



A New Agenda for Mental Health in the Americas

Report of the Pan American
Health Organization High-Level
Commission on Mental Health
and COVID-19

PAHO



Pan American
Health
Organization



World Health
Organization
REGIONAL OFFICE FOR THE
Americas

A New Agenda for Mental Health in the Americas

Report of the Pan American
Health Organization High-Level
Commission on Mental Health
and COVID-19

Washington, D.C., 2023

PAHO



Pan American
Health
Organization



World Health
Organization
REGIONAL OFFICE FOR THE
Americas

A New Agenda for Mental Health in the Americas: Report of the Pan American Health Organization High-Level Commission on Mental Health and COVID-19

ISBN: 978-92-75-12722-3 (PDF)

ISBN: 978-92-75-12723-0 (Print version)

© Pan American Health Organization, 2023

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO license (CC BY-NC-SA 3.0 IGO).



Under the terms of this license, this work may be copied, redistributed, and adapted for non-commercial purposes, provided the new work is issued using the same or equivalent Creative Commons license and it is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that the Pan American Health Organization (PAHO) endorses any specific organization, product, or service. Use of the PAHO logo is not permitted.

Adaptations: If this work is adapted, the following disclaimer should be added along with the suggested citation: “This is an adaptation of an original work by the Pan American Health Organization (PAHO). Views and opinions expressed in the adaptation are the sole responsibility of the author(s) of the adaptation and are not endorsed by PAHO.”

Translations: If this work is translated, the following disclaimer should be added along with the suggested citation: “This translation was not created by the Pan American Health Organization (PAHO). PAHO is not responsible for the content or accuracy of this translation.”

Suggested citation: Pan American Health Organization. *A New Agenda for Mental Health in the Americas: Report of the Pan American Health Organization High-Level Commission on Mental Health and COVID-19*. Washington, D.C.: PAHO; 2023. Available from: <https://doi.org/10.37774/9789275127223>.

Cataloguing-in-Publication (CIP) data: Available at <http://iris.paho.org>.

Sales, rights, and licensing: To purchase PAHO publications, email: sales@paho.org. To submit requests for commercial use and queries on rights and licensing, visit: <https://www.paho.org/en/publications/permissions-and-licensing>.

Third-party materials: If material that is attributed to a third party, such as tables, figures, or images, is reused from this work, it is the user’s responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned material or component from this work rests solely with the user.

General disclaimers: The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of PAHO concerning the legal status of any country, territory, city, or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers’ products does not imply that they are endorsed or recommended by PAHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by PAHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall PAHO be liable for damages arising from its use.

NMH/MH/2023

Design: © Prographics

Cover photo: © PAHO

Contents

- Acknowledgments v
- Acronyms and abbreviations vi
- Foreword vii
- Note from the Chair ix
- Executive summary xi
- Members of the Commission xiv
- Introduction** **1**
- The case for better mental health** **5**
- Mental health in the Americas** **7**
- A New Agenda for Mental Health in the Americas: a call to action** **19**
- Recommendations** **23**
- 1. Elevate mental health at the national and supranational levels 23
- 2. Integrate mental health into all policies 29
- 3. Increase the quantity and improve the quality of financing for mental health 33
- 4. Ensure the human rights of people living with mental health conditions 38
- 5. Promote and protect mental health across the life course 45
- 6. Improve and expand community-based mental health services and care 53
- 7. Strengthen suicide prevention 60
- 8. Adopt a gender transformative approach to mental health 66
- 9. Address racism and racial discrimination as a key determinant of mental health 73
- 10. Improve mental health data and research 80
- Conclusion 85
- References 86
- Annexes** **97**
- Annex 1. List of official Commission meetings and participants 97
- Annex 2. Key recommended resources 100

Tables

Table 1	Key strategic actors and partners.	27
Table 2	Examples of non-health sector policies that can benefit mental health.	30

Figures

Figure 1	PAHO High-Level Commission on Mental Health and COVID-19 timeline	2
Figure 2	Potential social and economic benefits of investing in mental health	6
Figure 3	Regional years lived with disability (YLD) distribution (%)	7
Figure 4	Regional disability-adjusted life years (DALYs) distribution (%)	7
Figure 5	Ranking of suicide mortality rate per country in the Americas, 2019	8
Figure 6	Age-adjusted suicide mortality rate in the Americas, 2000–2019	9
Figure 7	Service coverage for psychosis by WHO Region	10
Figure 8	Comparison of disruptions by tracer services in countries that responded to all three survey rounds: Q3 2020 (Round 1), Q1 2021 (Round 2), Q4 2021 (Round 3).	12
Figure 9	NAMHA cross-cutting principles.	21
Figure 10	Conceptual framework for sustainable mental health financing	34
Figure 11	Sustainable funding opportunities for mental health	35
Figure 12	Model network of community-based mental health services	41
Figure 13	Universal social protection systems	46
Figure 14	Governments' role advancing workplace mental health	50
Figure 15	How governments can support the advancement of digital technologies.	57
Figure 16	How service users and their families can be involved in the health system	58
Figure 17	LIVE LIFE cross-cutting foundations and key effective evidence-based interventions for suicide prevention	61
Figure 18	Best practices for reporting on suicide	64
Figure 19	Key actions for governments to reduce gender inequality and promote women's empowerment	68
Figure 20	Approaches towards gender-based violence prevention.	69
Figure 21	Key components of a plan against racial discrimination	76

Box

Box 1	International and Inter-American Instruments for Human Rights.	39
-------	--	----

Acknowledgments

This report, the fruit of the work of the Pan American Health Organization (PAHO) High-Level Commission on Mental Health and COVID-19, would not have been possible without the initiative and leadership of former PAHO Director, Dr. Carissa F. Etienne, and current Director, Dr. Jarbas Barbosa da Silva Jr.

