy or plan, and 16 (64% of the 25 countries that responded) have stand-alone mental health legislation.
- Since 2017, 22 countries and territories (56% of the 39 that responded) have updated their mental health policy or plan.
- Twenty-four countries and territories (71% of the 34 that responded to this indicator) have developed or updated their mental health policy or plan in accordance with international and regional human rights instruments.
- Twenty-seven countries and territories (69% of the 39 that responded) have a dedicated authority or independent body that monitors their mental health facilities to assess compliance with international human rights instruments.



## Financial and human resources for mental health

- A median of 3% of total government health expenditure is allocated to mental health in the Region.
- The median number of mental health workers in the Region is 14.9 per 100 000 population.
- Psychiatrists make up the smallest proportion of the mental health workforce in the Region at 7%.



## Availability of mental health services

- There are 13.58 mental health inpatient beds per 100 000 population in the Region, unequally distributed across subregions.
- The median number of inpatient mental health facilities for children and adolescents in the Region is 0.07 per 100 000 population.
- In the Region, 58.5% of patients stay in inpatient care less than one year, while 27.6% stay more than five years.
- There is a median of 1.1 mental health outpatient facilities per 100 000 population.



## Mental health promotion and prevention

- Twenty-one countries and territories (66% of the 32 that responded) have at least two functioning national multisectoral mental health and prevention programs.
- Of the programs reported to be functioning, most are concerned with mental health promotion in schools, early child development, disaster preparedness and risk reduction, and suicide prevention.
- Suicide remains an important public health problem in the Region of the Americas as the regional age-standardized suicide rate is 9.0 per 100 000 population.

# INTRODUCTION

Initiated in 2001, the World Health Organization (WHO) *Mental Health Atlas* aims to provide an up-to-date overview of mental health resources and services around the world. It is a valuable source of data to measure the progress toward the achievement of the objectives and targets set out in the Comprehensive Mental Health Action Plan 2013–2030 (1). The Pan American Health Organization (PAHO) produced a regional *Mental Health Atlas* report for the Americas in 2014, and again in 2017. As such, this report is intended to provide the data needed for health planners and policymakers in countries and territories to measure their progress, and will also act as a baseline to monitor achievements toward 2030 targets.

## Methodology

For all intents and purposes, the data presented in this report are derived from a questionnaire compiled by designated focal points in each country/territory, with support from the PAHO/WHO Representative Office in each country/territory and at the regional level.

The questionnaire collects data on the following areas related to mental health:

1. Governance in the context of the mental health system;
2. Financial and human resources for mental health;
3. Availability of mental health services;
4. Mental health promotion and prevention.

The information on suicide rates comes from the WHO Global Health Estimates database. The database provides a comprehensive and comparable set of cause of death estimates from year 2000 onward, consistent with and incorporating United Nations agency, interagency, and WHO estimates for population, births, all-cause deaths, and specific causes of death (2).

As of 1 July 2019, low-income economies are defined as those with a gross national income (GNI) per capita of USD 1025 or less, calculated using the World Bank Atlas method for 2019; lower-middle-income economies are those with a GNI per capita of between USD 1026 and USD 3995; upper-middle-income economies are those

with a GNI per capita of between USD 3996 and USD 12 375; and high-income economies are those with a GNI per capita of USD 12 376 or more.

Data on age-standardized suicide rates per 100 000 population were taken from the WHO Global Health Observatory (3).

Frequency distributions and measures of central tendency (e.g., means, medians) were calculated as appropriate for these country groupings. Rates per 100 000 population were calculated for a range of data points and for specific age groups, e.g., children and adolescents, using the official United Nations population estimates revision for 2019 (4).

Additional details on the methodology can be viewed in the *WHO Mental Health Atlas 2020* report (5).

## Participating countries and territories

Overall, 39 countries and territories in the Region of the Americas participated (at least partially) in the *Mental Health Atlas 2020* representing 95% of the total number of countries and territories. For the purposes of this report, the term “countries” will be used to refer to countries and territories. Participating countries are listed below by subregion:

**Central America, Mexico, and Latin Caribbean:** Costa Rica, Cuba, Dominican Republic, El Salvador, Guatemala, Haiti, Honduras, Mexico, Nicaragua, and Panama.

**Non-Latin Caribbean:** Anguilla, Antigua and Barbuda, Aruba, Bahamas, Barbados, Belize, Bermuda, Cayman Islands, Curaçao, Guyana, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, and Turks and Caicos Islands.

**North America:** Canada, and United States of America.

**South America:** Argentina, Bolivia (Plurinational State of), Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay, and Venezuela (Bolivarian Republic of).

For the purposes of this report, country-level data were aggregated by subregions (as specified above) and by World Bank income groups for 2019, as follows:



**Low-income:** Haiti.

**Lower-middle-income:** Bolivia (Plurinational State of), El Salvador, Honduras, and Nicaragua.

**Upper-middle-income:** Anguilla, Argentina, Belize, Brazil, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, Guatemala, Guyana, Jamaica, Mexico, Paraguay, Peru, Saint Lucia, Saint Vincent and the Grenadines, Suriname, and Venezuela (Bolivarian Republic of).

**High-income:** Antigua and Barbuda, Aruba, Bahamas, Barbados, Bermuda, Canada, Cayman Islands, Chile, Curaçao, Panama, Saint Kitts and Nevis, Trinidad and Tobago, Turks and Caicos Islands, United States of America, and Uruguay.

The data presented herein are based on 2018 for seven countries, 2019 for 25 countries, and 2020 for seven countries.

Territories were included in the analysis, which may produce some differences in the results when compared with the global *Mental Health Atlas 2020*.

## Limitations

Although best efforts were made to obtain information from countries on all variables, some countries in the Region could not provide data for several indicators. Also, the specific countries that provided data, whether overall or for specific questions, differed from previous years, which may limit the ability to directly compare this report with the 2014 and 2017 editions of the *Mental Health Atlas of the Americas*. The most notable limitation to this round of the Atlas was that the data collection was ongoing during the global COVID-19 pandemic, which may have affected the quality and completeness of data collected, as well as impacted the within-country consultation process with various departments within ministries. It is also important to acknowledge the limitations of self-reported data, often made by a single focal point. Related to this is the fact that most of the information provided here relates to the country, and thereby potentially overlooks substantial variability within countries regarding, for example, the degree of policy implementation, the availability of services, or the existence of promotion or prevention programs in rural versus urban areas or remote versus central parts of the country.



# 1. Governance of the mental health system

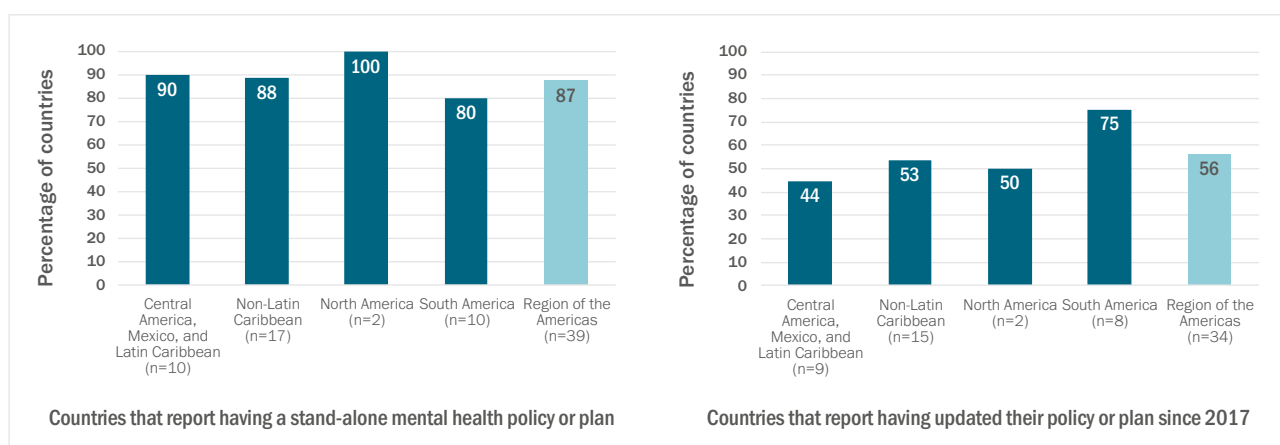
## Mental health policies and plans

Mental health policy can be broadly defined as an official statement of a government that conveys an organized set of values, principles, and objectives to improve the mental health of a population and reduce the burden of mental disorders. A mental health plan is a detailed scheme for action on mental health that usually includes setting principles for strategies and establishing timelines and resource requirements. The existence of mental health policies and plans helps to improve the organization and quality of mental health service delivery, as well as enhance access for people with mental health conditions and their families.

Policies and plans for mental health may be stand-alone or integrated into other general health or disability policies or plans. They are considered valid if they have been approved or published by the ministry of health, other line ministries, or the country's parliament.

Overall, 34 countries (out of 39; 87%) have a stand-alone mental health policy or plan; 19 of these countries (56%) have updated their policy or plan since 2017 (Figure 1.1). Twenty-seven out of the 34 countries (79%) with a stand-alone mental health policy or plan have updated their policy or plan within the last 10 years (i.e., since 2011) (Figure 1.1).

**FIGURE 1.1. Existence and revision status of stand-alone mental health policies or plans for countries in the Region of the Americas and its subregions**



Of the five countries in the Region that do not have stand-alone mental health policies, two have mental health policies and plans integrated into other policies or plans relating to general health or disability (one country did not respond to the respective question).

Countries were also asked whether they have a mental health plan or strategy for children and/or adolescents, either as a stand-alone document or as an integrated element of the national policy/plan adopted by the government. Overall, 20 countries (out of 38; 53%) have a mental health plan or strategy for both children and adolescents, nine (45%) of which have updated their plan or strategy since 2017; one country has a mental health

plan or strategy for children and one for adolescents, which has been updated since 2017; one country has a mental health plan or strategy for children only, which has been updated since 2017. Among responding countries, 70% in Central America, Mexico, and Latin Caribbean, 31% in Non-Latin Caribbean, 100% in North America, and 70% in South America have a mental health plan or strategy for children and/or adolescents.

The percentages of responding countries with stand-alone mental health policies/plans have steadily increased since the *Mental Health Atlas 2014* (80%) and *Mental Health Atlas 2017* (82%).

To evaluate the compliance of mental health policies or plans with international human rights instruments, five checklist items are used:

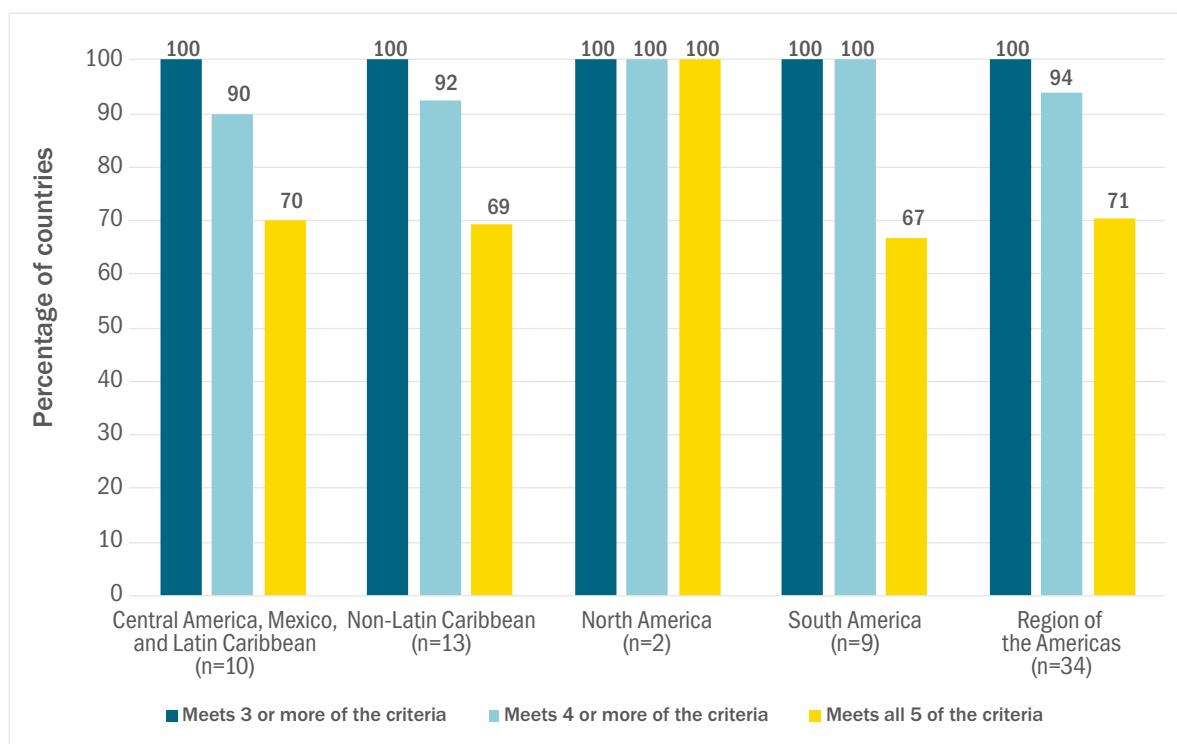
1. The policy/plan promotes the participation of persons with mental disorders in decision making processes.
2. The policy/plan promotes a recovery approach to mental health care.
3. The policy/plan promotes a full range of services and supports to enable people to live independently and be included in the community.

