MENTAL HEALTH ATLAS OF THE AMERICAS

DECEMBER 2015

GUIDELINESS

Pan American Health Organization

World Health Organization
REGIONAL OFFICE FOR THE Americas

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KEY FINDINGS

GLOBAL REPORTING ON CORE MENTAL HEALTH INDICATORS

- 32 countries and territories at least partially completed the Atlas questionnaire.
- 42% of our countries and territories regularly compile mental health service activity data covering at least the public sector.

MENTAL HEALTH SYSTEM GOVERNANCE

- 81% of our countries and territories have a stand-alone policy or plan for mental health; 52% have a stand-alone law for mental health.
- 50% of our countries and territories have a stand-alone policy that was updated within the past 10 years, is partially or fully implemented, and has a satisfying compliance with human rights standards.
- 34% of our countries and territories have a stand-alone legislation that is partially or fully implemented and has a satisfying compliance with human rights standards.

FINANCIAL AND HUMAN RESOURCES FOR MENTAL HEALTH

- Financial resources on mental health are US$ 6.96 per capita (median) with a range that goes from $1 to $273. A large proportion of these funds goes to inpatient care (75%), especially to mental hospitals (73% of the total funds).
- The median number of mental health workers is 21 per 100,000 population.

MENTAL HEALTH SERVICE AVAILABILITY

- The median number of mental hospital beds is 6.5 per 100,000 population; extreme variation was reported between subregions (from below 4 to over 70 beds).

MENTAL HEALTH PROMOTION AND PREVENTION

- 37% of our countries and territories have at least two functioning mental health promotion and prevention programmes; out of almost 60 mental health promotion and prevention programmes reported, over half (59%) were aimed at improving mental health literacy or combating stigma and discrimination.

1. INTRODUCTION

The WHO Mental Health Atlas was first produced as the *Atlas of Mental Health Resources in the World 2001* (WHO, 2001). Since then, subsequent updates have been published (WHO, 2005; WHO, 2011). The Mental Health Atlas (http://www.who.int/mental_health/evidence/ atlas/mental health_atlas _2014/en/) provides up-to-date information on the availability of mental health services and resources across the world as well as baseline data towards meeting the established targets of the *Comprehensive mental health action plan 2013-2020* (http://www.who.int/mental_health/publications/action_plan/en/). Information and data for the Mental Health Atlas are obtained via a questionnaire compiled by designated focal points in each WHO Member State.

The purpose of this report is to provide a regional and more detailed overview of the mental health situation in the countries and territories of the Pan American Health Organization/World Health Organization (PAHO/WHO). Data from the main critical areas of the mental health system development, including governance, financial and human resources, service availability and delivery, and promotion and prevention are individually presented.

1.1 METHODOLOGY

The Mental Health Atlas project required a number of administrative and methodological steps, such as the development of the questionnaire, dissemination and submission of the questionnaire, and data clarification, cleaning and analysis. For more details, see *Mental Health Atlas 2014* (WHO, 2014). For the present report, WHO headquarters provided PAHO with a regional data set that only included information about the countries of the Region. After the data was analyzed, a report based on a template that WHO headquarters provided, was written.

1.2 LIMITATIONS

A number of limitations should be mentioned at this point. While best attempts have been made to obtain information from all countries on all variables and indicators, not all countries participated and those countries that did participate, not all provided data for all indicators. This important limitation should be kept in mind when examining the results. Reasons for missing data can be that data for an indicator does simply not exist, or cannot be reported in the manner specifically requested in the Atlas questionnaire. For example, as mentioned in the *Mental Health Atlas 2014* (WHO, 2014), some countries had difficulty providing information about the mental health budget in the requested format because mental health care is integrated within the primary care system or broken down using different expenditure or disease categories.

2. PARTICIPATING COUNTRIES

PAHO's countries and territories that appear in Table 1 have completed the 2014 WHO Mental Health Atlas Questionnaire. In total, 32 countries and territories at least partially completed the questionnaire. However, this represents 96% of the total regional population. It is important to note that not all countries answered the questionnaire to full completion and any discrepancies will be noted in the respective paragraph.

For the purpose of this report, and to facilitate subregional comparisons, the countries and territories (all considered countries in the report) that completed the Questionnaire were grouped into four subregions, as follows: 1. Central America, Mexico and the Latin Caribbean; 2. Non-Latin Caribbean; 3. South America; 4. Canada and the United States.

Table 1. Participating countries and territories in the Americas, by subregion

Central America, Mexico and the Latin Caribbean (N=9)	Non-Latin Caribbean (N=12)	South America (N=9)	Canada and United States (N=2)
Costa Rica	Anguilla	Argentina	Canada
Cuba	Barbados	Bolivia	United States
Dominican Republic	Belize	Brazil	
El Salvador	Dominica	Chile	
Guatemala	Grenada	Colombia	
Haiti	Guyana	Ecuador	
Honduras	Jamaica	Paraguay	
Mexico	Saint Lucia	Peru	
Panama	Saint Martin	Uruguay	
	Saint Vincent and the Grenadines		
	Suriname		
	Trinidad and Tobago		

3. MENTAL HEALTH SYSTEM GOVERNANCE

One of the objectives of the Mental health action plan relates to strengthened leadership and governance for mental health. Mental health policies and legislation as well as stakeholder involvement are defined as key components of good governance and leadership.

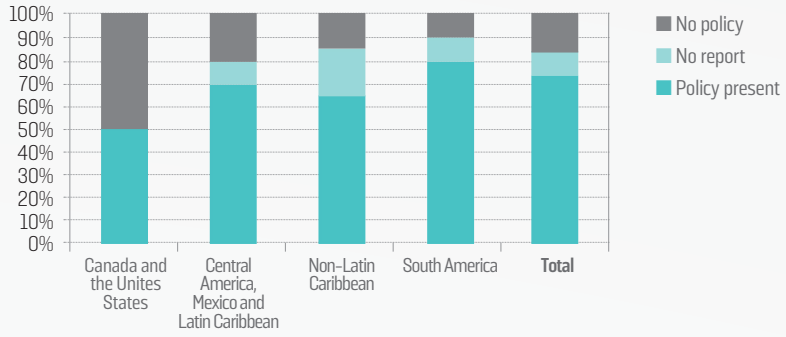
3.1 MENTAL HEALTH POLICY

Good governance and leadership are partly implemented through well-defined mental health policies and plans. Mental health policies and plans are essential tools for outlining and enforcing the mental health system framework. The existence of an explicit mental health policy and plan helps improve the organization and quality of mental health services delivery, accessibility, community care, and the engagement of people with mental disorders as well as their families.

Mental health policy refers to an organized set of values, principles and objectives to improve mental health and reduce the burden of mental disorders in a population. A mental health policy may be broadly defined as an official statement of a government that conveys an organized set of values, principles, objectives and areas for action to improve the mental health of a population. 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 Mental Health Atlas assesses whether countries have an approved mental health policy and plan as well as their implementation. At the regional level, the vast majority of the participating countries (81%) have a stand-alone mental health policy or plan. Figure 1 shows a more detailed view.