PAHO acknowledges the significant contributions of the Members of the High-Level Commission on Mental Health and COVID-19 in participating in plenary debates, working groups, and stakeholder consultations to develop the report. PAHO offers sincere gratitude to the Co-Chairs of the Commission, Her Excellency Ms. Epsy Campbell Barr and Ambassador Nestor Mendez, for leading the Commission and the production of this report.

After discussions and debates by the members of the Commission, the report was prepared by the Mental Health and Substance Use Unit of PAHO, under the general supervision of Dr. Anselm Hennis, Director of the Department of Noncommunicable Diseases and Mental Health, and Dr. Renato Oliveira e Souza, Chief of the Mental Health and Substance Use Unit. The content, informed by the discussions of the PAHO

High-Level Commission on Mental Health and COVID-19, was written by Sarah Ramsey, Amy Tausch, and Alessandra Trianni. Arantxa Cayon and Sofia Guerrero led the design of the report.

PAHO acknowledges the important contributions of Martha Koev, Ana Soria Galvarro, and Alexander Rivera in organizing consultations, coordinating Commission meetings and events, assisting the Commission Chair in the development of the final report, and engaging with key stakeholders.

PAHO thanks its Colombia Country Office for hosting the Commission's in-country meeting and recognizes the many experts who have contributed to the Commission's discussions. A special thanks to Dévora Kestel, Director of the Department of Mental Health and Substance Use at the World Health Organization. PAHO is also grateful for the contributions of Ricardo Araya, Yuri Cutipé, Marcio Gagliato, Timothy Morgan, Michael Pietrus, Denise Razzouk, Zila Sanchez, and Benedetto Saraceno for sharing their technical expertise with the Commission, and to the invaluable participation of all who took part in the Commission's consultations.

Acronyms and abbreviations

COVID-19	coronavirus disease 2019
CRPD	Convention on the Rights of Persons with Disabilities
DALY	disability-adjusted life year
GBV	gender-based violence
HIV	human immunodeficiency virus
IASC	Inter-Agency Standing Committee
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer and other identities
mhGAP-HIG	Mental Health Gap Action Programme Humanitarian Intervention Guide
mhGAP-IG	Mental Health Gap Action Programme Intervention Guide
MHPSS	mental health and psychosocial support
NAMHA	A New Agenda for Mental Health in the Americas
PAHO	Pan American Health Organization
PHC	primary health care
UHC	universal health coverage
WHO	World Health Organization
YLD	years lived with disability

Foreword



© PAHO

The Region of the Americas has been facing a significant mental health crisis for some time. While mental health and substance use conditions are highly prevalent in the Region, the vast majority of people living with these conditions do not receive the vital care that they require. Good mental health is much more than the absence of a mental health condition; it is essential to our overall health and well-being, our quality of life, and our ability to thrive and become our best selves as part of a larger community. When any individual is prevented from thriving and reaching their full potential, we as a society are all held back.

More than 30 years ago, countries in Latin America adopted the landmark Declaration of Caracas, which laid the groundwork for a major paradigm shift in mental health care, away from long-stay psychiatric institutions to delivering mental health services in the community. While we have seen some important advances in mental health since this Declaration,

unfortunately we are still far from realizing its vision of achieving quality, rights-based mental health care for all. Today, people with mental health conditions still experience widespread stigma and discrimination, abuse, and denial of their basic human rights. Deeply rooted social injustices in the Americas, such as systemic racism, continue to fuel significant inequities in access to mental health care, leaving the most marginalized in our society even further behind.

The mental health impact of the COVID-19 pandemic on our Region has been unprecedented, creating new mental health challenges for many of our people across generations. The prevalence of mental health conditions has risen significantly, particularly among those persons living in vulnerable conditions. Weak and chronically underresourced mental health services have experienced major disruptions as health systems have fallen short in their response to meet the challenges of the global public health emergency. On a positive note, the pandemic has stimulated the development of innovative approaches to delivering mental health care, such as tele-mental health, and demonstrated the capacity of our Region to meet adversity with solidarity and compassion.

In 2022, the Pan American Health Organization established the High-Level Commission on Mental Health and COVID-19 to guide the Organization and its Member States in strengthening mental health in the Region of the Americas following the pandemic. I trust that this report, the culmination of the Commission's work, will serve to catalyze a

much-needed transformation in mental health care across the Region.

The COVID-19 pandemic has been a wakeup call for the Americas. While we acknowledge that there can be no health without mental health, we must translate these words into immediate actions. We must work together to build back better mental health systems and services that are equitable, resilient, and sustainable in the face of increasing and emerging threats to mental health in the Region, such as climate change. This goal

Jarbas Barbosa da Silva Jr.
Director
Pan American Health Organization

will not be achieved without improved synergy across sectors, the integration of mental health into all levels of care, and a greater emphasis on addressing the social determinants of mental health.