4. The policy/plan pays explicit attention to respect for the human rights of people with mental disorders.

5. The policy/plan promotes transition toward community-based mental health services.

Among the 36 countries that have a mental health policy or plan (whether stand-alone or integrated), 34 countries responded to this indicator. One hundred percent of those countries consider their policy or plan to fulfill three or more human rights checklist items; 94% consider their policy or plan to fulfill four or more human rights checklist items; and 71% consider their policy or plan to fulfill all five human rights checklist items (Figure 1.2).

**FIGURE 1.2. Scores on the human rights checklist for countries with mental health policies or plans in the Region of the Americas and its subregions**



Compared to the previous mental health atlas, the percentage of countries indicating full compliance of their mental health policies/plans with human rights

instruments has slightly increased in the Region, and full compliance has increased from 63% in 2014 to 71% in 2020.

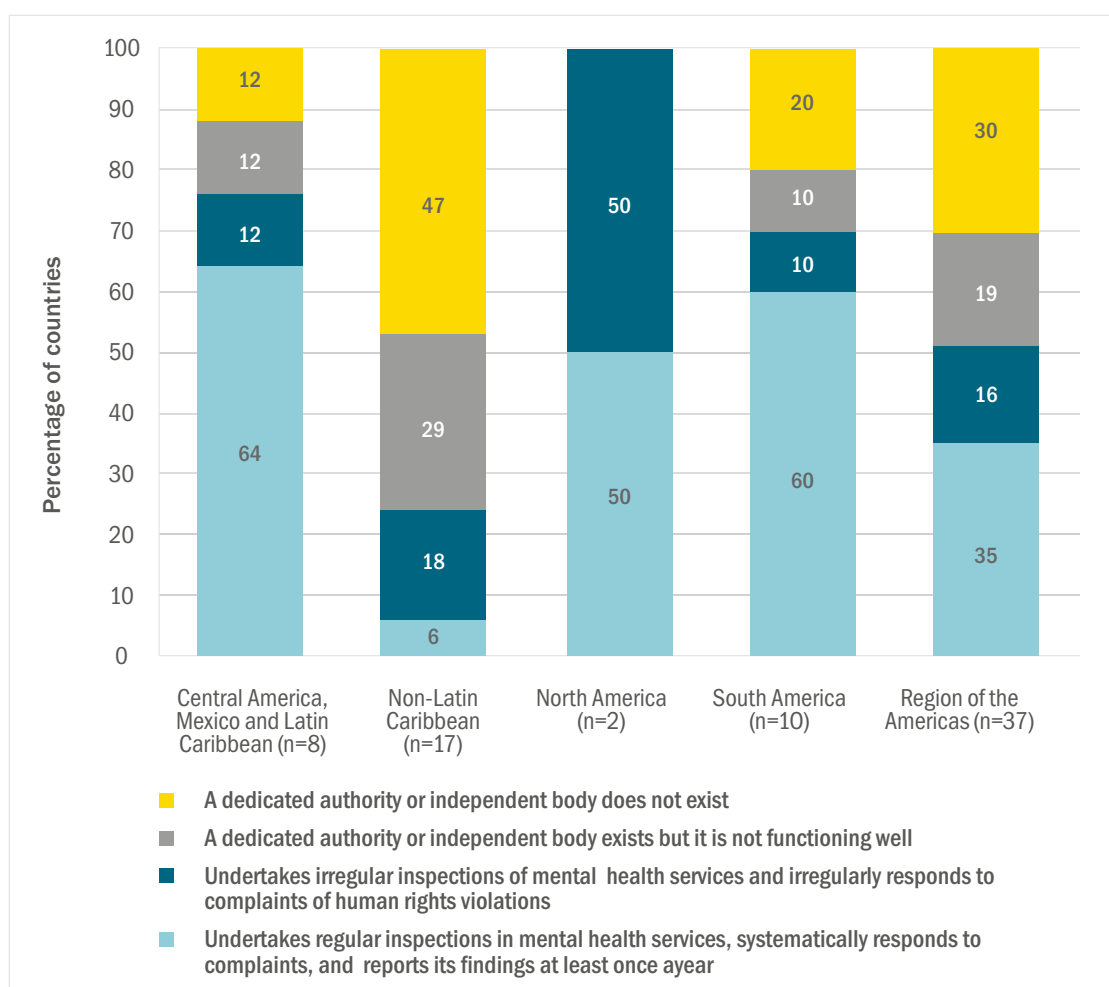
## Mental health legislation

Mental health legislation involves specific legal provisions related explicitly to mental health, and generally focuses on protecting the human rights of people with mental health conditions, involuntary hospitalization and treatment, supervised discharge, professional training, and the structure of mental health services. Mental health legislation is a key component of good governance.

A total of 25 (out of 39; 64%) countries report having a stand-alone mental health law; three of which (12%) have updated their mental health legislation since 2017. Of the 14 countries in the Region that do not have stand-alone mental health law, 12 (86%) have mental health legislation that is integrated into general legislation relating to general health or disability; three of which (25%) have updated their mental health legislation since 2017.

To assess progress on aligning mental health legislation with international human rights instruments, countries were asked whether they have a specific authority or independent body to assess such alignment, and to describe its level of functioning. Sixty-nine percent of countries have a dedicated authority or independent body; however, 19% of countries reported that the relevant authority or body is not functioning well (e.g., there is no budget or staff). Thirty-five percent of countries reported that the relevant authority or body carries out regular inspections in mental health services, systematically responds to complaints, and reports its findings at least once a year (Figure 1.3).

**FIGURE 1.3. Existence of a dedicated authority or independent body to assess compliance with international human rights instruments in the Region of the Americas, by subregion**



To determine compliance of mental health laws with international human rights instruments, five checklist items are used:

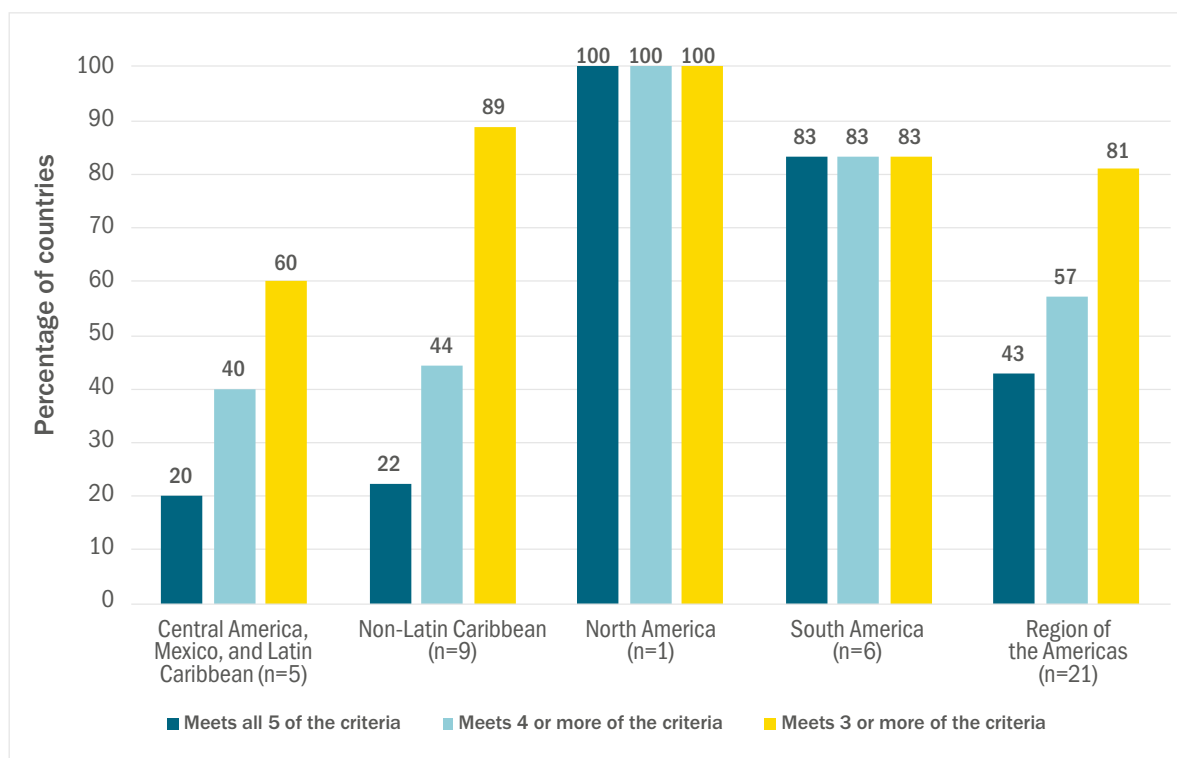
1. Legislation promotes the transition toward community-based mental health services.
2. Legislation promotes the right of people with mental health conditions to exercise their legal capacity.
3. Legislation prevents coercive practices.
4. Legislation enables people with mental health conditions to protect their rights and file appeals and complaints to an independent legal body.
5. Legislation provides for regular inspections of human rights conditions in mental health services by an independent body.

Regarding the degree of compliance of a country's mental health law with human rights instruments, Figure 1.4 illustrates responding countries' self-rating of the five items in the checklist constructed for this purpose.

Of the 21 countries that responded to this question, 17 (81%) of those countries consider their law to fulfill three or more human rights checklist items; 12 (57%) consider their law to fulfill four or more human rights checklist items; and nine (43%) consider their law to fulfill all five human rights checklist items.

Figure 1.4 shows that the majority of responding countries considered that their law promotes at least one of the standards.

**FIGURE 1.4. Degree to which legislation aligns with human rights instruments in the Region of the Americas and its subregions**



## Stakeholder participation

The implementation of mental health policies/plans and laws requires collaboration between multiple sectors. Successful stakeholder collaboration requires strong leadership and intersectoral engagement.

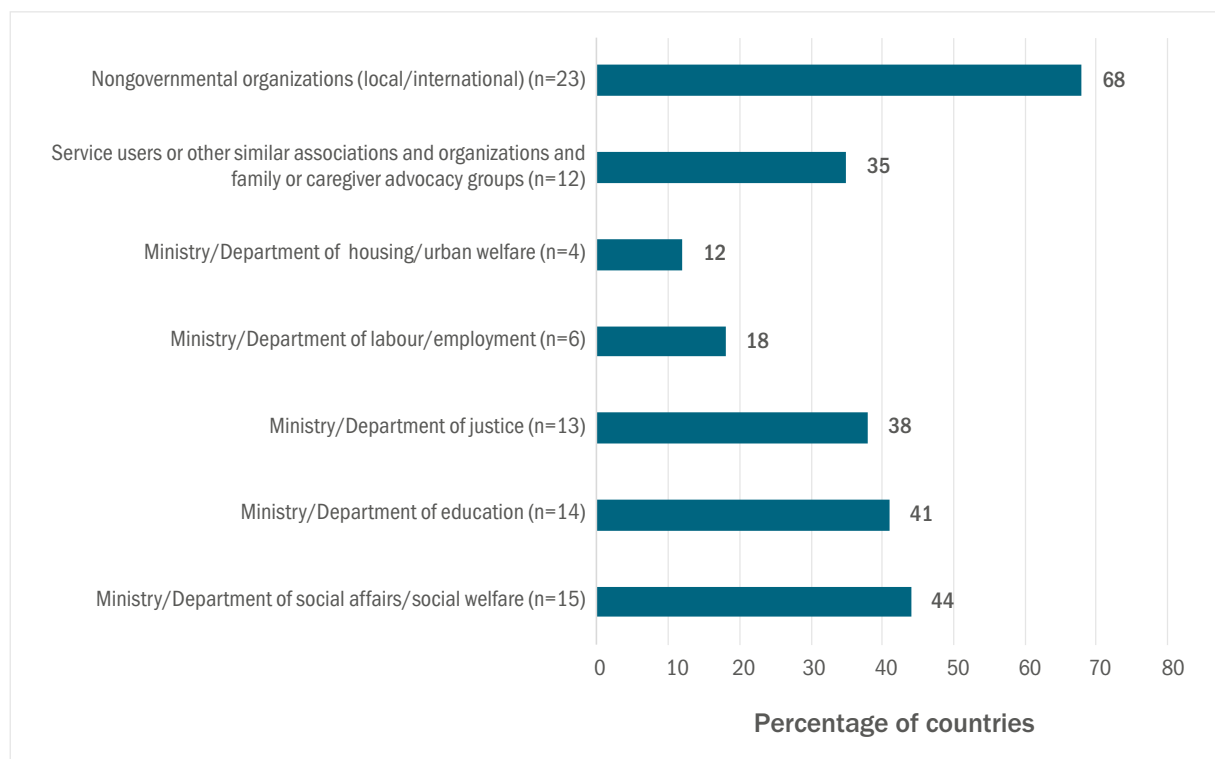
In the Atlas questionnaire, efforts were made to learn about stakeholder participation in each participating country. Countries were asked to specify whether there is ongoing collaboration between governmental mental health services and other departments, services, and sectors. Thirty-six (out of 39 countries; 92%) reported at least one formal collaboration with stakeholders.