Figure 1. Mental health stand-alone policies or plans, by subregion

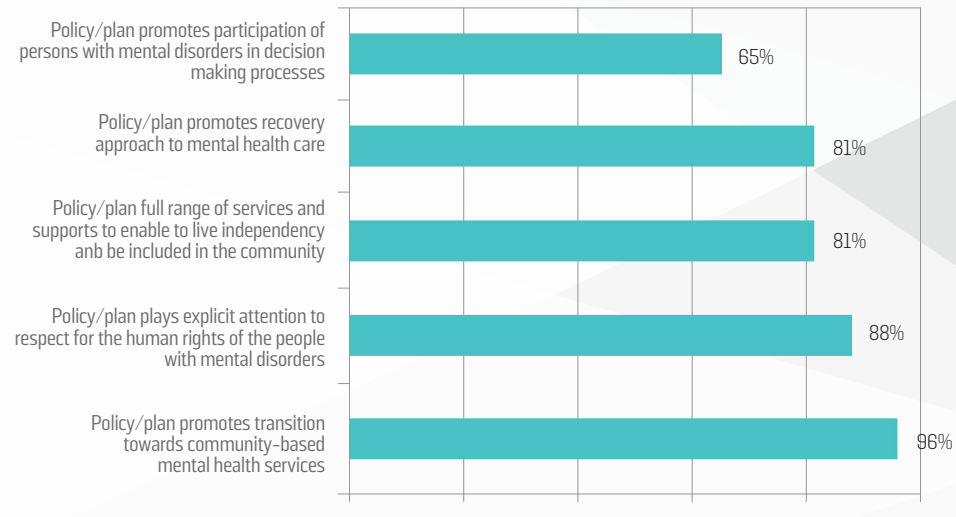


The majority (85%) of the countries in the Region that do have stand-alone policies have implemented or updated them within the past 10 years (since 2005). Amongst the six countries (19%) that do not have a stand-alone policy for mental health, four of them (67%) do have policies and plans for mental health integrated into those for general health or disability. Only two countries reported that have neither a stand-alone policy nor a policy integrated into those for general health.

Concerning the current status of policies and plans for mental health, these were not developed in only 6% of the countries, are available but not implemented in 13%, partially implemented in 72%, and fully implemented in 9% of the countries.

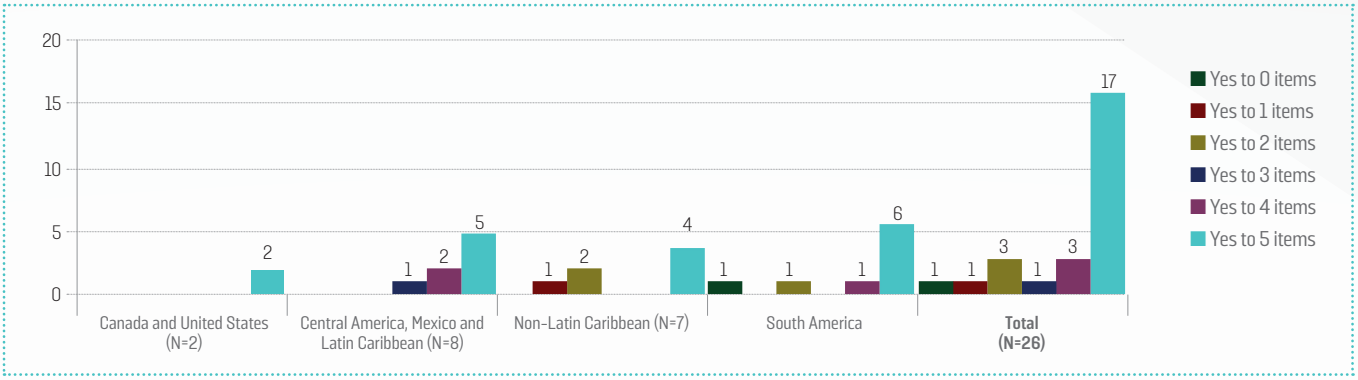
Another important issue, apart from the update of the policy, is the compliance with international human rights instruments, as described below. Figure 2 shows the level of compliance of mental health policies and plans with human rights instruments.

Figure 2. Compliance of mental health policy/plan with human rights instruments (%)



As Figure 2 indicates, the majority of countries (96%, 25 out of 26) consider their mental health policy/plan promotes the transition towards community-based mental health services (including mental health care integrated into general hospitals and primary care). Based on a Checklist of five instruments, countries were given a score out of five for evaluating the completeness of the policy/plan.

Figure 3. Degree of compliance of mental health policy/plan with international human rights instruments



As Figure 3 indicates, 21 out of the 26 countries with full or partial implementation have a score of 3 or higher. This indicates that around 81% of the countries with policies (both stand-alone and integrated) have a high compliance with human rights instruments. Moreover, 17 of the responding countries have the maximum score of 5 and have, therefore, demonstrated full compliance. In addition, 13 out of 26 countries (50%) in our Region have a stand-alone policy that was updated within the past 10 years, is partially or fully implemented, and has a satisfying compliance with human rights instruments.

3.2 MENTAL HEALTH LEGISLATION

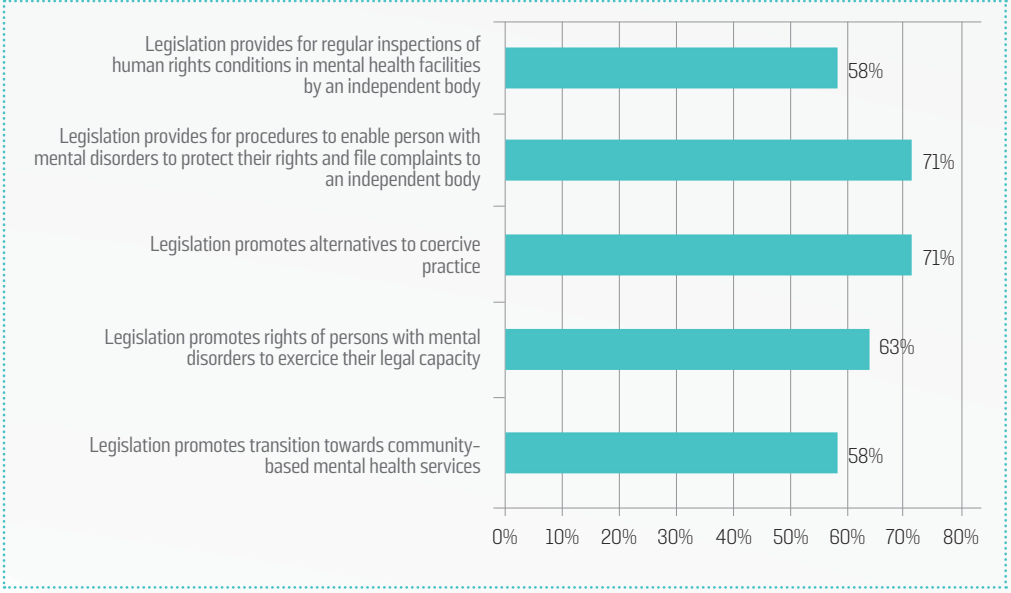
Mental health legislation is also a key component of governance. Mental health legislation refers to specific legal provisions that are primarily related to mental health, which typically focus on issues such as civil and human rights protection of people with mental disorders, involuntary admissions and treatment, guardianship and professional training and service structure. Out of 31 countries that responded to this item, about half (52%) has a stand-alone law for mental health and about a third (35%) has a law that is integrated with general health or disability legislation.

What varies greatly is the year of approval of the law: more than a third of the countries (38%) approved their mental health legislation before 1990, one country (6%) in the period 1991-2000, almost half of the countries (44%) in the period 2001-2010, and only two countries (13%) since 2010.

Another significant factor is the grade of implementation of the legislation: in about a fifth of the countries[1] (20%) the legislation was not developed or, if available, was not implemented. Similarly to countries with a stand-alone law where implementation is high in 14 out of 16 countries (88%), nine out of the eleven countries (82%) where the legislation is integrated in the general health-disability legislation also have a high grade of implementation. Figure 4 shows the degree of compliance of mental health laws with international human rights instruments.

[1] Please note, the number of countries that provided information on this item was 30 (N=30).

Figure 4. Degree of compliance of legislation with human rights instruments



As far as legislation compliance with international human rights instruments is concerned, more than half of the countries (14 out of 24[2]) have a legislation that promotes the transition towards community-based mental health services. Also in the case of the legislation, using a total score for evaluating the completeness of the law in terms of human rights, a third (33%) of the countries has a total score of less than 3 points, indicating a partial compliance, while two-thirds (67%) have a total score of 3 or higher, indicating a high compliance.

Summarizing the information available on mental health legislation, about 34% of countries[3] have a specific and stand-alone law, partially or totally implemented, and with a satisfying (score greater than or equal to 3) compliance with human rights standards. In addition, the use of a composite indicator helps to track and monitor the level of adequacy in this area.

3.3 STAKEHOLDER INVOLVEMENT

The involvement of the stakeholders, and particularly of the families and users associations, contains different issues. Table 2 shows the implementation rates of the 31 countries that provided information on these items.