I thank the High-Level Commission on Mental Health and COVID-19 for its relevant contributions on the way forward as we continue our work together to improve the mental health of the people of the Americas.

Note from the Chair



© Office of Epsy Campbell Barr

The PAHO High-Level Commission on Mental Health and COVID-19 was an extraordinary opportunity to discuss the new perspectives on mental health in the Hemisphere, based on the social, economic, and cultural conditions that we are facing.

Investing in mental health is crucial to promote equitable and sustainable human development for all to live with well-being and dignity. If we offer high-quality and accessible mental health services, we will enjoy excellent benefits: healthier people with greater resources to face difficulties, better management of emotions, and extraordinary abilities to create more harmonious work, family, and personal environments.

Mental health care and services are highly beneficial, as they become an essential strategy for promoting, protecting, and defending a fundamental human right and generating high economic benefits by laying the foundations of more productive economies. Furthermore,

investing in mental health has been shown to yield high financial returns. For example, every USD 1 invested in scaling up treatment for depression and anxiety leads to a return of USD 4 in better health and the ability to work. In addition, case studies from the Americas have shown that scaling up treatment for anxiety, depression, and psychosis could produce high rates of return and restore healthy life years over the course of 15 years.

This report, elaborated after collective reflection and listening to key experts and stakeholders, is a new opportunity to address mental health challenges in the Americas comprehensively. Accordingly, we propose A New Agenda for Mental Health in the Americas (NAMHA) as a call to action for countries in the Americas to seize the opportunity presented by the pandemic and prioritize and reform mental health care, both now and for the future. NAMHA outlines 10 recommendations with corresponding action points and case examples from the Americas highlighting successful models to guide implementation.

NAMHA recognizes the essential role of all actors, including governmental, nongovernmental, civil society, and private sector, in generating, implementing, and monitoring strategies and initiatives that positively impact people's mental health and allow them optimal health conditions for a dignified life.

While no one was immune from the mental health impact of the pandemic, some groups, including historically marginalized communities

and those living in conditions of vulnerability, were disproportionately affected. Higher rates of mental health symptoms were documented in health and front-line workers, women, people of African descent, Indigenous peoples and other ethnic groups, and people with preexisting mental health conditions. For this reason, NAMHA proposes specific actions for groups that have had their mental health significantly impacted.

Implementing all these recommendations will require recognizing the urgency of the current mental health crisis and unequivocally committing to prioritizing mental health like never before. There is today a significant opportunity to achieve a turning point for reshaping our societies, considering mental health as a critical factor for development and well-being. We must act to build back better mental health systems and services.

**Her Excellency Epsy Campbell Barr,
Chair of the PAHO High-Level Commission on Mental Health and COVID-19**

Executive summary

Overview

The effects of the COVID-19 pandemic on the Region of the Americas extend far beyond the nearly 3 million lives lost to the disease. Economies in the Region have been devastated, generating increases in unemployment, poverty, and inequality. Health, education, and social services have also been severely disrupted. In response to these circumstances, mental health conditions have surged, while mental health services have struggled to meet the new, increased, and urgent demand.

Prior to the pandemic, poor mental health structural limitations and barriers for accessing quality mental health and wellness services and lack of funding were already major and growing contributors to overall ill-health in the Region – with the Americas being the only World Health Organization (WHO) Region where suicide rates have been increasing. In 2020, median government funding for mental health as a proportion of total health spending was a mere 3%, with nearly half of these funds allocated to psychiatric hospitals, which can be associated with poorer treatment outcomes and human rights violations, in particular with reference to long-term psychiatric hospitalization. A historical lack of prioritization and investment in mental health has resulted in weak mental health systems and poor service coverage and quality. The care needs of most people in the Region living with mental health and substance use conditions have remained unmet, especially those living in conditions of vulnerability, including historically discriminated populations such as Indigenous and Afro-descendant communities.

Mental health conditions have surged, while mental health services have struggled to meet the new, increased, and urgent demand.

The pandemic has sparked increased discourse on mental health, highlighting the extent of the crisis and putting systemic failings in mental health services under fresh scrutiny. Governments of the Region are under pressure to make sound policy choices to strengthen mental health within the broader agenda of post-pandemic recovery.

Recognizing that policymakers needed clear guidance on the immediate priorities, the Pan American Health Organization (PAHO) convened the High-Level Commission on Mental Health and COVID-19. The Commission, led by Her Excellency Epsy Campbell Barr, former Vice President of Costa Rica, and Ambassador Nestor Mendez, Assistant Secretary General of the Organization of American States, includes 17 members representing governments, health organizations, academia, civil society, and people with lived experience from across the Region. During the past year, the Commission worked to analyze the effects of the pandemic – including innovative good-practice solutions – against the background

of the pre-pandemic state of mental health. The Commissioners identified priority areas in mental health for the Americas and consulted key stakeholders and experts to develop appropriate recommendations.

The result of their expert assessment is A New Agenda for Mental Health in the Americas (NAMHA).

A New Agenda for Mental Health in the Americas

NAMHA is a package of priority mental health policy and strategy actions that are crafted for incorporation into countries' post-pandemic recovery strategies. It explicitly builds on the underlying and cross-cutting principles of universal health coverage, human rights, equity and nondiscrimination, empowerment of people with mental health conditions and their families, and harnessing the benefits of multisectoral action, where different sectors and actors pool financial resources, knowledge, and skills.