Countries were then asked to state the number and type of stakeholders currently collaborating with government

mental health services in the planning or delivery of mental health promotion, prevention, treatment, and rehabilitation services. A collaboration with stakeholders was a functional collaboration only when at least two of the three following checklist items were endorsed:

1. Is there a formal agreement or joint plan with the stakeholder?
2. Is there dedicated funding from or to the stakeholder for service provision?
3. Are there regular (at least once per year) meetings with the stakeholder?

**FIGURE 1.5. Stakeholders with which countries have functional collaborations**



Of the 36 countries reporting at least one formal collaboration with stakeholders, 34 provided enough information to establish who the stakeholders were and whether such collaborations were functional. Twenty-seven (79%) countries have a functional collaboration with at least one stakeholder: four (15%) have one functional collaboration, nine (33%) have two functional collaborations, two (7%) have three functional collaborations, six (22%) have four functional collaborations, three (11%) have five functional

collaborations, one (4%) has six functional collaborations, and two (7%) have seven functional collaborations. Overall, the majority (68%) of countries have functional collaborations with nongovernmental organizations; 44% have a functional collaboration with the ministry/department of social affairs/social welfare; 41% have a functional collaboration with the ministry/department of education; and 38% have a functional collaboration with the ministry/department of justice (Figure 1.5).





## 2. Financial and human resources for mental health

The availability of dedicated financial resources for mental health is critical in developing, implementing, and maintaining mental health services and making progress toward program goals.

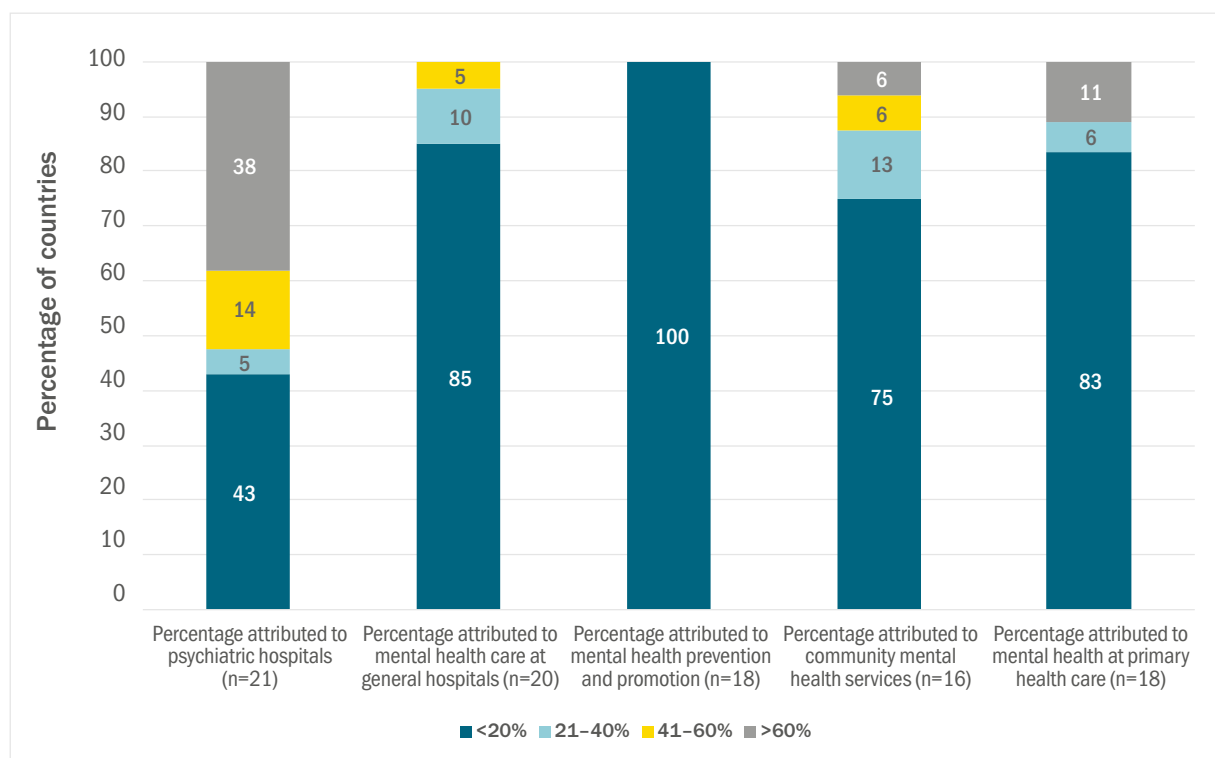
### Government mental health expenditure

Governments are the main source of financing for the care and treatment of severe mental health conditions in the Region. Based on the countries that provided sufficient information to calculate the mental health expenditure as a percentage of total government health expenditure (n=23), a median of 3% of total government health expenditure is allocated to mental health in the Region: 1.8% in Central America, Mexico, and Latin Caribbean, 5% in Non-Latin Caribbean, and 1.8% in South America (data were not provided for any country in North America).

With respect to allocation of mental health expenditure, in the Region:

- 43% of countries (n=21) allocate < 20% of their mental health expenditure to psychiatric hospitals, while 38% of countries allocate > 60%;
- 85% of countries (n=20) allocate < 20% of their mental health expenditure to mental health care at general hospitals, 10% allocate 21–40%, and 5% allocate 41–60%;
- 100% of countries (n=18) allocate < 20% of their mental health expenditure to mental health prevention and promotion;
- 75% of countries (n=16) allocate < 20% of their mental health expenditure to community mental health services, while only 6% of countries allocate > 60%;
- 83% of countries (n=18) allocate < 20% of their mental health expenditure to mental health at the primary care level, while 11% allocate > 60% (Figure 2.1).

**FIGURE 2.1. Percentage of mental health expenditure attributed to specific areas of the mental health sector in the Region of the Americas**

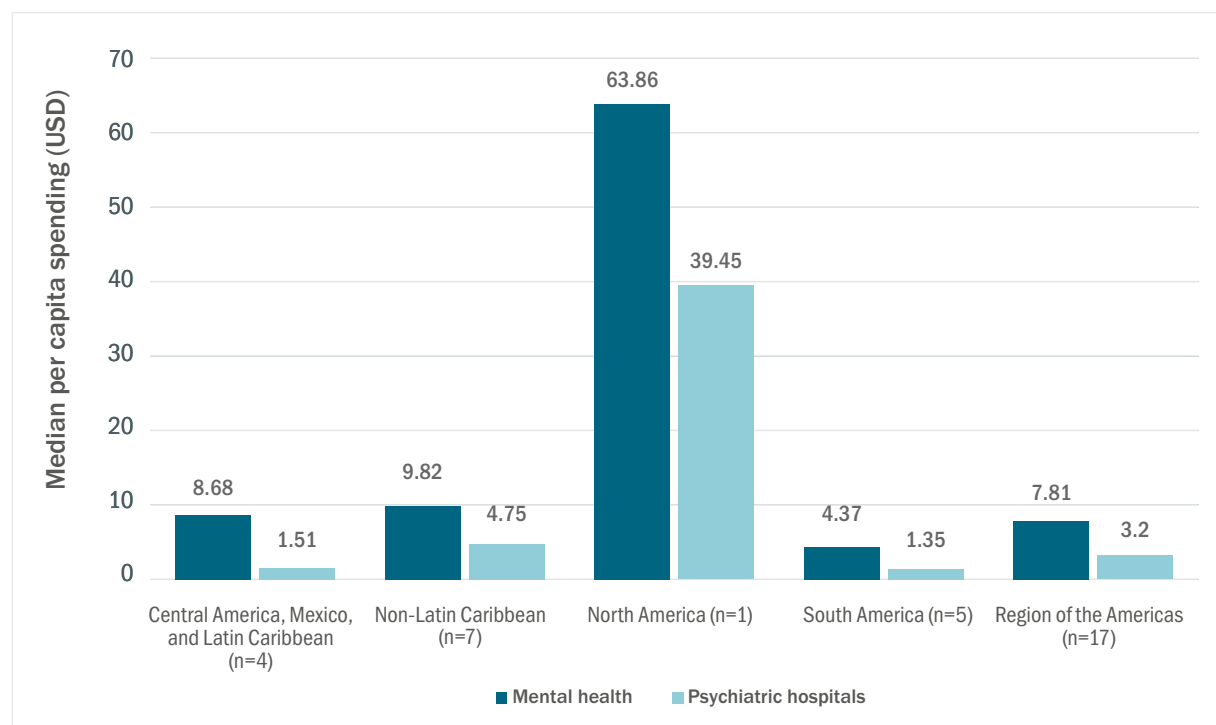




Seventeen countries provided full information on mental health spending, along with specific information on psychiatric hospitals. Median annual per capita mental health spending in the countries that responded is USD 7.81 (Figure 2.2), down from USD 13.8 in 2017

(comparisons are limited as different countries were included in both Atlas versions). There were notable variations between subregions and income groups (Figure 2.3).

**FIGURE 2.2. Median per capita spending on mental health and psychiatric hospitals in the Region of the Americas and its subregions**

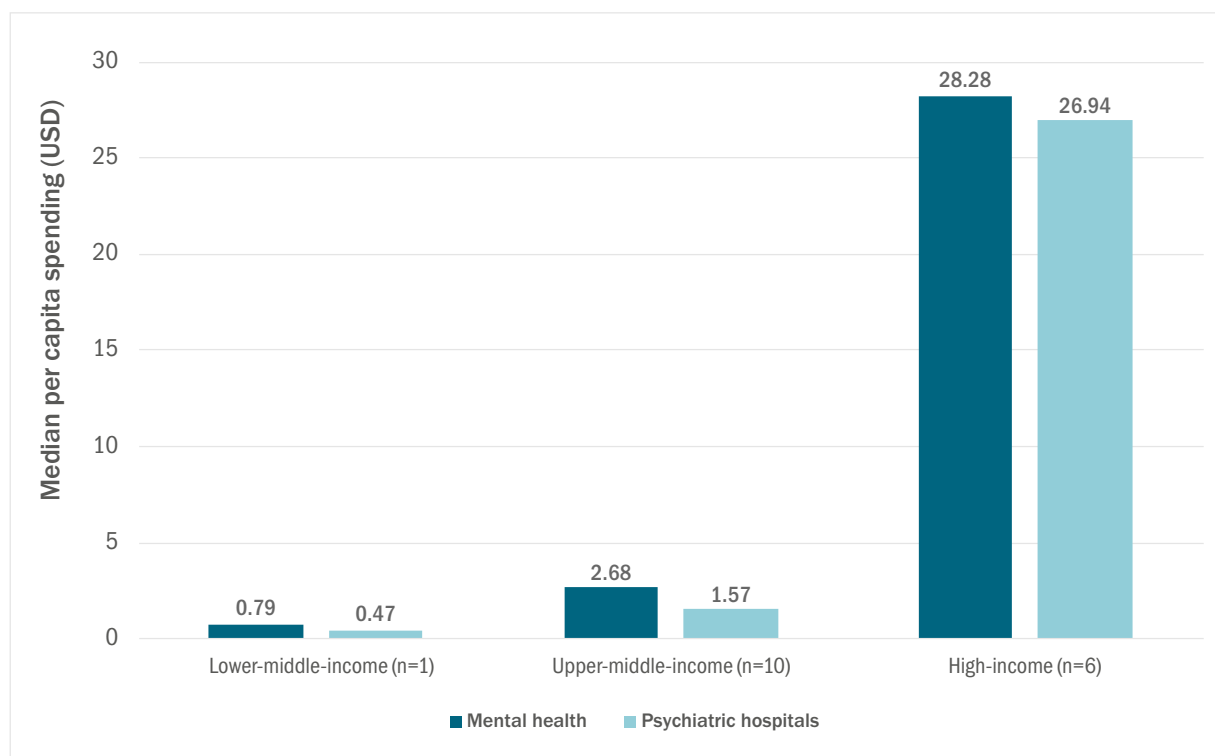


*Note:* Figure only includes data from countries able to provide full information on mental health spending, along with specific information on psychiatric hospitals.

Based on the data provided by the countries that responded (n=17), a median of 43% of annual public expenditure on mental health is allocated to psychiatric hospitals in the Region, ranging from 17% in Central America, Mexico, and Latin Caribbean to nearly 62% in North America. In high-income countries, 95% of public

expenditure on mental health is allocated to psychiatric hospitals, while 59% of public expenditure on mental health is allocated to psychiatric hospitals in lower- and upper-middle-income countries.

**FIGURE 2.3. Median government spending on mental health and psychiatric hospitals per capita, in the Region of the Americas, by income group**



Note: Figure only includes data from countries able to provide full information on mental health spending, along with specific information on psychiatric hospitals. Data were not available for low-income countries.

## Inclusion of mental health conditions in national health insurance or reimbursement schemes

Universal health coverage means that all people have access to the health services they need, when and where they need them, without suffering financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.