[2] Please note, data is only reported for those 24 countries who reported partial or full implementation of a law covering mental health (N=24).
[3] Please note, the number of countries that provided information for this analysis is 26 (N=26).

Table 2. Implementation rates for each domain (%)

Domain	Measure	Not implemented	Partially implemented	Fully implemented
Information	Ministry of Health gathers and disseminates information about organizations of persons with mental and psychosocial disabilities, and of families and carers.	42%	35%	23%
Policy	Ministry of Health has developed and published a formal policy on the participation of persons with mental and psychosocial disabilities in the formulation and implementation of mental health policies, plans, legislation and services.	26%	55%	19%
Early involvement	Persons with mental and psychosocial disabilities, as well as families and carers, are involved from the beginning in the formulation and implementation of mental health policies and laws, and given adequate notice.	39%	45%	16%
Participation	Ministry of Health systematically involves persons with mental and psychosocial disabilities in planning, policy, service development and evaluation. The majority of committees and subcommittees developing the areas above have representation of an organization of persons with mental and psychosocial disabilities or at least one person with a mental and psychosocial disability.	55%	39%	6%
Resources	Ministry of Health reimburses costs of participation of persons with mental and psychosocial disabilities and provides resources to allow participation (physical location, transport, remuneration or reimbursement of expenses, interpreters, attendant carers and meeting support personnel).	39%	35%	26%

As shown in this table, full implementation is rare (on average only 18% of the countries reported full implementation regarding different components. Non-implementation was most frequently reported (on average 40% of the countries reported non-implementation regarding different domains). However, for some items (especially for *policy*, but also *early involvement*), partial implementation was reported more frequently.

4. FINANCIAL AND HUMAN RESOURCES FOR MENTAL HEALTH

4.1 GOVERNMENT MENTAL HEALTH SPENDING

The government is the primary source of funds for care and treatment of severe mental disorders[4] (through national health insurance and reimbursement schemes); in only two countries, households are the main source (through direct out-of-pocket payments or private insurance). Regarding the second ranked sources, employers (42%) and non-governmental organizations (33%) seem to be the main financial resources for mental health, while households (21%) and the government (4%) were reported less frequently. Variation between the subregions is reported below.

[4] Please note, the number of countries that provided information for this analysis is 24 (N=24).

Table 3. Main source of funds for care and treatment of severe mental disorders

Subregion	N	Government (national insurance)		NGO's (for profit or not for profit)		Employers (social health insurance)		Households (private insurance, out-of pocket)	
		First ranked	Second ranked	First ranked	Second ranked	Primer lugar	Segundo lugar	First ranked	Second ranked
Total	24	92%	0%	0%	33%	0%	42%	8%	21%
Canada and United States	1	100%	0%	0%	0%	0%	100%	0%	0%
Central America, Mexico and the Latin Caribbean	7	86%	0%	0%	57%	0%	43%	14%	0%
Non-Latin Caribbean	7	100%	0%	0%	14%	0%	29%	0%	57%
South America	9	89%	11%	0%	33%	0%	45%	11%	11%

As Table 3 shows, in two subregions (Canada and the United States and the Non-Latin Caribbean) the government is the only source of funds for care and treatment of severe mental disorders. In all subregions, the government is the main source of funding. In the Non-Latin Caribbean, the second ranked source are households (57%). In comparison to the average ranking of 21%, but also compared to the other subregions (0%, 0% and 11%), this is (by far) the highest secondary source within the household ranking across our Region.

The mental annual spending per person across our countries[5] is US$ 6.96 per capita (median) with a range that goes from $1 to $273 USD.

Concerning spending for mental health services in our Region[6], the proportion of funding dedicated to community mental health facilities is far from optimal, given that mental hospitals absorb 73% of the total budget allocated for all mental health facilities and about 97% of the budget for inpatient facilities.

In general, inpatient facilities absorb about 75% of the total spending and outpatient facilities about 25%.[7] It is important to note that very limited data on spending for the different outpatient facilities was provided by countries. Hence, a more detailed analysis was not possible.

4.2 MENTAL HEALTH WORKFORCE

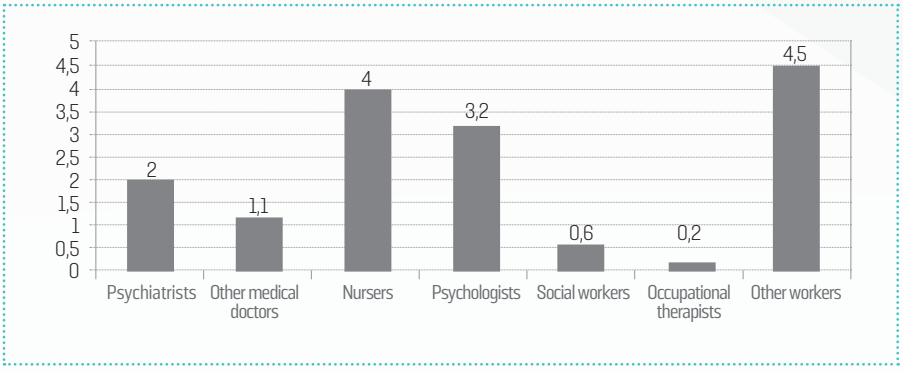
Countries were requested to provide estimates of the total number of mental health professionals working in the country, broken down by specific occupation such as psychiatrists, other medical doctors, nurses, psychologists, social workers, occupational therapists and other paid workers.

Participation rates and estimates vary across countries and items. Countries that were able to provide at least partial estimates are included in the analysis.

The total rate[8] of professionals working in mental health services is 21.1 per 100,000. The variation between subregions is significant: a higher workforce was reported for the Non-Latin Caribbean with a rate of 69.2 workers, whereas in South America the rate was 27.7 workers and in Central America, Mexico and the Latin Caribbean only 8.7 workers per 100,000 population.

[5] Please note, only Brazil, Chile, Dominican Republic, Ecuador, Jamaica, Mexico, Paraguay, Peru, Suriname and the United States provided information and were included in the analysis (N=10).
[6] Please note, only Chile, Brazil, Dominican Republic, Ecuador, Jamaica, Mexico, Paraguay, Peru and Suriname provided data for the analysis (N=9).
[7] Please note, only a few countries reported data on this item (N=9). One of them (Brazil) reported a high spending on outpatient facilities. Excluding the outline value of Brazil leads to a more representative result.
[8] Please note, only Belize, Brazil, Chile, Dominica, Dominican Republic, Ecuador, Grenada, Guatemala, Honduras, Jamaica, Mexico, Panama, Paraguay, Peru, Saint Vincent and the Grenadines and Suriname provided information and were included in the analysis (N=16).

Figure 5. Median rate of human resources working in the mental health sector per 100,000 population

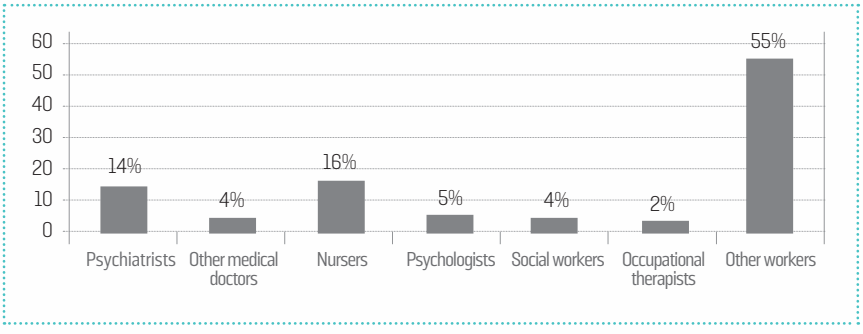


As Figure 5 shows, in our Region[9] the median rate of human resources per 100,000 working in the mental health sector varies across professions from 0.2 occupational therapists to 4.5 other workers. In terms of the total composition of the mental health workforce[10], 10% are psychiatrists, 12% other medical doctors, 15% nurses, 14% psychologists, 5% social workers, 3% occupational therapists, and 39% other workers.