NAMHA has therefore been prepared to advance the national social and development agenda of high-level authorities in the Americas, namely Heads of State and Government. NAMHA will also serve as an operational and guidance tool for leaders of government departments including health, education, finance, social welfare, development, justice, employment, and labor, as well as for local government legislators and policymakers at all levels of government.

While focused on actions in the immediate term, NAMHA aligns with current global and regional mental health and development objectives, including the WHO Comprehensive Mental Health

NAMHA presents approaches to address the crisis generated by the COVID-19 pandemic in the short term, while laying robust foundations for the longer term.

Action Plan 2013–2030, the PAHO Policy for Improving Mental Health, and the 2030 Agenda for Sustainable Development.

It presents a framework based on evidence and experience that can be tailored to local situations, while addressing barriers and challenges. With this contextual adaptation, all countries, irrespective of resource constraints, can implement NAMHA to improve the mental health of their populations.

NAMHA outlines 10 recommendations with corresponding action points, accompanied by case examples from the Americas which highlight successful models to guide implementation. It is important to note that the recommendations are not intended to be exhaustive; rather, they prioritize the areas of action deemed to be the most urgent for the Region. NAMHA presents evidence-based approaches to address the crisis generated by the COVID-19 pandemic in the short term, while laying robust foundations for the longer term – in order to ensure optimal improvements in mental health care in the Region of the Americas.

Summary of Recommendations



1.

Elevate mental health at the national and supranational levels – specifies the foundational ways to establish mental health as a national development priority, include mental health in universal health coverage, and develop strategic partnerships and alliances to advance and advocate for mental health at the national level and beyond.



2.

Integrate mental health into all policies – promotes the integration of mental health into all areas of health as well as across sectors and in emergency and disaster responses.



3.

Increase the quantity and improve the quality of financing for mental health – outlines how to mobilize increased financing for mental health and allocate it more efficiently and equitably.



4.

Ensure the human rights of people living with mental health conditions – advocates for strengthening human rights for mental health through legislation and policy, transitioning services from psychiatric institutions to community-based care, and capacity building in human rights across sectors.



5.

Promote and protect mental health across the life course – highlights important environments and strategies for promoting mental health and preventing mental conditions at key life stages including childhood and adolescence, adulthood and older age.



6.

Improve and expand community-based mental health services and care – delineates actions to improve service coverage and quality by integrating mental health into primary health care, making services culturally competent, harnessing digital interventions, building capacity in mental health and psychosocial support (MHPSS), and empowering service users and their families.



7.

Strengthen suicide prevention – provides concrete guidance on evidence-based strategies to prevent suicide and its risk factors through the development of national suicide prevention strategies; public policy on means reduction and alcohol use; capacity building to respond to self-harm and suicide.



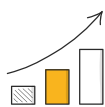
8.

Adopt a gender transformative approach to mental health – lays out actions to reduce gender inequalities and address gender-based violence and harmful masculinities, key threats to mental health.



9.

Address racism and racial discrimination as a key determinant of mental health – emphasizes the need to combat systemic racism targeting Indigenous peoples, people of African descent, and other ethnic groups by working with these communities to understand racism and its potential solutions, establishing national action plans against racism and racial discrimination, strengthening policy and legislation, and creating anti-racist environments.



10.

Improve mental health data and research – proposes actions to improve the availability and quality of mental health data through the expansion of mental health data collection, data disaggregation, strengthened monitoring and evaluation, and research in priority areas of mental health.

Members of the Commission

The Commission is composed of 17 diverse representatives of government, health organizations, academia, civil society, and people with lived experience from across the Region of the Americas, with the Chair being Her Excellency Epsy Campbell Barr, former Vice President of Costa Rica, and Co-Chair, Ambassador Nestor Mendez, Assistant Secretary General of the Organization of American States.

Chair: Epsy Campbell Barr, Former Vice President of Costa Rica

Co-Chair: Nestor Mendez, Assistant Secretary General, Organization of American States

Rubén Alvarado Muñoz, Full Professor, Department of Public Health, School of Medicine, Universidad de Valparaíso, Chile

Mary Bartram, Director, Mental Health and Substance Use, Mental Health Commission of Canada

Paul Bolton, Mental Health and Psychosocial Support Coordinator, United States Agency for International Development

Pamela Collins, Director of the University of Washington Consortium for Global Mental Health, University of Washington, United States

Paulina Del Rio, President and Co-Founder of Fundación José Ignacio, Chile

Shirley J. Holloway, President, Board of Directors, National Alliance on Mental Illness, United States

Katija Khan, President, Caribbean Alliance of National Psychological Associations, Trinidad and Tobago

María Elena Medina-Mora, Director of the Faculty of Psychology, National Autonomous University of Mexico

Ana Cristina Mendoza, Psychologist, Guatemala

Paulo Rossi Menezes, Professor of Preventative Medicine, University of São Paulo, Brazil

Carmen Montón Giménez, Permanent Observer of Spain to the Organization of American States

Alejandra Mora Mora, Executive Secretary of the Inter-American Commission of Women, Organization of American States

Shekhar Saxena, Professor of the Practice of Global Mental Health, Harvard T. H. Chan School of Public Health, United States

Juan Pablo Uribe, Global Director, Health, Nutrition & Population and the Global Financing Facility, World Bank Group

Sahar Vasquez, Co-Founder, Mind Health Connect, Belize

Salud Mental, una prioridad.