Of the countries that answered the question related to whether care and treatment of persons with mental health conditions (psychosis, bipolar disorder, depression) are included in national health insurance or reimbursement schemes (n=32), 88% responded in the affirmative: 80% (8 out of 10 countries) in Central America, Mexico, and Latin Caribbean, 85% (11 out of 13 countries) in Non-Latin Caribbean, and 100% (all nine countries that responded) in South America.

In response to a question about how people with severe mental health conditions pay for services, in 23% of

countries (n=39), persons pay at least 20% toward the cost of services, in 13% of countries persons pay mostly or entirely out of pocket for services, and in 64% of countries, persons pay nothing at the point of service use (i.e., they are fully insured). With respect to how people with severe mental health conditions pay for psychotropic medicines, in 26% of countries (n=38), persons pay at least 20% toward the cost of medicines, in 13% of countries, persons pay mostly or entirely out of pocket for medicines, and in 61% of countries, persons pay nothing at the point of sale (i.e., they are fully insured).

## Mental health workforce

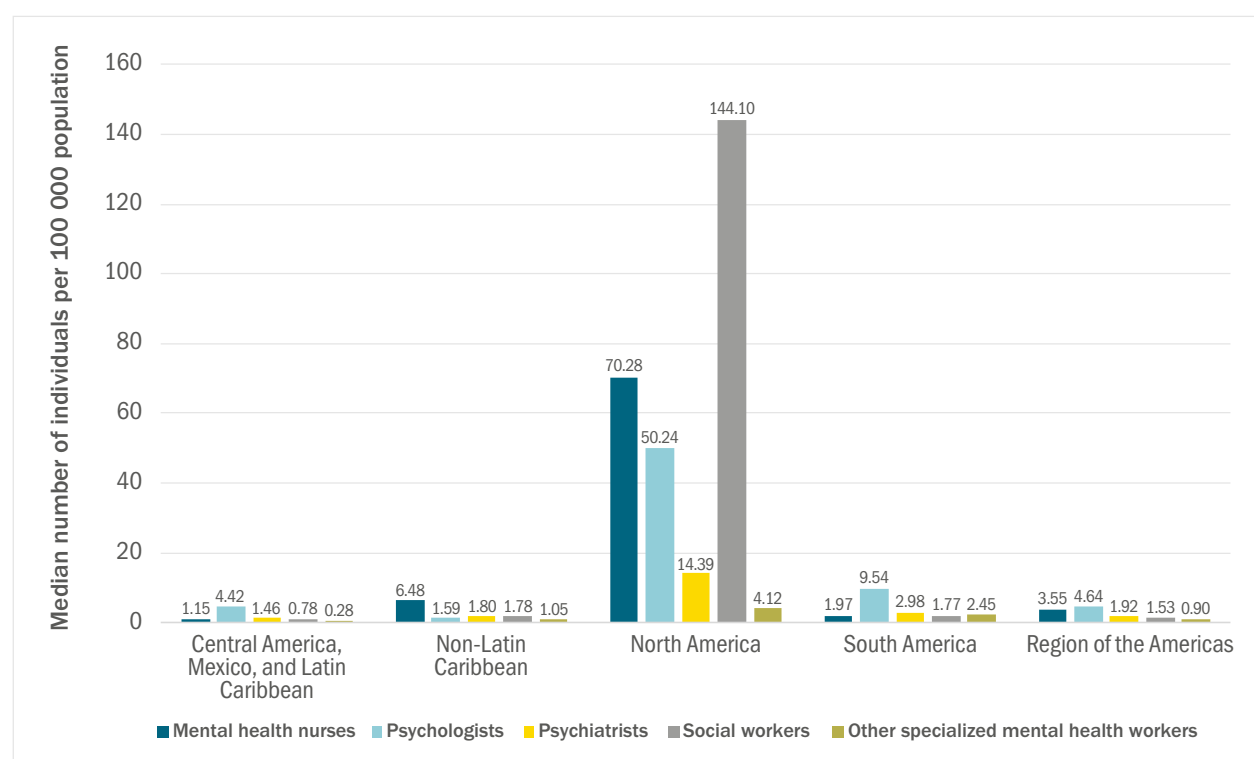
Human resources are the most valuable asset of any mental health service. Financial resources are essential for achieving the objectives of plans and programs, and for developing and maintaining mental health services.

Countries were asked to estimate the total number of mental health professionals working in the country, with a breakdown by profession type including psychologists, mental health nurses, psychiatrists, social workers, and

other specialized mental health workers. A total of 33 countries were able to provide at least partial data for this indicator. Based on the data provided, the regional median is 14.9 mental health workers per 100 000 population. There were substantial differences across subregions (8.2 mental health workers per 100 000 population in Central America, Mexico, and Latin Caribbean, 20.4 per 100 000 population in Non-Latin Caribbean, 283.1 per 100 000 population in North America, and 23.9 per 100 000 population in South America) and income groups (2.1 per 100 000 population in low-income countries, 3.1 per 100 000 population in lower-middle-income countries, 12.7 per 100 000 population in upper-middle-income countries, and 51.3 per 100 000 population in high-income countries).

The median number of individuals working in the mental health sector per 100 000 population for all profession types is the highest in North America, to a great extent (Figure 2.4). The median number of psychologists per 100 000 population is higher than all other types of mental health professionals in Central America, Mexico, Latin Caribbean, and South America, while the median number of mental health nurses is higher than all other types of mental health professionals in Non-Latin Caribbean, and the median number of social workers is higher than all other types of mental health professionals in North America. The median rate of human resources in the Region varies across the different professions, from 0.9 other specialized mental health workers per 100 000 population to 4.6 psychologists per 100 000 population.

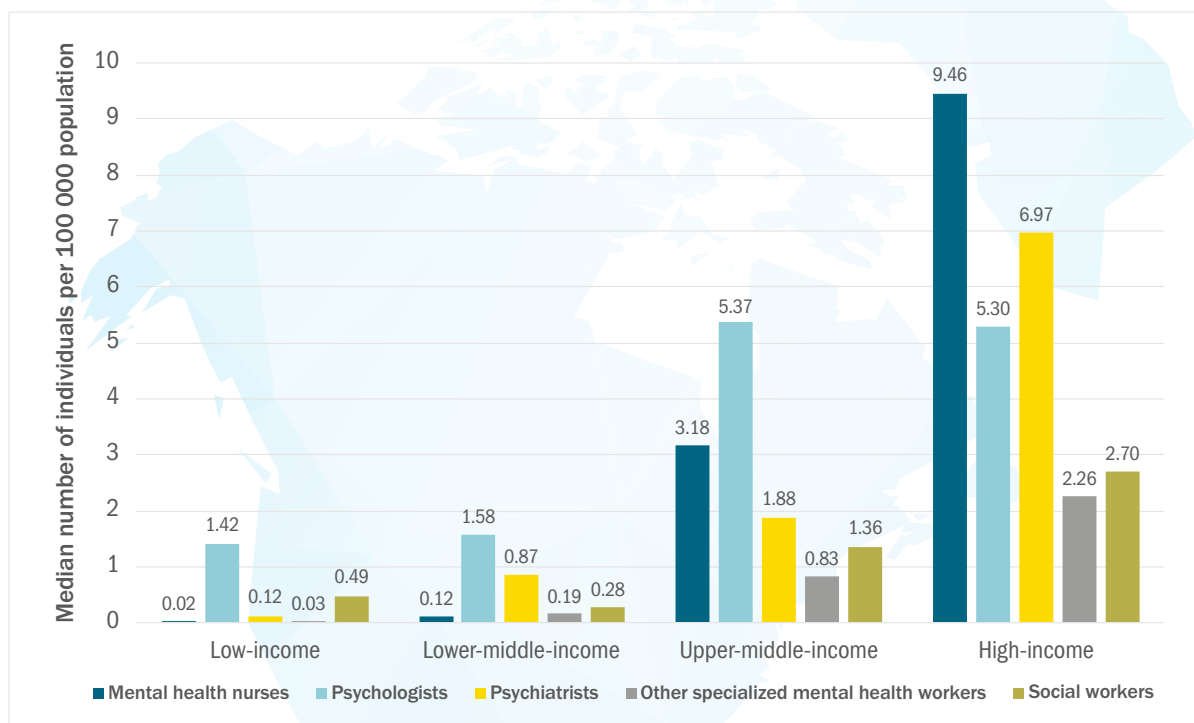
**FIGURE 2.4. Median number of individuals working in the mental health sector by type of profession (per 100 000 population) in the Region of the Americas and its subregions**



With respect to income groups, the median number of individuals working in the mental health sector per 100 000 population for all profession types is the highest in high-income and upper-middle-income countries (Figure 2.5). The median number of psychologists per

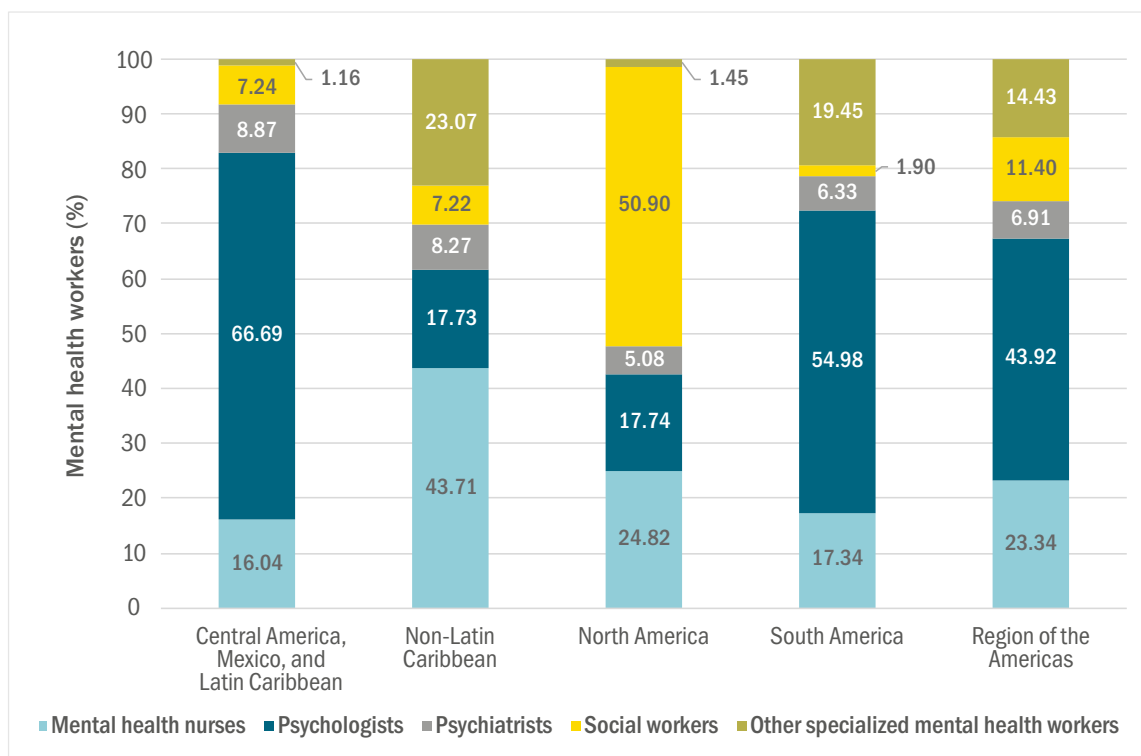
100 000 population is higher than all other types of mental health professionals in all income groups except for high-income countries, where the median number of mental health nurses per 100 000 population is the highest.

**FIGURE 2.5. Median number of individuals working in the mental health sector by type of profession (per 100 000 population) in the Region of the Americas, by income group**



Overall, psychologists make up 44% of the mental health workforce in the Region, mental health nurses make up 23%, other specialized mental health workers make up 14%, social workers make up 11%, and psychiatrists make up 7% of the mental health workforce in the Region (Figure 2.6).