4.2.1 Inpatient and outpatient facilities workforce

An important indicator of the process of de-institutionalization is the ratio between staff working at inpatient and outpatient care.[11] For each mental health professional working in outpatient services, on average, there are 1.4 working at inpatient facilities, mainly mental hospitals[12].

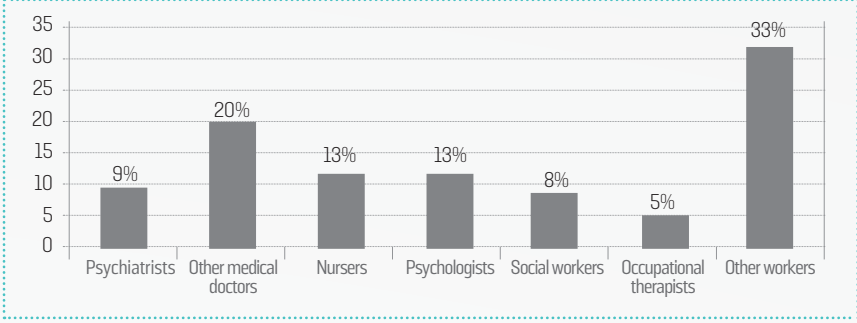
Figure 6. Percentage of mental health workers at inpatient care services



As Figure 6 shows, more than half of the workers at inpatient facilities are other workers, followed by nurses and psychiatrists. There are very few other medical doctors, social workers and occupational therapists.

[9] Please note, only Brazil, Chile, Dominica, Ecuador, Jamaica, Mexico, Panama, Paraguay and Peru provided Information and were included in the analysis (N=9).
[10] Please note, only Belize, Brazil, Chile, Dominica, Dominican Republic, Ecuador, Grenada, Guatemala, Honduras, Jamaica, Mexico, Panama, Paraguay, Peru, Saint Martin and Saint Vincent and the Grenadines were included (N=16).
[11] Please note, only Belize, Brazil, Chile, Cuba, Guatemala, Saint Martin and Suriname reported data and were included in the analysis (N=7).
[12] Please note, only few countries (N=7) reported data on this section. The inpatient-outpatient ratio of one country (Suriname) was reported to be much higher than in any other country and thus would have had a big influence on the median ratio of all countries. The outline value of Suriname was excluded in the analysis as this leads to a more representative result.

Figure 7. Percentage of mental health workers in outpatient care services[13]



As shown in Figure 7, most of the workers in outpatient facilities are other workers, followed by other medical doctors and nurses and psychologists. In general, the proportion of the total mental health workforce differs between inpatient and outpatient care services. For example, there are more psychiatrists and psychologists working at inpatient care, whereas there are more other medical doctors, social workers and occupational therapists working in outpatient services.

4.3 MENTAL HEALTH TRAINING IN PRIMARY CARE

The training of primary care staff in mental health is a crucial issue for the capacity of this sector to recognize and to treat patients with severe mental disorders. In our Region[14], the percentage of primary care staff receiving at least two days of training in the last two years is 2.7% for physicians and 1.6% for nurses and midwives. The percentage of professionals trained for each subregion is reported in Table 4.

Table 4. Percentage of mental health training in primary health care

	Physicians	Nurses and midwives
Non-Latin Caribbean (N=5)	0.52%	1.3%
South America (N=4)	1.2%	0.9%
Central America, Mexico and the Latin Caribbean (N=8)	4.3%	2.3%

As indicated in Table 4, the highest percentage of primary care staff receiving at least two days of training in the last two years was reported in Central America, Mexico and the Latin Caribbean. Additionally, whereas in Central and South America more physicians received training, in Non-Latin Caribbean more nurses and midwives did.

[13] Please note, only Brazil, Cuba, Saint Martin and Suriname provided information (N=4).
[14] Please note, 17 countries provided information on these items (N=17).

5. MENTAL HEALTH SERVICES AND INTERVENTIONS

5.1 INPATIENT CARE

Inpatient care is composed of mental hospitals, psychiatric wards in general hospitals, community residential facilities, and other residential facilities.

5.1.1 Mental hospitals

Mental hospitals are specialized hospital-based facilities that provide inpatient care and long-stay residential services for people with mental disorders. Usually, these facilities are independent and stand alone although they may have some links with the rest of the health-care system. In our Region, out of 29 countries that reported data, only one reported not having one. Therefore, mental hospitals are in most countries the main inpatient mental health facility. Table 5 shows a summary of the mental hospitals indicators that were reported in our Region[15].

Table 5. Median rates of mental hospitals indicators per 100,000 population

Indicators	Median rates				
	All countries	Central America, Mexico and the Latin Caribbean	South America	Non-Latin Caribbean	Canada and United States
Nº. of facilities	0.05	0.03	0.06	0.32	0.00
Nº. of beds	6.31	3.93	9	75.26	0.42
Nº. of admissions in the last year	44.15	19.37	18.19	424.03	UN

Based on reported data, there are 6.31 mental hospital beds per 100,000 population. It is noticeable that the highest number of facilities, beds and admissions are in the Non-Latin Caribbean.

In terms of length of stay, Table 6 shows the average (median) duration of stays in mental hospitals in our Region[16].

Table 6. Median percentage values of stay duration in mental hospitals

Indicators	Median values %				
	All countries (N=9)	Central America, Mexico and the Latin Caribbean (N=3)	South America (N=3)	Non-Latin Caribbean (N=3)	Canada and United States (N=0)
Patients staying less than 1 year	29%	29%	51%	16%	UN
Patients staying 1-5 years	15%	0%	37%	7%	UN
Patients staying more than 5 years	66%	71%	9%	77%	UN

[15] Please note, the number of countries reporting data for these items varied between 22 and 28.
[16] Please note, only nine countries provided information on this item (N=9).

On average, 66% of patients treated in mental hospitals stay more than 5 years, 33% stay less than a year, and 15% stay from 1 to 5 years. One noticeable difference between the subregions is that in Central America, Mexico and the Latin Caribbean the percentage of long-stay patients (more than 5 years) is 71%, much higher than in South America, where only 9% of patients stay longer than 5 years. However, it is important to notice a significant disparity among the three countries that provided this information: Brazil reported 0% of its patients staying more than 5 years; Paraguay, 43%; and Peru, 9%.

Twelve countries[17] provided information (at least partially) about gender distribution and length of stay in mental hospitals. For patients staying less than 1 year, there was a small gender difference reported (52% male, 48% female). However, for patients staying 1-5 years, a larger gender difference could be observed, 62% were male and only 38% female.

Among the countries that reported data on involuntary admissions (N=19), about one in three admissions was involuntary, with clear differences between subregions: in Central America, Mexico and the Latin Caribbean, 19%; in South America, 32%; in the Non-Latin Caribbean, 29%; and in Canada and the United States, 9%. Differences were also reported with respect to inpatient facilities: 44% of the total admissions in mental hospitals and 77% in psychiatric wards in general hospitals were involuntary.

5.1.2 Psychiatric wards in general hospitals

Psychiatric wards in general hospitals are psychiatric units that provide inpatient care within a community-based hospital facility (e.g. a general hospital). These units provide care to users with acute psychiatric problems and the period of stay is usually short (weeks to months). Table 7 shows a summary of indicators of psychiatric wards in general hospitals reported by countries[18] of our Region.

Table 7. Median rates of psychiatric wards at general hospitals indicators per 100,000 population

Indicators	Median rates				
	All countries	Central America, Mexico and the Latin Caribbean	South America	Non-Latin Caribbean	Canada and United States
Nº. of facilities	0.07	0.03	0.06	0.9	0.004
Nº. of beds	0.65	0.19	0.25	4.7	0.06
Nº. of admissions in the last year	57.98	12.27	30.90	137.58	UN

As Table 7 indicates, in the last year, the number of beds in psychiatric wards in general hospitals was much lower than the number of beds in mental hospitals (Table 5). Similar to the trend reported for mental hospitals, the Non-Latin Caribbean reported also the highest rates for each indicator in psychiatric wards in general hospitals.