Consejo Nacional de Salud Mental
Bogotá, Colombia
01/12/2022



OPS

Organización
Panamericana
de la Salud

Organización
Mundial de la Salud

Working session with the Mental Health Commission of Colombia, in Bogota, 1 December 2022. During their work, the High-Level Commission on Mental Health and COVID-19 met with experts, health managers and people with lived experience to learn first-hand about the challenges and solutions to improve mental health in the Region of the Americas.



Introduction

The first case of the new coronavirus disease 2019 (COVID-19) in the Region of the Americas was confirmed in the United States of America on 20 January 2020 (1). Since then, the Region has been disproportionately impacted by the global COVID-19 pandemic, accounting for 43% of all COVID-19 deaths worldwide (2). In addition to tremendous loss of life, the pandemic has contributed to an economic decline, rising rates of unemployment and poverty, and spikes in domestic violence and substance use across the Region. Studies also show the profound impacts of the pandemic on mental health in the Americas, including elevated rates of mental health conditions such as depression and anxiety disorders, as well as marked disruptions to essential services for mental health (3).

In response to the substantial impact of the COVID-19 pandemic on mental health in the Region, in early 2022, then Director of the Pan American Health Organization (PAHO), Dr. Carissa Etienne, established the High-Level Commission on Mental Health and COVID-19. The Commission's overall objective was to raise awareness of the critical importance of mental health in the Americas and to provide guidance to PAHO and its

The Region has been disproportionately impacted by the global COVID-19 pandemic, accounting for 43% of all COVID-19 deaths worldwide.

Member States on strengthening mental health in the Region during and after the COVID-19 pandemic, and it was tasked with developing a series of priority high-level recommendations.

During the past year, the Commission worked to analyze the effects of the pandemic – including innovative good-practice solutions – against the background of the pre-pandemic state of mental health. It met on three formal occasions, convened three technical working groups to examine key priority areas identified in greater depth, and consulted diverse stakeholders

FIGURE 1

PAHO High-Level Commission on Mental Health and COVID-19 timeline



and experts (Figure 1) (for a list of all official Commission meetings and their participants, please see Annex 1).

The result of their work is A New Agenda for Mental Health in the Americas (NAMHA). This document outlines the Commission's final recommendations for advancing mental health¹ in the Americas in the current context of the COVID-19 pandemic and beyond. It presents a framework based on evidence and experience that can be tailored to local situations, while addressing barriers and challenges. With this contextual adaptation, all countries, irrespective of resource constraints, can implement NAMHA to improve the mental health of their populations.

NAMHA outlines 10 recommendations with corresponding action points, accompanied by case examples from the Americas which highlight successful models to guide implementation. It is important to note that the recommendations are not intended to be exhaustive; rather, they prioritize the areas of action deemed to be the most urgent for the Region. NAMHA presents evidence-informed approaches to address the crisis generated by the COVID-19 pandemic in the short term, while laying robust foundations for the longer term – in order to ensure optimal improvements in mental health care in the Region of the Americas.

¹ For the purpose of this report, mental health conditions will refer to both mental and substance use conditions. References to mental health services and care include services for both mental health and substance use conditions. It is recognized that additional actions specific to substance use, which go beyond the scope of the Commission's recommendations, are needed to comprehensively address this major public health challenge in the Region.

FORTALECIMIENTO TERRITORIAL Y COMUNITARIO EN ESTRATEGIAS DE PREVENCIÓN DEL CONSUMO DE SUSTANCIAS PSICOACTIVAS

VIGENCIA 2021 - 2023

OBJETIVO

Fortalecer competencias académicas, conceptuales y prácticas para el diseño e implementación de estrategias de prevención del consumo de sustancias psicoactivas.

Objetivos específicos:

- Fortalecer competencias académicas, conceptuales y prácticas que favorezcan la prevención del uso de sustancias psicoactivas.
- Fortalecer aspectos dirigidos a la comunidad orientados a fortalecer competencias conceptuales asociadas a las sustancias psicoactivas.
- Modificar las influencias normativas asociadas al consumo temprano de alcohol con el fin de retrasar la edad de inicio de uso de esta sustancia.
- Promover y fortalecer el involucramiento parental como factor protector asociado al uso de sustancias psicoactivas y problemas de salud mental en niños, niñas y adolescentes.

BENEFICIARIOS

- Líderes y líderes comunitarios
- Autoridades territoriales
- Trabajadores de salud y promoción comunitaria
- Docentes y psico-orientadores
- Madres, padres y cuidadores
- Jóvenes y adolescentes

RESULTADOS

Competencias en el diseño e implementación de estrategias de prevención del consumo de sustancias psicoactivas dirigidas al sector educativo y a la comunidad para orientar la familia en la reducción del uso de sustancias psicoactivas y reducir el estigma de las personas con problemas de salud mental en la comunidad para instigar el uso de sustancias psicoactivas.

Desafíos

El consumo de sustancias psicoactivas debe desnormalizarse del contexto de salud y promoción comunitaria de la prevención del consumo de sustancias psicoactivas. La estrategia de reducción de factores de riesgo asociados al consumo de alcohol y del tabaco, se acortó en Colombia. El involucramiento parental en las familias, se generó con dificultad. La implementación de estrategias de prevención del consumo de sustancias psicoactivas y "prevención del alcohol y del tabaco".