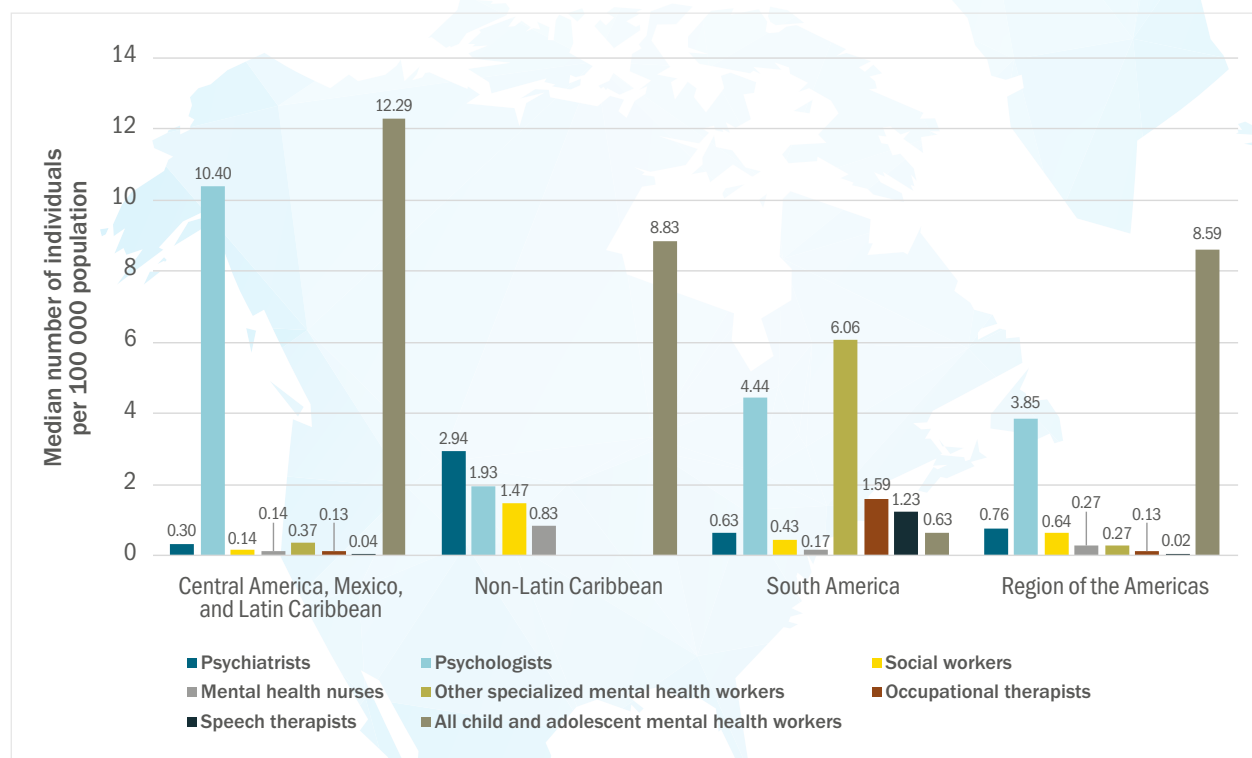
**FIGURE 2.6. Proportion of mental health workers in the mental health sector by type of profession in the Region of the Americas and its subregions**



Countries were also asked about individuals working in child and adolescent mental health services specifically (i.e., for those 0 to 19 years of age). Based on the countries that provided data, the regional median is 8.6 mental health workers per 100 000 population of children and adolescents, with notable differences across subregions

(12.3 mental health workers per 100 000 population of children and adolescents in Central America, Mexico, and Latin Caribbean, 8.8 per 100 000 population of children and adolescents in Non-Latin Caribbean, and 0.6 per 100 000 population of children and adolescents in South America; Figure 2.7).

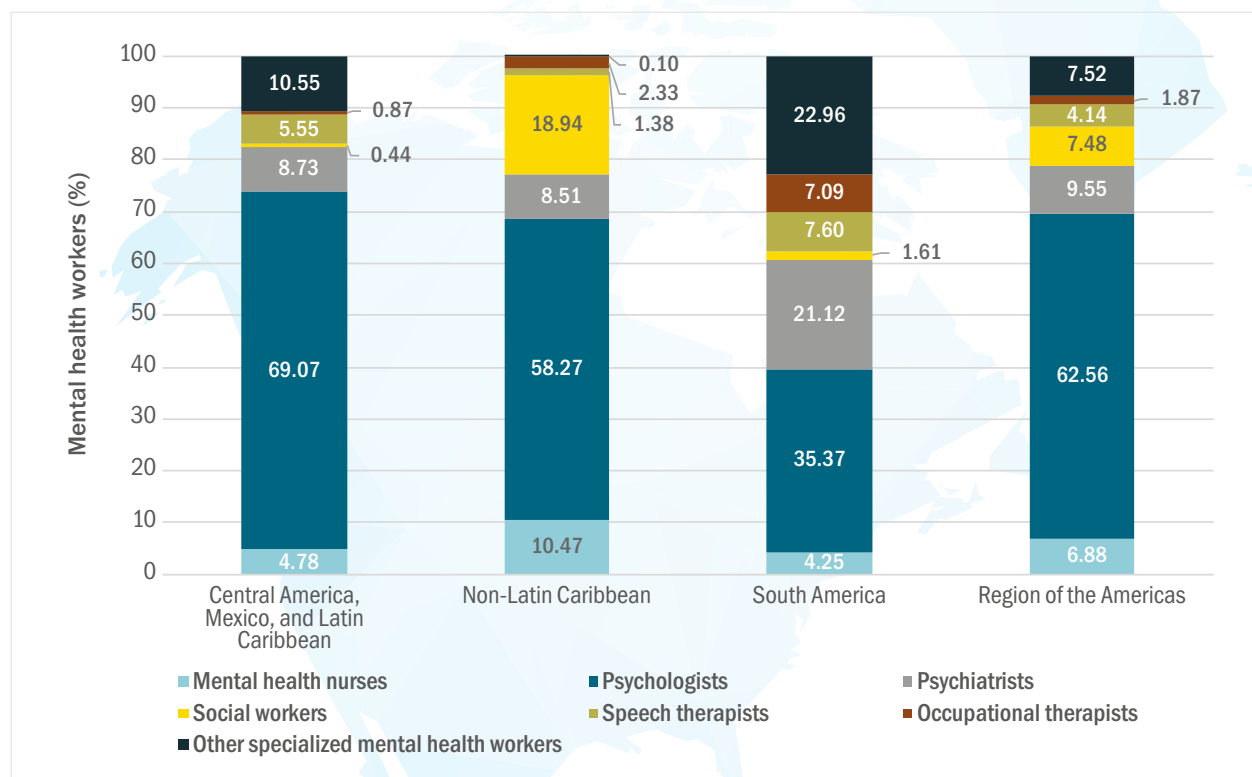
**FIGURE 2.7. Median number of individuals working in the child and adolescent mental health sector by type of profession (per 100 000 population) in the Region of the Americas and its subregions**



Note: Data were not provided for any country in North America.

Overall, psychologists make up 63% of the child and adolescent mental health workforce in the Region, psychiatrists make up 10%, other specialized mental health workers make up 8%, social workers make up 7%, mental health nurses make up 7%, speech therapists make up 4%, and occupational therapists make up 2% of the child and adolescent mental health workforce in the Region (Figure 2.8).

**FIGURE 2.8. Proportion of mental health workers in the child and adolescent mental health sector by type of profession in the Region of the Americas and its subregions**



Note: Data were not provided for any country in North America.

The regional median number of mental health workers changed from 16.2 workers per 100 000 population in 2014, to 11 in 2017, and to 15 in 2020. In addition to an actual increase in the total number of mental health workers in some responding countries, this change can be further explained by the fact that a higher number of

countries provided data on the number of mental health workers (33 responding countries in 2017 compared with 39 countries in 2020). Changes in values across years can also be explained by improvements in data quality reported over time.



### 3. Availability of mental health services

#### Integration of mental health into primary health care

The global Comprehensive Mental Health Action Plan 2013–2030 emphasizes the importance of decentralizing the focus of care and treatment from long-stay mental health hospitals to primary care settings. Out of the 38 countries that responded, 26 (68%) reported that guidelines for mental health integration into primary health care were available and adopted at the national level (Table 3.1). Countries were then asked to estimate

the percentage of primary care facilities that typically have available pharmacological and psychosocial interventions for mental health conditions. In the Region of the Americas, 38% (14/37) of responding countries reported having pharmacological interventions and 32% (12/38) reported having psychosocial interventions available and provided in more than 75% of their primary care centers.

**TABLE 3.1. Guidelines for mental health integration into primary health care available and adopted at national level and percentage of responding countries with availability and provision of pharmacological and psychosocial interventions in > 75% of primary care centers**

Region and subregion	Guidelines for mental health integration into primary health care available and adopted at national level, no. (%)	Pharmacological interventions in at least 75% of primary care centers, no. (%)	Psychosocial interventions in at least 75% of primary care centers, no. (%)
Central America, Mexico, and Latin Caribbean (n=10)	10 (100%)	2 (20%)	4 (40%)
Non-Latin Caribbean (n=17)	9 (53%)	8 (47%)	6 (35%)
North America (n=1)	0 (0%)	1 (100%)	1 (100%)
South America (n=10)	7 (70%)	3 (33%) <sup>a</sup>	1 (10%)
Region of the Americas (n=38)	26 (68%)	14 (38%) <sup>b</sup>	12 (32%)

<sup>a</sup> Out of 9 countries.

<sup>b</sup> Out of 37 countries.

The shift to mental health integration into primary health care through the training of primary care workers in the management of mental health conditions is necessary. The WHO Mental Health Gap Action Programme recommends the engagement of mental health specialists in capacity-building and on-the-job supervision and support of the primary care workforce (6). In the Region, 84% (32 out of 38) of countries report that primary healthcare workers receive such training, and 30 of those countries (94%) report that mental health specialists are involved in the respective training.

This reflects a critical gap between the existence and adoption of guidelines for the integration of mental health into primary health care and the limited integration of interventions for service delivery.

#### Inpatient and residential care

Inpatient and residential care comprises public and/or private, profit and non-profit, mental health hospitals, psychiatric wards in general hospitals, community residential facilities, and mental health inpatient facilities for children and adolescents (in both mental health and general hospitals).



Out of 38 countries, 97% report having inpatient facilities specifically for patients with mental health conditions. Eighty-two percent (31 out of 38) of countries have one or more mental health hospitals, 76% (29 out of 38) have one or more psychiatric units in a general hospital, and 54% (20 out of 37) have one or more mental health community residential facilities.

The median rate of total inpatient facilities was 0.37 per 100 000 population in the Region (compared to 0.29 per 100 000 in 2017). There were 13.58 beds per 100 000 population, unequally distributed across subregions (53.35 beds per 100 000 population in Non-Latin Caribbean compared to 3.53 beds per 100 000 population in Central America, Mexico, and

Latin Caribbean) and income groups (30.36 beds per 100 000 population in high-income countries compared to 2.39 beds per 100 000 population in low-income countries; Table 3.2). Similarly, the median admission rate per 100 000 population in inpatient facilities varied widely from 0.27 in low-income countries to 135.6 in high-income countries.

As for children and adolescents, among the 37 countries that responded to this indicator, 23 (62%) of them report having inpatient facilities for children and adolescents with mental health conditions. The median number of inpatient mental health facilities for children and adolescents in the Region is 0.07 per 100 000 population (based on data provided by 15 countries).

**TABLE 3.2. Inpatient and residential care, median number of facilities, beds, and admissions rate per 100 000 population, by facility type for the Region of the Americas, its subregions, and by income group**

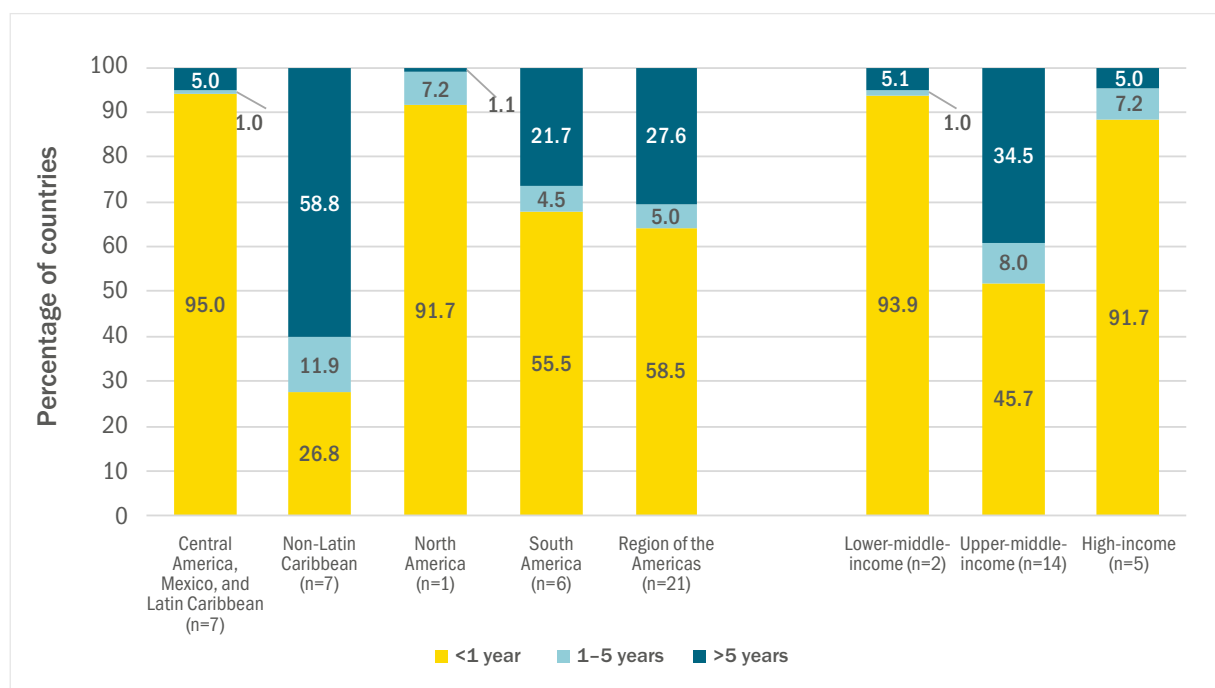
	Inpatient care <sup>a</sup>			Mental health hospitals			Psychiatric unit in general hospital			Mental health community residential facility		
	No. facilities	No. beds	No. admissions	No. facilities	No. beds	No. admissions	No. facilities	No. beds	No. admissions	No. facilities	No. beds	No. admissions
Region of the Americas (n=37)	0.37	13.58	59.39	0.04	4.84	25.95	0.10	0.71	11.07	0.01	0.13	0.00
Subregions												
Central America, Mexico, and Latin Caribbean (n=10)	0.11	3.53	26.20	0.03	3.24	18.42	0.03	0.19	7.78	0.01	0.15	0.29
Non-Latin Caribbean (n=11)	0.77	53.35	201.46	0.17	50.00	125.57	0.13	1.27	15.63	0.00	0.00	0.00
North America (n=1)	0.43	25.83	189.85	0.05	10.98	55.26	0.37	14.85	134.59	n/a	n/a	n/a
South America (n=10)	0.37	7.02	50.15	0.04	4.17	25.04	0.12	1.39	9.38	0.09	0.85	0.03
Income group												
Low-income (n=1)	0.04	2.39	0.27	0.02	1.86	n/a	0.01	0.05	n/a	0.02	0.48	0.27
Lower-middle-income (n=4)	0.06	3.53	39.09	0.03	3.36	20.61	0.02	0.15	4.48	0.00	0.00	0.00
Upper-middle-income (n=18)	0.36	12.51	67.97	0.04	6.78	27.14	0.07	0.66	3.00	0.01	0.13	0.00
High-income (n=9)	0.70	30.36	135.60	0.06	19.94	55.26	0.26	3.99	40.87	0.11	0.00	0.00

<sup>a</sup> Includes mental health hospitals, psychiatric units in general hospitals, and mental health community residential facilities.  
n/a = not available due to missing data.