5.1.3 Community residential facilities

A community residential facility is a non-hospital, community-based mental health facility providing overnight residence for people with mental disorders. Usually, these facilities serve users with relatively stable and chronic mental disorders who do not require intensive psychiatric interventions. Table 8 shows a summary of community residential facilities indicators reported by countries[19] of our Region.

[17] Please note, only Barbados, Brazil, Colombia, Ecuador, Guatemala, Haiti, Mexico, Panama, Paraguay, Peru, Saint Lucia and Suriname reported data on this item (N=12).
[18] Please note, the number of countries reporting data for these items varied between 17 and 25.
[19] Please note, the number of countries reporting data for these items varied between 13 and 24.

Table 8. Median rates of community residential facilities indicators per 100,000 population

Indicators	Median rates				
	All countries	Central America, Mexico and the Latin Caribbean	South America	Non-Latin Caribbean	Canada and United States
Nº. of facilities	0.007	0.00	0.08	0.14	0.001
Nº. of beds	0.05	0.00	0.80	2.80	UN
Nº. of admissions in the last year	0.00	0.00	0.95	0.18	UN

As Table 8 clearly shows, community-based residential care facilities are almost non-existent in our Region. An exception can be observed in the Non-Latin Caribbean, where the number of beds in community residential facilities is high.

5.1.4 Day treatment facilities

A mental health day treatment facility provides care and activities for groups of users during the day (half or one full day). These facilities generally: i) are available to groups of users at the same time (rather than delivering services individually); ii) expect users to stay at the facilities beyond the periods during which they have face-to face contact with staff (i.e. the service is not simply based on users leaving immediately after consultation with staff); and iii) involve a half or one full day attendance. Table 9 shows a summary of day treatment facilities indicators reported by countries[20] of our Region.

Table 9. Median rates of day treatment facilities indicators per 100,000 population

Indicators	Median rates				
	All countries	Central America, Mexico and the Latin Caribbean	South America	Non-Latin Caribbean	Canada and United States
Nº. de establecimientos	0.00	0.00	0.15	0.00	0.00
Nº. de camas	0.00	0.00	0.43	0.00	0.3
Nº. de ingresos en el último año	1.97	1.97	376.7[21]	0.00	UN

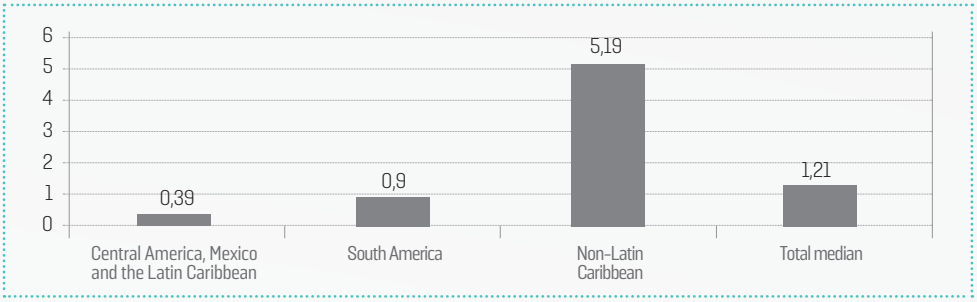
As Table 9 indicates the reported rates are very poor. However, it is important to note that this item suffered from a low response rate.

5.2 OUTPATIENT CARE

Outpatient care is composed of hospital outpatient departments, mental health outpatient clinics, community mental health centres, community-based mental health care facilities, including day-care centres. In our Region, there is a median of 1.21 outpatient facilities and about 1,520 visits per 100,000 population. Figure 8 shows the median rates of outpatient facilities by subregion[22].

[20] Please note, the number of countries reporting data for these items varied between 12 and 19 countries.
[21] Please note, only Brazil and Chile provided data on this item (N=2).
[22] Please note, only 20 countries provided data on this item (N=20).

Figure 8. Median rates of outpatient facilities per 100,000 population



As this figure shows, the rates vary a lot across subregions. In terms of visits, the lowest median, 1,108 visits per 100,000 population, was reported for Central America, Mexico and the Latin Caribbean, whereas a median of 4,438 visits was reported for South America and one of 4,643 visits for the Non-Latin Caribbean.

5.3 CONTINUITY OF CARE AFTER DISCHARGE

The proportion of persons discharged from mental hospitals and psychiatric wards in general hospitals who had a follow-up visit in an outpatient facility is an important and widely used indicator to measure the continuity of care between the inpatient and the outpatient sector.

Figure 9. Percentage of continuity of care after discharge

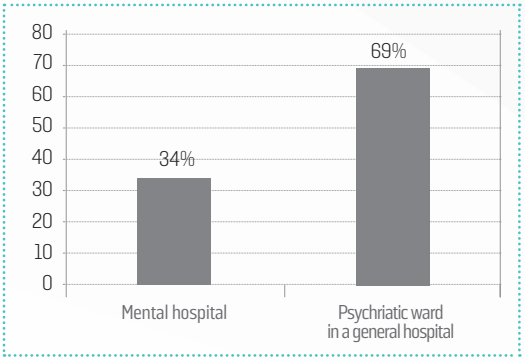


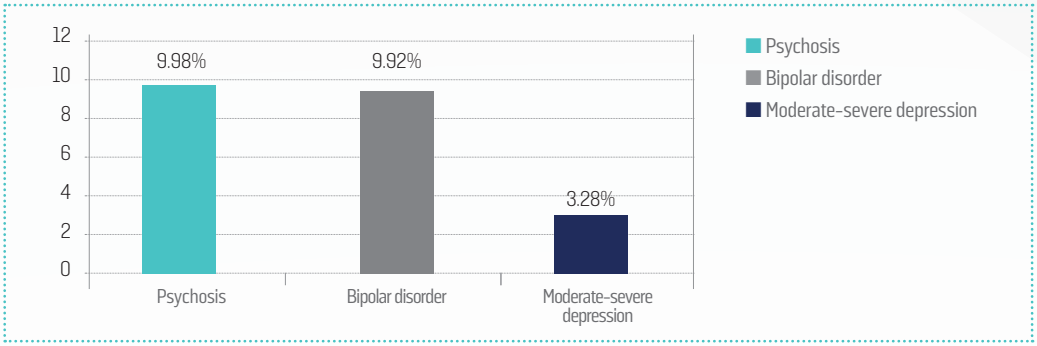
Figure 9 shows the median rate of continuity of care after discharge for the eight countries[23] that reported data. Thirty-four percent (34%) of mental hospitals reported a follow-up visit in an outpatient facility. Generally, psychiatric wards in general hospitals guarantee a better continuity of care than mental hospitals.

[23] Please note, only Barbados, Belize, Dominica, Dominican Republic, Ecuador, Guatemala, Paraguay and Saint Lucia provided information for the analysis (N=8).

5.4 TREATED PREVALENCE

Treated prevalence refers to the proportion of people with mental disorders served by mental health systems.

Figure 11. Treatment prevalence (%) for psychosis, bipolar disorder and moderate-severe depression[24]