PROGRAMA PARA LA REDUCCIÓN DE BRECHAS EN SALUD MENTAL

mhGAP uso intercultural

VIGENCIA 2017 - 2022

RESULTADOS

- Desarrollo de una experiencia piloto con el uso de mhGAP en el sector educativo.
- Diseño de la Guía de Uso Intercultural mhGAP.
- Diseño de la cartilla de salud mental para comunidades indígenas.
- Formación en el uso de la Guía a 300 profesores.
- Inclusión del uso de la Guía en 5 Instituciones de Salud (IPS) indígenas.
- Aprendizajes mutuos entre la medicina occidental y tradicional.

Desafíos y desafíos

Equipos interdisciplinarios y multisectoriales. Continúa en el momento de implementación y fortalecimiento de la acción intercultural. Sentido de pertenencia y compromiso.

Third meeting of the High-Level Commission on Mental Health in Bogotá, Colombia.



The case for better mental health

Mental health is much more than the absence of a mental health condition. Rather, it is “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (4). The lack of mental health care, services, and funding has enormous and far-reaching health, social, and economic impacts, not only for individuals, but for their families, communities, and society as a whole.

Mental health conditions are some of the leading causes of disability worldwide, compromising the ability of affected individuals to study, work, and fully participate in their communities (5). Mental health is inextricably linked to many physical diseases, both communicable and noncommunicable, through bidirectional relationships. For example, mental health conditions can place people at an increased risk of HIV, tuberculosis, cardiovascular disease, cancer, and diabetes, while people living with these conditions are also more susceptible to experiencing mental health conditions (6). Mental health conditions are associated with poor outcomes for those suffering from chronic conditions and may lead to a reduction in life

The lack of mental health care, services, and funding has enormous and far-reaching health, social, and economic impacts, not only for individuals, but for their families, communities, and society as a whole.

expectancy by 10 to 25 years in people with severe mental health disorders (7). They also represent a risk factor for suicide, which claims the lives of more than 700 000 people worldwide each year (8).

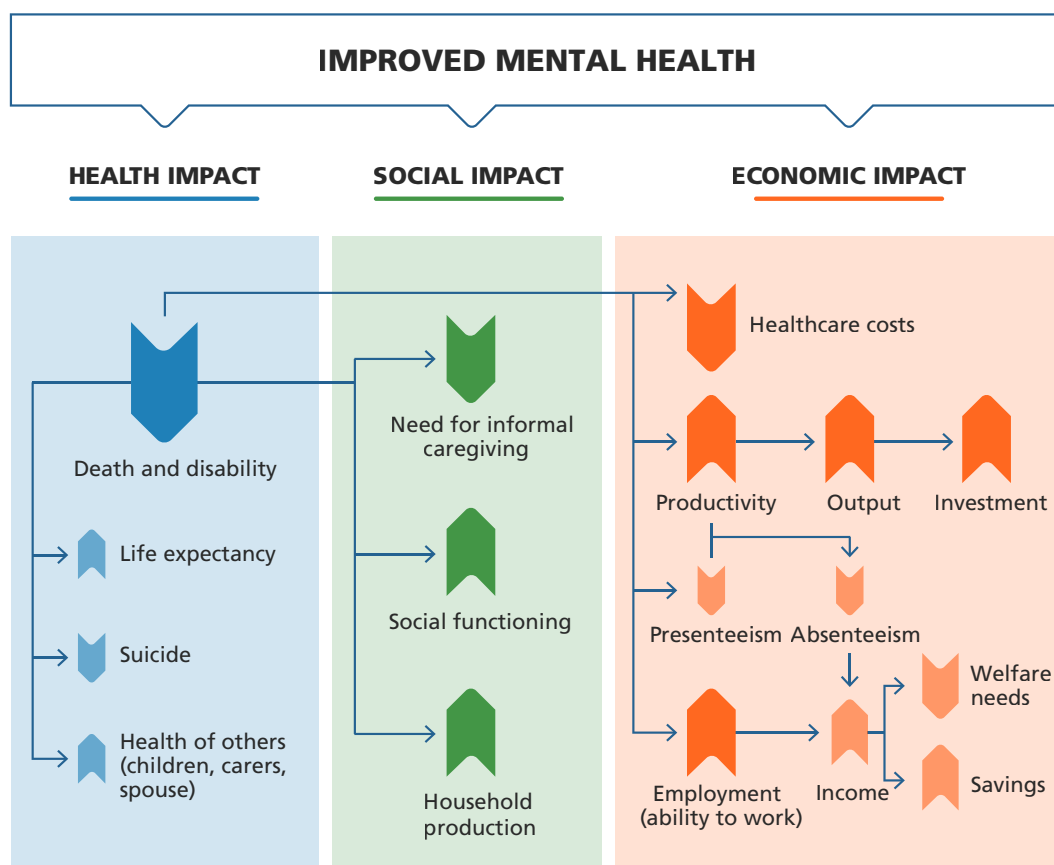
In addition to its impact on health, mental health conditions can also lead to unemployment, poverty, homelessness, and incarceration, with major social and economic consequences at the household and societal levels. Depression and anxiety alone cost the global economy USD 1 trillion each year (9), primarily in reduced

productivity, and it has been estimated that by 2030, mental ill-health will account for USD 6 trillion in losses per year, more than half of the global economic burden attributable to noncommunicable diseases (10).