In the Region, 58.5% of patients stay in inpatient/residential care less than one year, while 5% stay between one and five years, and 27.6% stay more than five years (Figure 3.1). There is much variation across subregions,

as well as by income group. Table 3.3 provides the duration of stay in mental health hospitals for male and female patients in the Region of the Americas and its subregions.

**FIGURE 3.1. Duration of stay in mental health hospitals, by subregion and income group (median percentage values)**



Note: Values do not add to 100% due to the use of median percentages. Data were not provided for any low-income country.

**TABLE 3.3. Duration of stay in mental health hospitals for male and female patients in the Region of the Americas and its subregion**

Duration	Central America, Mexico, and Latin Caribbean		Non-Latin Caribbean		South America		Region of the Americas	
	Males	Females	Males	Females	Males	Females	Males	Females
< 1 year	56.0	44.0	55.8	44.2	53.7	46.3	55.1	44.9
1-5 years	86.9	28.4	78.7	21.3	52.5	47.5	73.1	27.3
> 5 years	44.8	55.2	62.4	37.6	51.0	49.0	57.6	42.4

Note: Data were not provided for any country in North America.

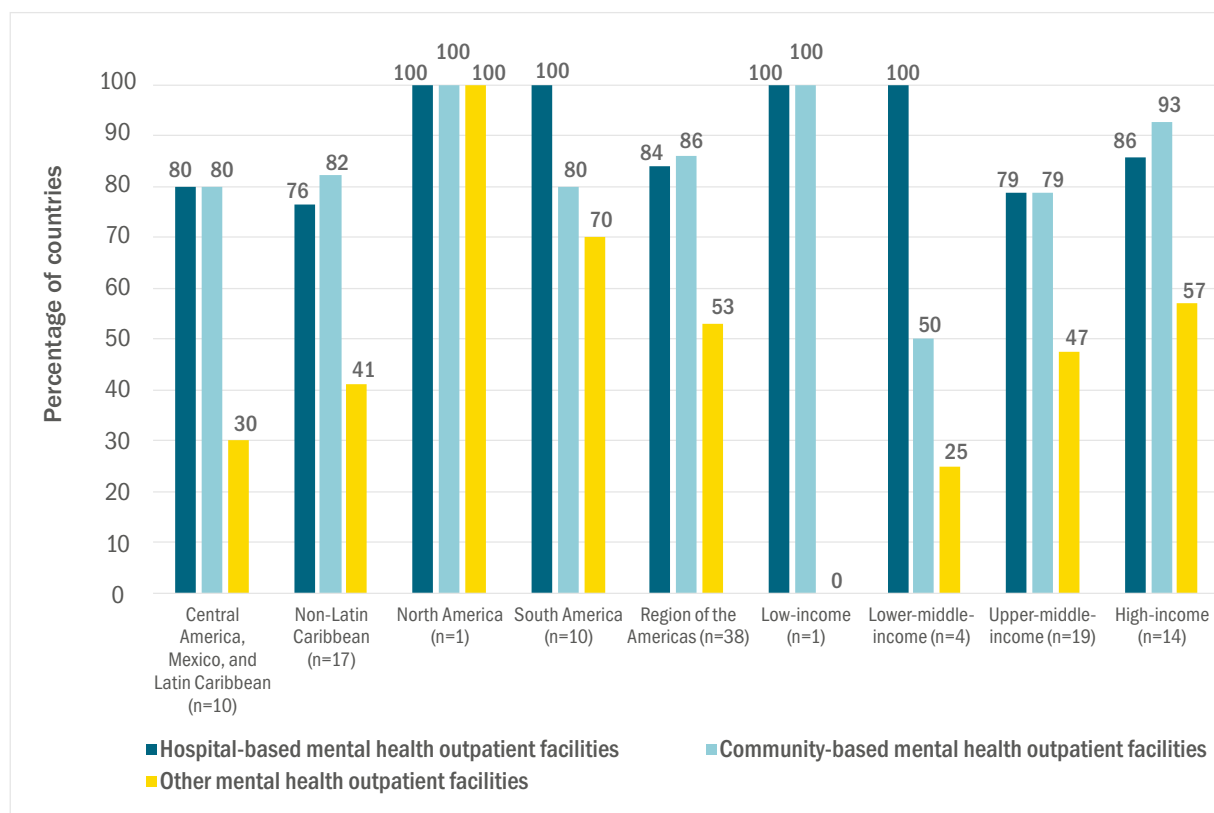
## Outpatient care

Outpatient care consists of both public and private and non-profit and for-profit facilities, including hospital-based outpatient facilities (e.g., outpatient departments and/or clinics located in mental and/or general hospitals, including those for specific mental health conditions, treatments, or user groups), community-based mental health outpatient facilities (e.g., community mental health centers), and other outpatient facilities (e.g., residential facilities for specific mental health conditions).

Outpatient care serves persons with both chronic and acute, and mild and severe, mental health conditions.

In the Region of the Americas, 84% (32/38) of countries report that they have hospital-based mental health outpatient facilities, 86% (31/36) of countries report that they have community-based mental health outpatient facilities, and 53% (18/34) of countries report that they have other mental health outpatient facilities, such as day treatment facilities (Figure 3.2).

**FIGURE 3.2. Percentage of countries with outpatient mental health facilities in the Region of the Americas, its subregions, and by income group**



Among those countries in the Region with such facilities, there is a median of 1.1 mental health outpatient facilities per 100 000 population. Facility-specific rates are: 0.3 hospital-based mental health outpatient facilities per 100 000 population, 1.6 community-based mental health outpatient facilities per 100 000 population, and 0.14 other mental health outpatient facilities per 100 000 population.

In the Region, the median number of visits to mental health outpatient facilities per 100 000 population was 2936.1. There was a median of 914.9 hospital-based mental health outpatient visits per 100 000 population, 1559.1 visits per 100 000 population to community-based mental health outpatient facilities, and 104.9 visits per 100 000 population to other mental health outpatient facilities. There was slightly more utilization of outpatient services by females (56% of total visits) than males (44% of total visits, n=15).

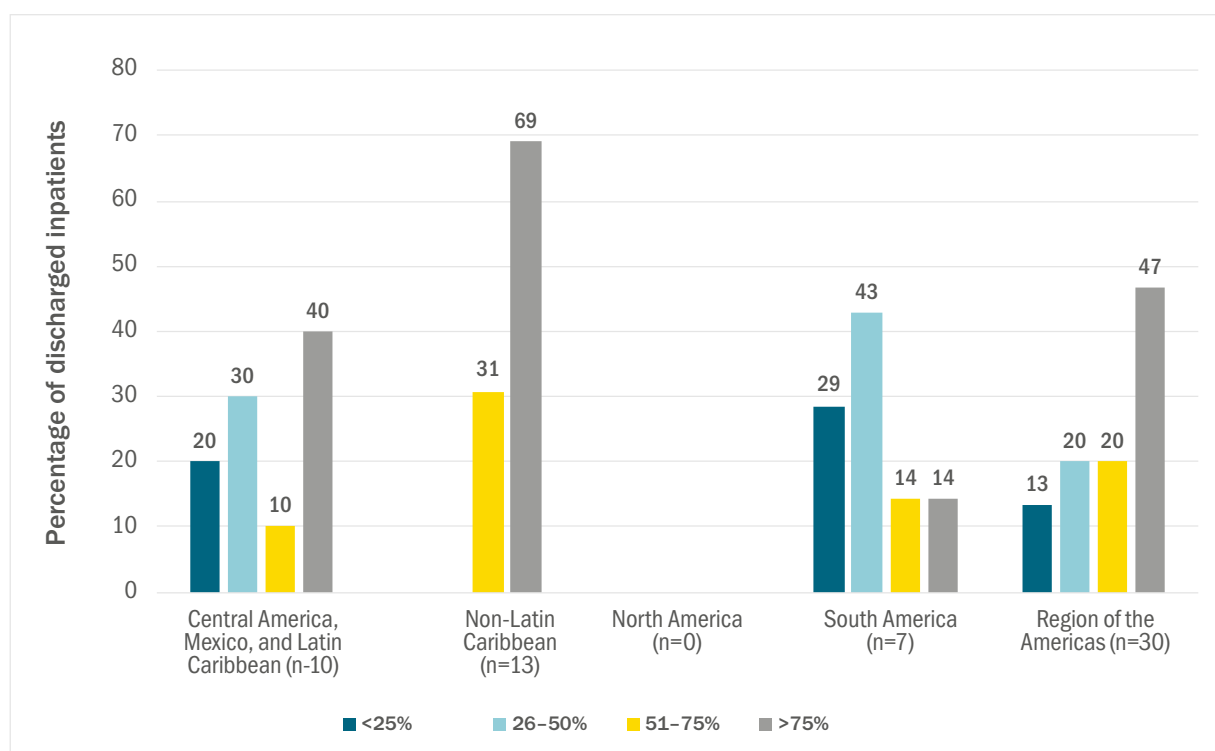
## Continuity of care

When evaluating continuity of care, one marker that indicates the quality of the mental healthcare system is the proportion of patients discharged from hospital units who receive monitoring within one month.

In the Region, 13% of countries report that 25% or less of discharged inpatients received a follow-up outpatient visit

within one month, 20% of countries report that 26–50% of discharged inpatients received a follow-up outpatient visit within one month, 20% of countries report that 51–75% of discharged inpatients received a follow-up outpatient visit within one month, and 47% of countries report that more than 75% of discharged inpatients received a follow-up outpatient visit within one month (Figure 3.3).

**FIGURE 3.3. Percentage of discharged inpatients who received a follow-up outpatient visit within one month**



## Community-based mental health services

One of the key objectives of the Comprehensive Mental Health Action Plan 2013–2030 is to provide comprehensive, integrated, and responsive mental health and social care services in community-based settings. Global Target 2.2 of the plan is for 80% of countries to have doubled their number of community-based mental health facilities by 2030.