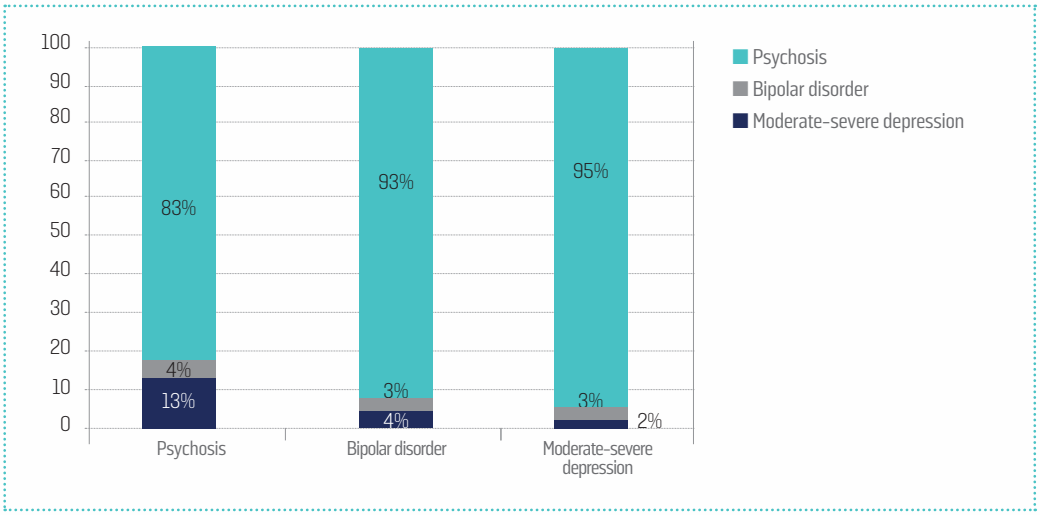


As indicated in Figure 11, the gap between the actual (estimated) prevalence and the amount of treated individuals in the mental health systems is big. About 7 out of 212 individuals per 100,000 population with moderate-severe depression (3%), 4 out of 37 with bipolar disorder (10%), and 2 out of 15 with psychosis (10%) get a treatment at any kind of mental health service (mental hospital, psychiatric ward in a general hospital, outpatient facilities). It is worth noting that, although moderate-severe depression is the most prevalent mental disorder in our Region and globally, the gap between people with a moderate-severe depression and the ones served by the mental health system is the biggest (3,28%).

5.5 SERVICE UTILIZATION FOR SEVERE MENTAL DISORDERS

Service utilization for each type of mental health facility (inpatient and outpatient facility) was calculated as the number of people treated annually for a specific mental disorder divided by the total number of patients with this disorder treated in mental health facilities. Figure 12 shows service utilization for specific severe mental disorders in our Region.

Figure 12. Percentage of service utilization across facilities for severe mental disorders



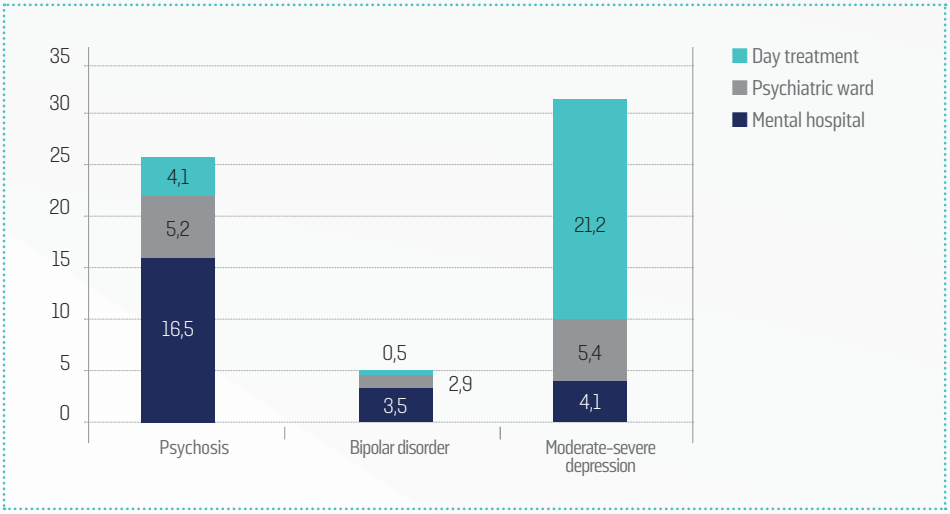
[24] Please note, only Brazil, Chile, Cuba, El Salvador, Guatemala, Paraguay and Peru provided information for this analysis (N=7).

As indicated in this figure, across severe mental disorders, outpatient facilities are the most frequently used services (between 83% and 93%), and mental hospitals are the second.

5.5.1 Inpatient service utilization

The total amount[25] of treated patients with severe mental disorders per 100,000 population in special inpatient mental services (mental hospital, psychiatric ward and day treatment) is 25 for psychosis, 7 for bipolar disorder, and 30 for moderate-severe depression. Figure 13 shows a summary of inpatient service utilization for psychosis, bipolar disorder and moderate-severe depression per 100,000 population.

Figure 13. Inpatient service utilization (per 100,000 population) for psychosis, bipolar disorder and moderate-severe depression



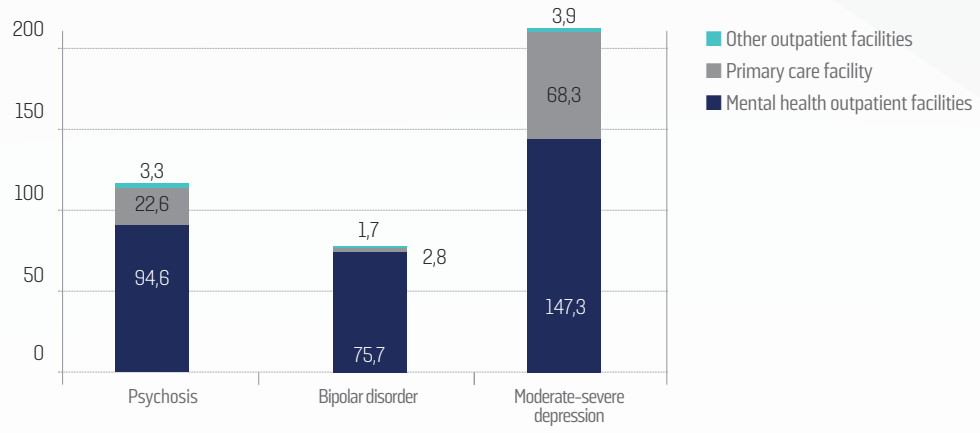
As shown in this figure, in our Region, the mental hospital is the most frequently used inpatient service for psychosis and bipolar disorder, whereas day treatment is the one most chosen for moderate-severe depression. For bipolar disorder, there is a poor utilization of any of the three inpatient services.

5.5.2 Outpatient service utilization

The total amount[26] of treated patients with severe mental disorders per 100,000 population in outpatient mental services (mental health outpatient facilities, primary care facilities, other outpatient facilities) is 120 for psychosis, 80 for bipolar disorder, and 220 for moderate-severe depression. Figure 14 shows a summary of outpatient service utilization for psychosis, bipolar disorder and moderate-severe depression per 100,000 population.

[25] Please note, only eight countries reported data on this item (N=8).
[26] Please note, only 13 countries provided information on this item (N=13).

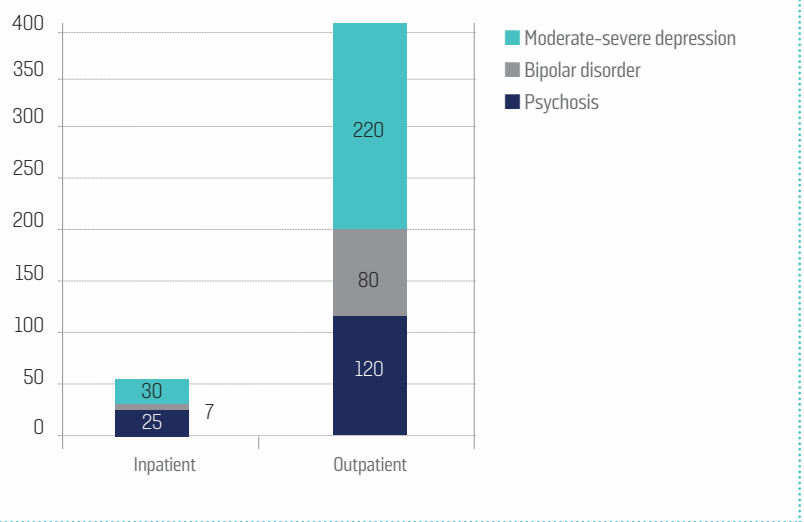
Figure 14. Outpatient service utilization (per 100,000 population) for psychosis, bipolar disorder and moderate-severe depression



As Figure 14 shows very clearly, for all these three mental disorders, mental health outpatient facilities are the most frequently used services. As is the case with inpatient facilities, persons with moderate-severe depression are also the ones who most frequently use outpatient facilities.

Finally, Figure 15 shows a comparison of service utilization between inpatient and outpatient facilities.