Furthermore, it is widely recognized that mental health care must be free from discrimination, as a fundamental right for all. Inadequate mental health care, as well as the discrimination and abuses experienced by people living with mental health conditions, violate this right and constitute a gross social injustice and inequity. It is essential that governments meet their obligation to respect, protect, and fulfill all people's right to mental health.

Prioritizing and investing in improved mental health can bring about positive health, social, and economic impacts on a large scale, including increases in life expectancy, increased household production, and a reduction in healthcare costs, among others (see Figure 2). Treating mental health conditions has been shown to yield high economic returns; every USD 1 invested in scaling up treatment for depression and anxiety leads to a return of USD 4 in better health and ability to work (11). Investment case studies from the Region of the Americas have shown that scaling up treatment for anxiety, depression, and psychosis in Jamaica (12) and Peru (13) could produce high rates of return and restore healthy life years over the course of 15 years.

FIGURE 2
Potential social and economic benefits of investing in mental health



Source: World Health Organization. World mental health report: transforming mental health for all. Geneva: WHO; 2022. Available from: <https://www.who.int/publications/item/9789240049338>.

Mental health in the Americas

A heavy burden

Unmet mental health needs are a huge contributor to the disease burden in the Region of the Americas. Mental, neurological, and substance use conditions and suicide (MNSS) account for more than one-third of total years lived with disability (YLDs) and a fifth of total disability-adjusted life years (DALYs) (14) (Figures 3, 4). Depression is the second highest cause of years lived with disability in women and the third highest in men (15). The Americas has the highest prevalence of anxiety disorders and the second-highest rate of depressive

disorders of all the World Health Organization (WHO) Regions.

Alcohol consumption also has a large impact in the Region, with 8.2% of the general population over 15 years of age suffering from an alcohol use disorder. The prevalence rate for alcohol use disorders among women is the highest of all the WHO Regions, and the second highest among men. It is estimated that 5.5% of all deaths and 6.7% of DALYs are attributable to alcohol consumption (16).

FIGURE 3

Regional years lived with disability (YLD) distribution (%)

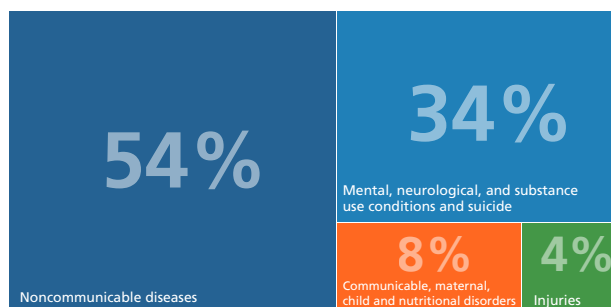
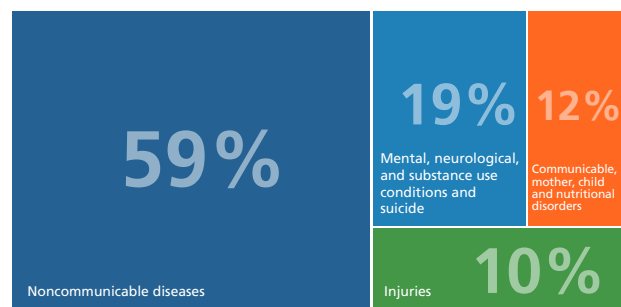


FIGURE 4

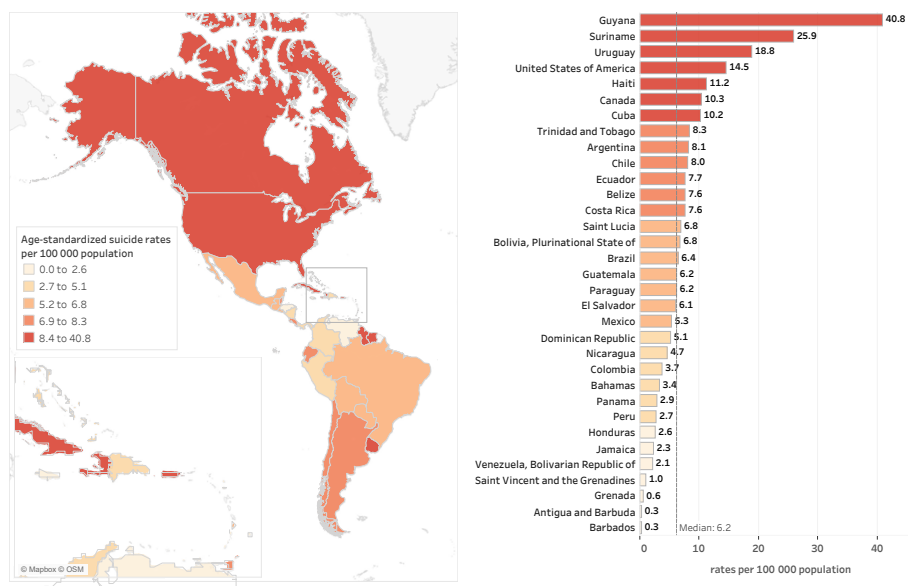
Regional disability-adjusted life years (DALYs) distribution (%)



Source: Pan American Health Organization. The Burden of Mental Disorders in the Region of the Americas, 2018. Washington, DC: PAHO; 2018. Available from: <https://iris.paho.org/handle/10665.2/49578>.