Community-based mental health services are defined as services that are provided in the community, outside a

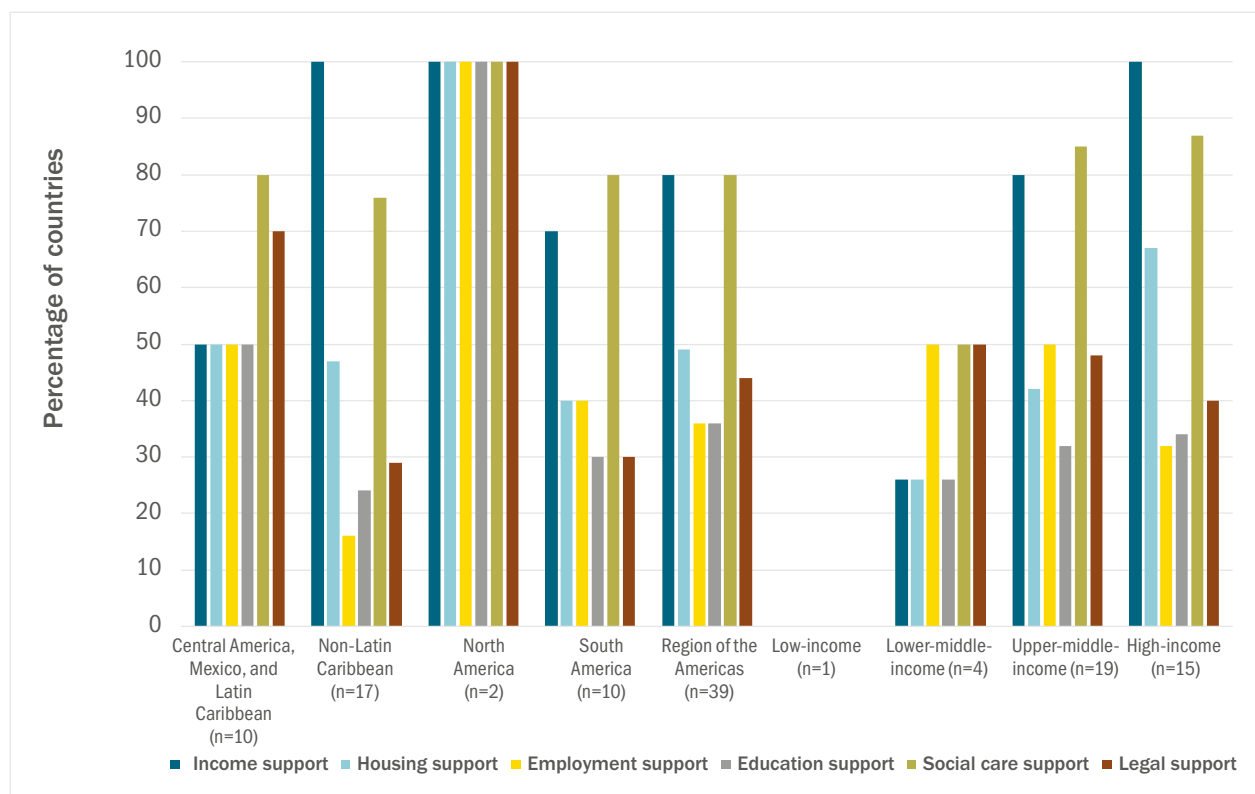
hospital setting. Data for this indicator include countries' reported number of community-based outpatient facilities (e.g., community mental health centers), other outpatient services (e.g., day treatment facilities), and mental health community residential facilities for adults.

In the Region of the Americas, the median number of adult community-based mental health facilities is 1.57 per 100 000 population, with no significant changes from 2017 (1.61 per 100 000 population).

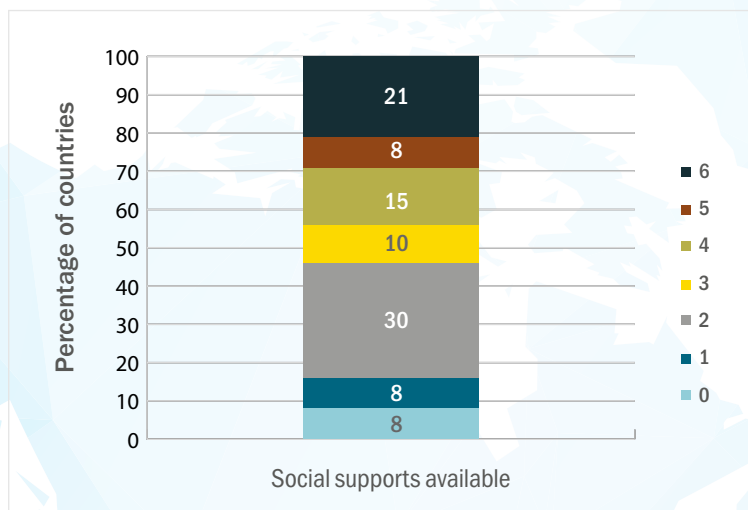
## Social support

Social support is usually defined as a range of interpersonal relations or connections that have an impact on an individual's functioning, and that include support provided by individuals and by social institutions.

**FIGURE 3.4. Percentage of countries providing social supports to people with severe mental health conditions in the Region of the Americas and its subregions, by income group and support type**



**FIGURE 3.5. Number of social supports provided by countries in the Region of the Americas**



In the Region, the majority of countries provide income support (80%) and social care support (80%) for people with severe mental health conditions. About half of countries (49%) provide housing support to people with severe mental health conditions, 44% provide legal support, 36% provide employment support, and 36%

provide education support (Figure 3.4). Overall, 48% of countries in the Region provide at least three types of social supports to people with severe mental health conditions (Figure 3.5).



## 4. Mental health promotion and prevention

### Mental health promotion and prevention programs

The promotion of mental health and the prevention of mental health conditions was highlighted in the Sustainable Development Agenda adopted at the United Nations General Assembly in September 2015. Sustainable Development Goal (SDG) number 3 aims to ensure healthy lives and, among other targets, to promote mental health and well-being. SDG Target 3.4 is, by 2030, to reduce by one-third premature mortality from noncommunicable diseases through prevention and treatment and promotion of mental health and well-being, the suicide rate being an indicator (3.4.2) for this target.

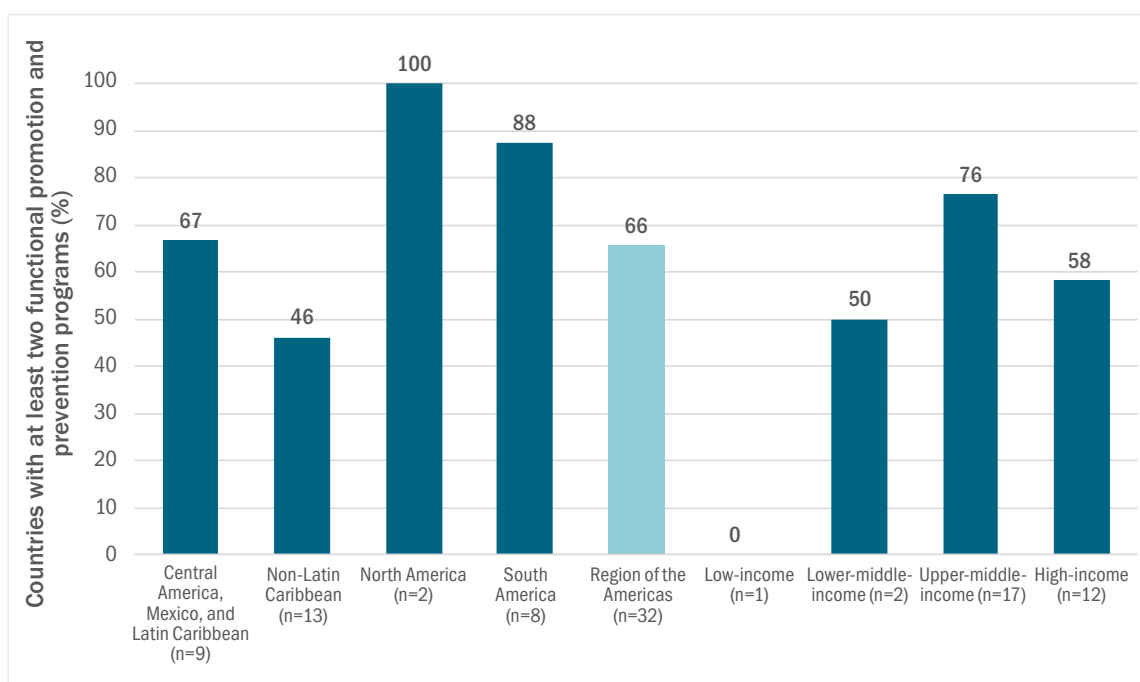
A program for promotion and prevention was considered to be a functional program only when at least two of the

three following characteristics were endorsed:

1. Human and financial resources;
2. A defined implementation plan;
3. Evidence of progress and/or impact.

In all, 21 of the 32 countries (66%) that responded to this indicator have at least two functional programs for mental health promotion and prevention, with the highest rates in South America (88%) and North America (100%; Figure 4.1).

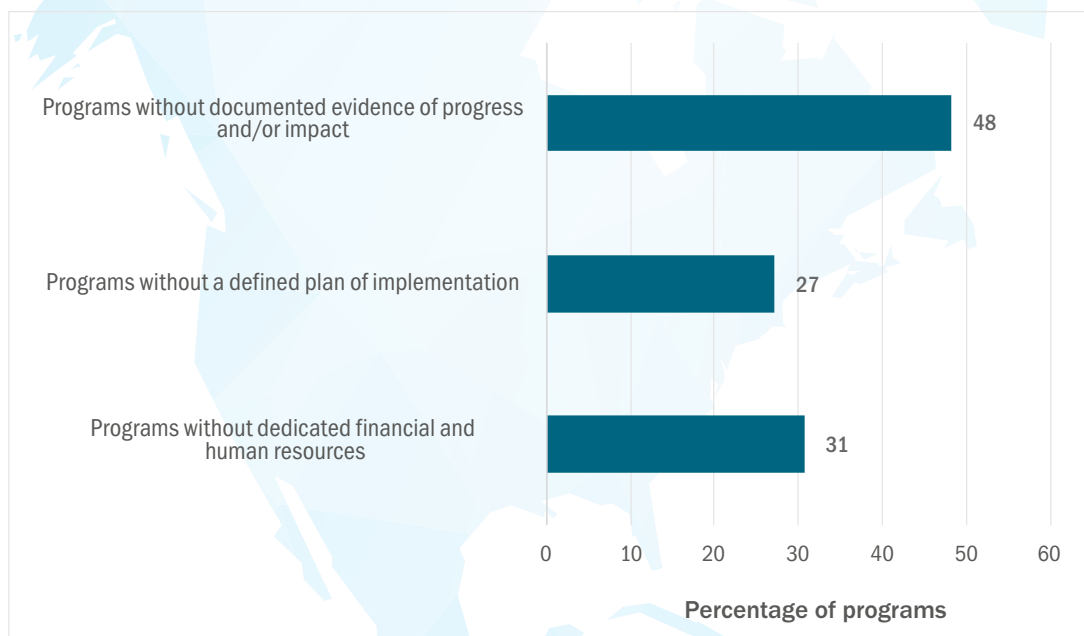
**FIGURE 4.1. Proportion of countries with at least two functional promotion and prevention programs in the Region of the Americas and its subregions, by income group**



In order to identify areas of improvement for such programs, frequent limitations to functionality were ascertained. Of the 114 mental health promotion and prevention programs reported in the Region, 48% are

without documented evidence of progress and/or impact, 31% are without dedicated financial and human resources, and 27% are without a defined plan of implementation (Figure 4.2).

**FIGURE 4.2. Most frequent limitations to functionality of promotion and prevention programs, by frequency of no fulfillment of each of the three criteria across all reported programs**

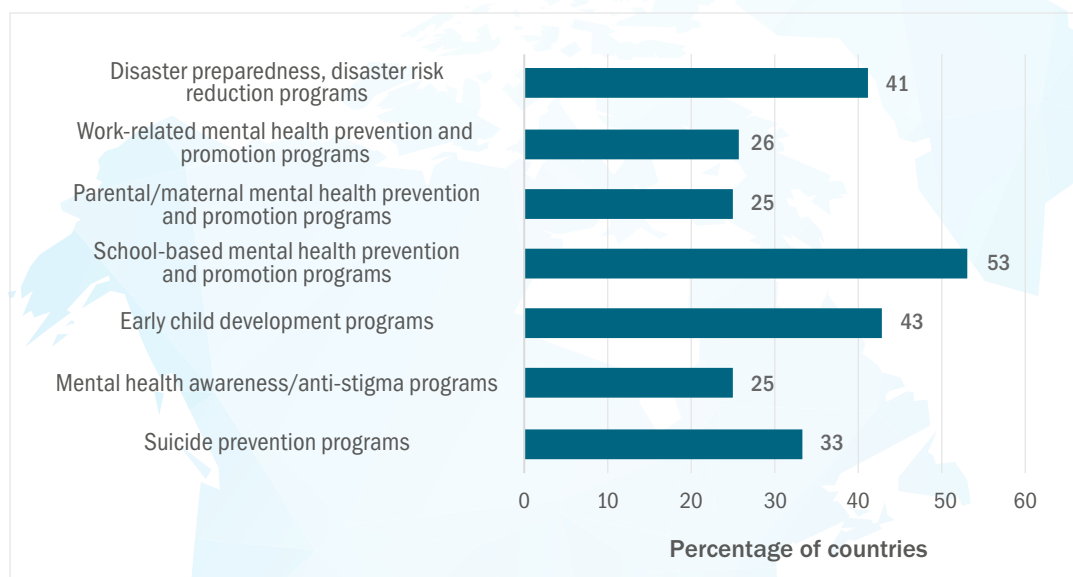


With respect to the types of programs reported, more than half (53%) of the 32 responding countries had school-based mental health prevention and promotion programs, 43% had early child development programs, 41% had

disaster preparedness and/or disaster risk reduction programs, and 33% had suicide prevention programs (Figure 4.3).