Figure 15. Total of patients with psychosis, bipolar disorder and moderate-severe depression treated at inpatient services vs. outpatient per 100,000 population



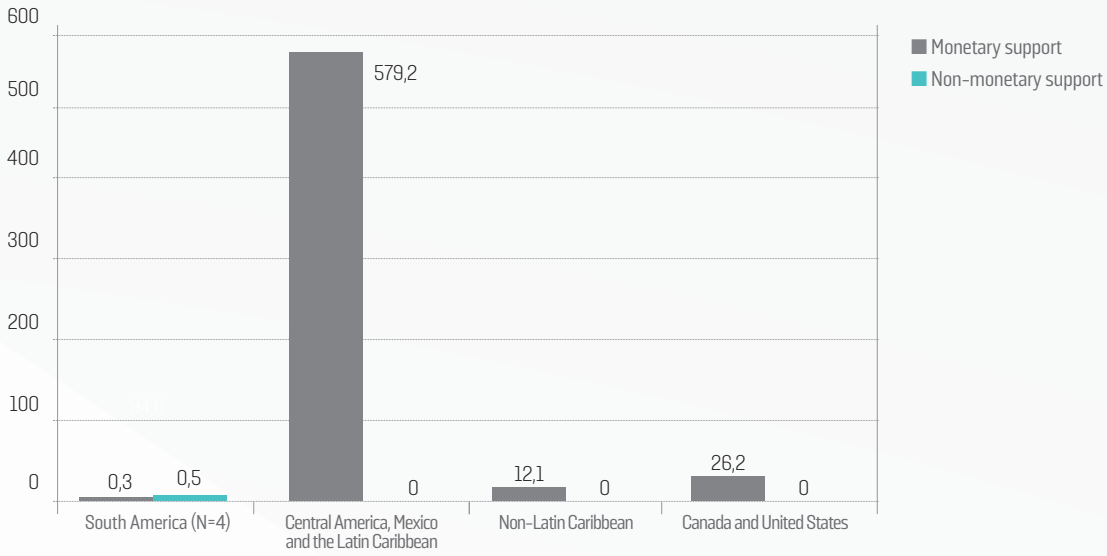
This figure is showing very clearly that there is a much higher utilization of outpatient services (mental health outpatient facilities, primary care centres, other outpatient health facilities) than of inpatient and day care services (mental hospitals, psychiatric wards in general hospitals, mental health day treatment facilities).

Another conclusion that can be drawn from figures 13, 14 and 15 is that the most treated severe mental disorder in both, inpatient and outpatient care settings, is moderate-severe depression.

5.6 SOCIAL SUPPORT

The rate of individuals with severe mental disorders who receive disability payments, income support or other forms of non-monetary support (e.g. housing support, access to employment, educational assistance) varies strongly between countries[27] and subregions. Figure 16 shows the rate of persons with severe mental disorders who received monetary or non-monetary support for each subregion.

Figure 16. Number of patients (per 100,000 population) with severe mental disorders receiving social support, by subregion



However, this item had a low response rate and, therefore, it is important to note that wide variations among subregions could be observed and should be taken into account when interpreting the results. For example, in South America, the rate of monetary support varied from 0.0 to 109 per 100,000 population; in Central America, Mexico and the Latin Caribbean, the rate varied from 0.0 to 1027 per 100,000. Furthermore, in all countries the rate of persons with monetary support was higher than that of persons with non-monetary support. These differences should be attributed mainly to the difficulties met in collecting information related to non-monetary support..

6. MENTAL HEALTH PROMOTION AND PREVENTION

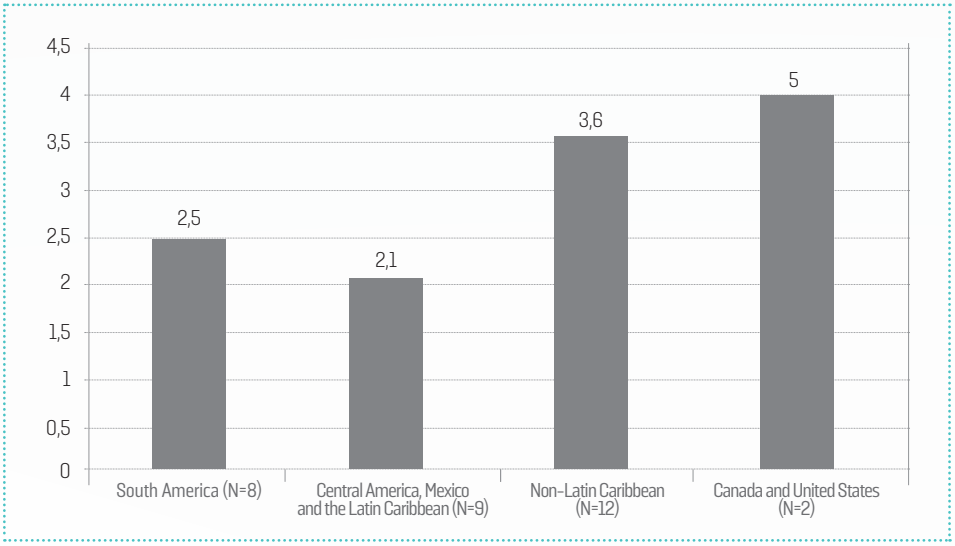
In the context of national efforts to develop and implement mental health policies and programmes, not only is it vital to meet the needs of persons with defined mental disorders, but also to protect and promote the mental well-being of all citizens. Accordingly, Objective 3 of the *Mental health action plan 2013-20120* deals with the implementation of strategies for mental health promotion and prevention, including prevention of suicide and self/harm (*Mental Health Atlas*, 2014, WHO).

In total, countries[28] reported 90 promotion and prevention programs: 20 in South America; 19 in Central America, Mexico and the Latin Caribbean; 43 in the Non-Latin Caribbean; and 8 in Canada and the United States. Figure 16 illustrates the average number of mental health promotion and prevention programmes per subregion.

[27] Please note, only Belize, Brazil, Chile, Columbia, Dominican Republic, Guatemala, Mexico, Panama, Saint Lucia, Saint Vincent, Suriname and the United States provided information on this item (N=12).
[28] Please note, 30 countries provided information on this item (N=30).

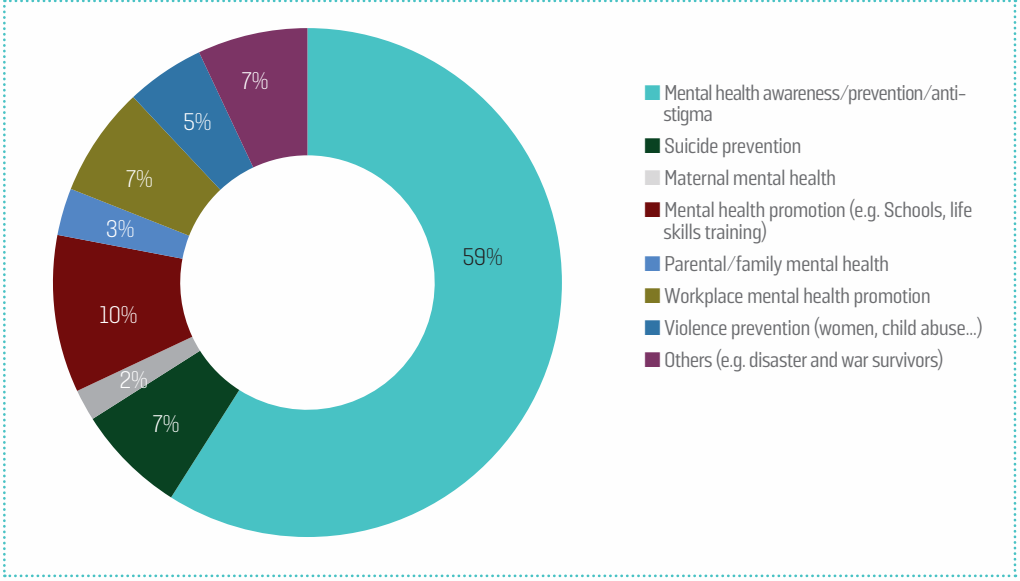
Three (3) was the average number of mental health promotion and prevention programmes across all countries that reported data about this ítem (N=30). Rate variations were observed among subregions: 0 to 5 programmes in South America; 0 to 10 programmes in Central America, Mexico and the Latin Caribbean as well as in the Non-Latin Caribbean; and 0 to 8 in Canada and the United States. In the Region, 14 out of 30