**FIGURE 4.3. Type of mental health promotion and prevention programs in the Region of the Americas**



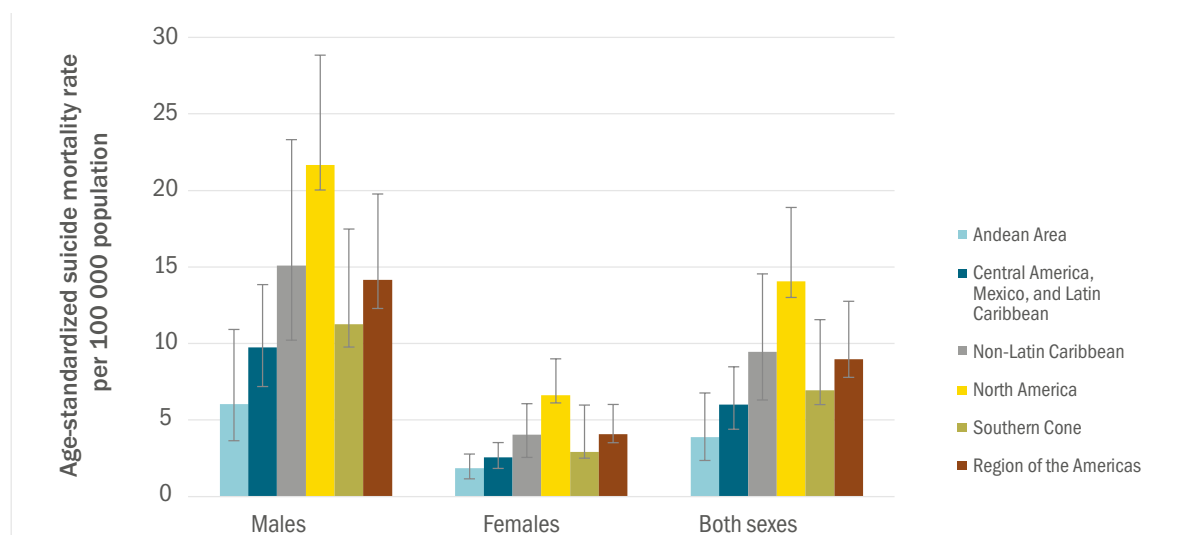
## Suicide prevention

Based on the WHO Global Health Estimates database, in the Region of the Americas in 2019, the age-standardized suicide mortality rate was 9.0 per 100 000 population (14.2 per 100 000 males and 4.1 per 100 000 females; Figure 4.4) (7).

The subregion with the highest suicide mortality rate in 2019 was North America at 14.1 per 100 000 population (21.7 per 100 000 males and 6.6 per 100 000 females),

followed by Non-Latin Caribbean at 9.5 per 100 000 population (15.1 per 100 000 males and 4.1 per 100 000 females) (Figure 4.4). The subregion with the lowest suicide mortality rate in 2019 was the Andean Area at 3.9 per 100 000 population (6.1 per 100 000 males and 1.9 per 100 000 females). This ranking of subregions with respect to the suicide mortality rate has remained relatively stable across the last five years.

**FIGURE 4.4. Age-standardized suicide mortality rates per 100 000 population (95% CI) in the Region of the Americas and its subregions, 2019**



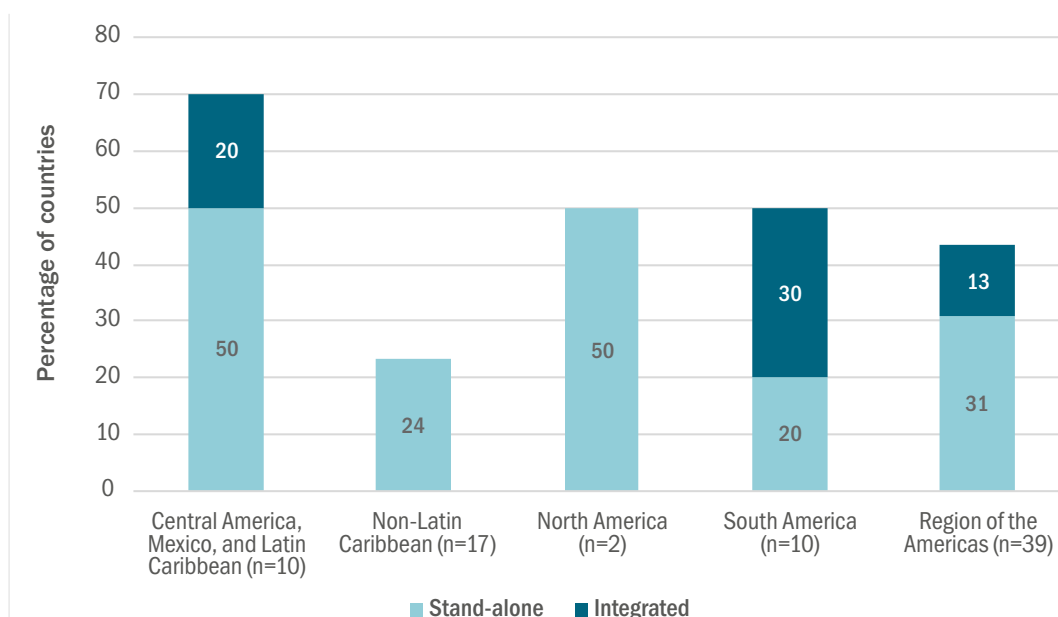
Notes: Andean Area: Bolivia (Plurinational State of), Colombia, Ecuador, Peru, Venezuela (Bolivarian Republic of); Southern Cone: Argentina, Brazil, Chile, Paraguay, Uruguay.

Source: Pan American Health Organization. Suicide Mortality in the Americas. Regional Report 2015-2019. Washington, D.C.: PAHO; 2021. Available from: <https://iris.paho.org/handle/10665.2/55297>.

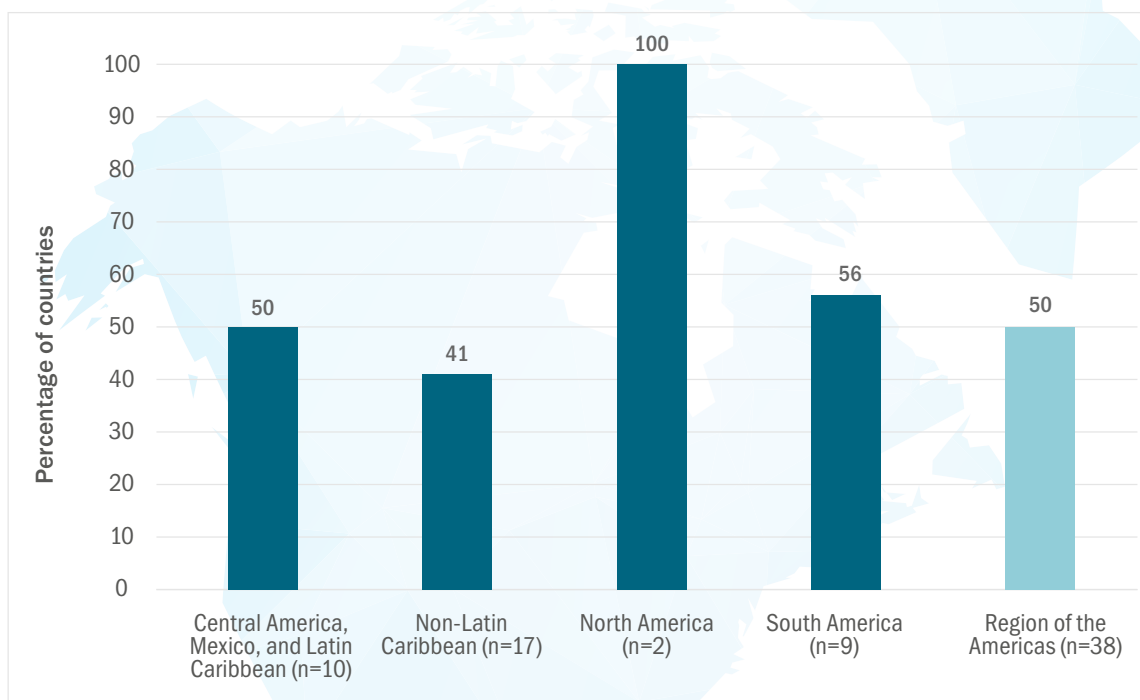
Overall, 17 countries (44%) have a national suicide prevention strategy/policy/plan; 12 of those countries (71%) have a stand-alone suicide prevention strategy/policy/plan, and five (29%) have a suicide prevention policy

that is integrated into mental health or other health strategy/policy/plan (Figure 4.5). Of the 17 countries with a national suicide prevention strategy/policy/plan, 10 (59%) have updated their strategy/policy/plan since 2017.

**FIGURE 4.5. Percentage of countries with a stand-alone or integrated suicide prevention strategy/policy/plan in the Region of the Americas and its subregion**



**FIGURE 4.6.** Percentage of countries with suicide prevention training programs for gatekeepers in the Region of the Americas and its subregions



Countries were also asked to indicate whether or not they have suicide prevention training programs for gatekeepers (for example, teachers, police, firefighters, other first responders, and faith leaders). Overall, 19 of the 38

countries (50%) that responded to this indicator reported that they do have suicide prevention training programs for gatekeepers (Figure 4.6).

## 5. CONCLUSIONS

Comparing 2020 data with the findings of the 2014 and 2017 issues of the *Mental Health Atlas of the Americas* is difficult, as some of the indicators have changed as a result of feedback received by the representatives of the Member States, and also because the countries that completed the questionnaire for this edition of the Atlas are not identical to those that participated in the 2014 and 2017 editions. Thus, the ability to use the different editions of the Atlas to compare data over time is limited. Nevertheless, the *Mental Health Atlas of the Americas 2020* provides the data needed for countries to measure their progress toward meeting the goals set forth in the global Comprehensive Mental Health Action Plan 2013–2030.

For mental health policy and legislation, most countries (87%) have a stand-alone mental health policy/plan, and the percentages of responding countries have steadily increased since publication of the *Mental Health Atlas of the Americas 2014* (80%) and *Mental Health Atlas of the Americas 2017* (82%). Compared to previous editions of the *Mental Health Atlas*, the percentage of countries indicating full compliance of their mental health policies/plans with human rights instruments has slightly increased in the Region, and full compliance increased from 63% in 2014 to 71% in 2020. However, challenges exist in assessing the degree to which these plans, policies, and legislation align with regional and global plans and human rights instruments, as well as how fully they are being implemented. Furthermore, policies/plans for children and adolescents are still lacking in almost half (48%) of the countries in the Region.

Investment in mental health in the Americas is still insufficient to meet the needs indicated by the regional mental health burden. Median public spending on mental health for the 14 countries that provided data on this indicator is a mere 3% of their health budgets. Adequate financing for mental health is fundamental to reducing the public health and economic burdens of mental, neurological, and substance use conditions, protecting the human rights of people with mental health conditions, and creating equitable access to mental health care.

Countries have been reducing the number of psychiatric beds (15 countries reporting reductions of at least 15% in the number of psychiatric hospital beds) and integrating mental health into primary health care (32 countries

reporting that health workers at the primary care level receive training in the management of mental health conditions), both intended to build the capacity of mental health systems to provide care in community-based settings and to enhance outpatient service coverage. However, despite some progress, outpatient service coverage in the Region has not increased as expected and mental health hospitals in the Region still have a large number of beds. This highlights the need to enhance efforts to shift mental health services to the community as well as to further integrate mental health into primary health care. Factors such as the numbers of providers and facilities providing outpatient mental health services are also likely to be key to success on this target.

Suicide remains a public health issue of critical importance in the Region. Available data from 34 countries indicate that the average annual suicide rate has increased. While national suicide prevention strategies have advanced since 2013, the scope of these strategies and their degree of implementation vary widely. Moreover, operational multisectoral mental health promotion and prevention programs have been implemented in 29 countries but still lack “functionality”, and do not include a mental health and psychosocial support component of disaster preparedness and/or disaster risk reduction.

During the unprecedented time of the COVID-19 pandemic, the need for mental health care and support has been even more important than ever before. This public health crisis has contributed to a rise in mental health and substance use conditions and a worsening of preexisting ones across the Americas (8), placing added strain on the Region’s mental health resources. As a result of the pandemic, mental health systems in the Region are facing a greater demand for services, which will require even greater financial investment in community-based mental health care. As COVID-19 continues to impact the mental health of populations and much-needed mental health services in the Americas, it is essential that countries in the Region utilize data from the *Mental Health Atlas 2020* to advocate for strengthening and scaling up mental health resources and services in order to address the immediate and long-term mental health effects of the COVID-19 pandemic and to build back better mental health systems for the future.

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The *Mental Health Atlas* of the World Health Organization is the best-known and most comprehensive source of information on mental health resources globally. It aims to provide up-to-date information on the existence of mental health services and resources, including mental health policies and legislation, financing, the availability and utilization of mental health services and human resources, and mental health promotion and prevention.

This 2020 edition of the *Mental Health Atlas of the Americas*, based on data from 2018 to 2020, is an important compilation of information on mental health systems in the Member States of the Pan American Health Organization (PAHO). During the unprecedented time of the COVID-19 pandemic, the need for mental health care and support has been even more important than ever before. As COVID-19 continues to impact the mental health of populations and much-needed mental health services in the Americas, it is essential that countries in the Region utilize data from the *Mental Health Atlas 2020* to advocate for strengthening and scaling up mental health resources and services in order to address the immediate and long-term mental health effects of the COVID-19 pandemic and to build back better mental health systems for the future.

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