Figure 17. Average number of mental health promotion and prevention programmes



countries (about 47%) have at least two mental health promotion and prevention programmes. In terms of *functional national and multisectoral* promotion and prevention programmes, 11 out of 30 countries (about 37%) have at least two. To be considered *functional,* the programme needs to have at least two of the three following characteristics: a) dedicated financial and human resources; b) a defined plan of implementation; and c) evidence of progress and impact. In total, 58 functional mental health promotion and prevention programmes were detected. Figure 18 illustrates the topic and themes of all the functional programmes

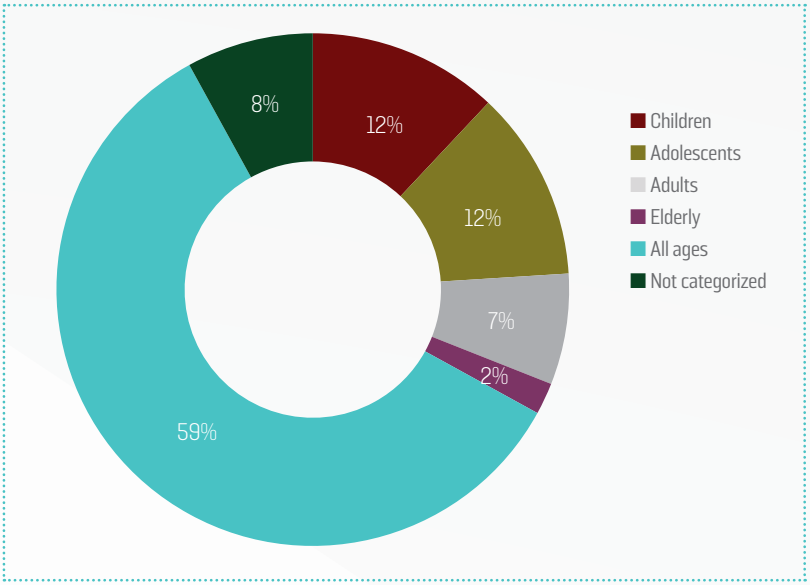
Figure 18. Topic/themes of mental health promotion and prevention functional programmes (%)



Looking across the types of programmes reported, over a half (59%) could be described as mental health awareness programmes aimed at improving mental health literacy or combating stigma and discrimination. The next most common types were mental health promotion programmes (10%), and 7% each of the following: suicide prevention, workplace mental health promotion and others.

Age groups are another interesting factor when looking at promotion and prevention programmes. Figure 19 illustrates the targeted age groups in our Region.

Figure 19. Age groups targeted by the different programmes (%)



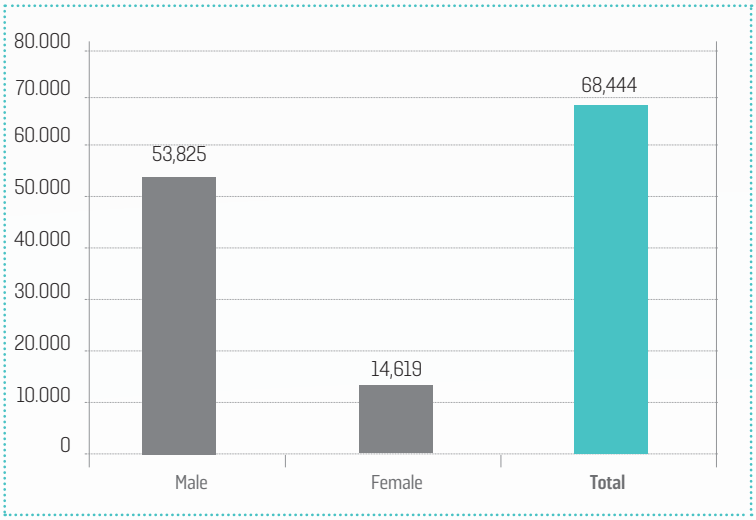
The majority (59%) of the mental health promotion and prevention programmes were targeted at all age groups. Both, children and adolescents are the second most commonly targeted age groups: 12% of the total, respectively.

6.1 SUICIDE PREVENTION

A particular prevention priority in the area of mental health concerns suicide, which accounted for an estimated 804,000 deaths in 2012 (WHO, 2014). For our Region, 14 countries provided information on suicide rates[29].

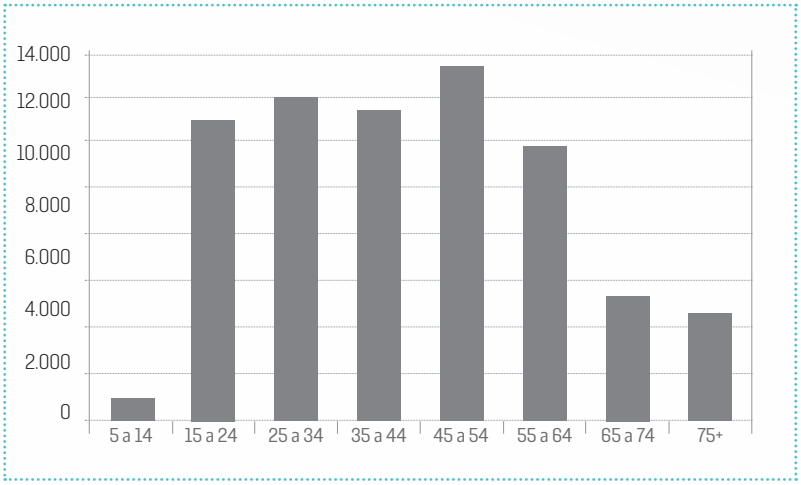
[29] Please note, only Argentina, Brazil, Canada, Colombia, Cuba, Dominica, Dominican Republic, Guatemala, Mexico, Panama, Saint Vincent, Suriname, Trinidad and Tobago and the United States provided information on this item (N=14).

Figure 20. Suicide reports in the Region



As illustrated in Figure 20, a significant gender difference can be observed in our Region (79% male *vs.* 21% female), in other words, males commit suicide more often than females. Additionally, Figure 21 shows age distribution across the Region.

Figure 21. Suicide rates per age group



As illustrated in Figure 21, the highest suicide rates were reported for the 45-54 age group followed by the 25-34 and the 35-44 years of age groups.

7. CONCLUSIONS AND FUTURE PERSPECTIVES

To sum up, 32 countries and territories from the Region of the Americas (partially) participated and reported data. This is about 96% of the total population of our Region.

In terms of mental health systems and governance, 81% of the countries have a stand-alone policy or plan for mental health, and 52% have a mental health stand-alone law. In addition, 50% of the countries have a stand-alone policy that was updated within the past 10 years, is partially or fully implemented, and has a satisfying compliance with human rights standards; and 34% have a stand-alone legislation that is partially or fully implemented and has a satisfying compliance with human rights standards.

Financial resources on mental health are about US$ 6.96 per capita (median) with a range that goes from $1 to $273. A large part of these funds goes to inpatient care (75%), especially to mental hospitals (73% of the total funds).

In the Region, the median number of mental health workers is 21 per 100,000 population and the median number of mental hospital beds is 6.5 per 100,000 population.

In terms of promotion and prevention programmes, 37% of our countries have at least two functioning mental health promotion and prevention programmes. Out of almost 60 functional mental health promotion and prevention programmes that were reported, over half (59%) were aimed at improving mental health literacy or combating stigma and discrimination

Regarding future perspectives, the understanding is that after the initial data collection held in 2014, another survey will be sent to countries every two years in order to measure progress towards meeting the Action plan goals (until 2020). Systematic collection and reporting of mental health indicators will hopefully lead to an increase of overall completion rates, providing meaningful information on the current status of mental health services in the Americas, and enabling the monitoring of ongoing development processes and changes.

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