FIGURE 5

Ranking of suicide mortality rate per country in the Americas, 2019



Suicide on the rise

Each year in the Americas, nearly 100 000 people die by suicide, which not only impacts individuals and families, but entire communities. Among the 10 countries with the highest suicide rates worldwide, two countries, Guyana and Suriname, are in the Region of the Americas (Figure 5). Alarming, suicide rates have continued to climb in the Region; between 2000 and 2019, the regional age-adjusted suicide rate increased by 17% (from 7.3 to 9.0 per 100 000 population) (Figure 6). Notably, the Americas was the only WHO Region to experience an increase in suicide rate during this period (8).

Significant gaps in care

Despite the demonstrated high burden of mental health conditions and suicide in the Region of the Americas, only a small fraction of people living with mental health conditions receive the care they need. The mean treatment gap in the Americas for any mental condition was estimated to be 75.2%

in 2016, reaching as high as over 90% for some conditions and countries (17). In 2020, only an estimated 18% of people with psychosis in the Americas received treatment (see Figure 7).

Disparities and inequities

Depending on the local context, certain individuals and groups in society may be at a significantly higher risk of experiencing mental health challenges and/or face greater barriers to having access to or receiving quality mental health care. Underlying factors include financial, geographic, transportation, and language barriers, as well as lower mental health literacy, in addition to stigma and discrimination. These groups may (but do not necessarily) include but are not limited to (6):

- People living in poverty;
- Indigenous peoples, people of African descent and other ethnic groups;

- Women;
- People with mental health conditions;
- LGBTQI+ persons;
- People with disabilities;
- Migrants, refugees, and displaced people.

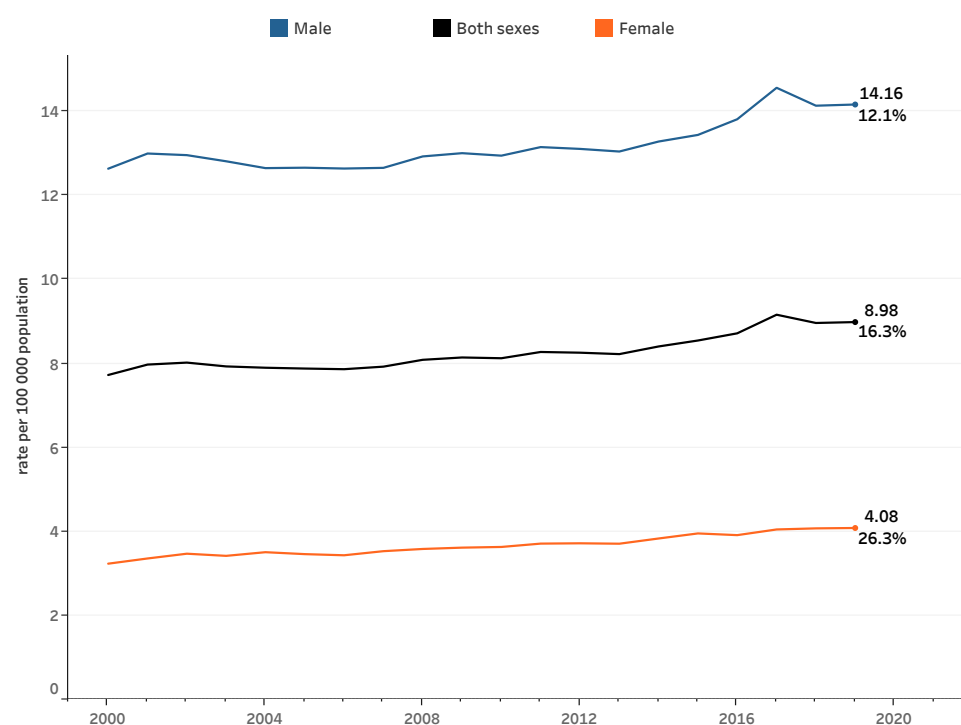
It is also important to recognize how intersecting forms of marginalization based on ethnicity, sex, age, sexual orientation, place of birth, language, religion, disabilities, or poverty can confer differing levels of disadvantage across individuals and social groups (18).

A largely inadequate response

Mental health has historically remained a neglected area of health, both globally and within the Region of the Americas. Despite the high burden attributable to mental health conditions in the Region, many countries have failed to prioritize mental health, resulting in weak mental health systems and services and a large treatment gap, leaving behind many of those in the most vulnerable situations.

Investment in mental health, both in terms of funding and human resources, falls considerably short of what is required to address the burden. In 2020, median government spending on mental health in the Americas was only 3% of total health

FIGURE 6
Age-adjusted suicide mortality rate in the Americas, 2000–2019



Source: Pan American Health Organization. The burden of suicide in the Region of the Americas. ENLACE data portal. Washington, DC: PAHO; 2021 [cited 4 March 2023]. Available from: <https://www.paho.org/en/enlace/burden-suicide>.

spending. Of this amount, nearly half (43%) was allocated to psychiatric hospitals (19). There is also a shortage of human resources for mental health in the Region, with many concentrated in large urban centers.

In many parts of the Region, mental health services remain highly centralized and are concentrated in psychiatric hospitals, as opposed to in the community, where care is more accessible and less likely to be associated with stigma and discrimination. These institutions have been associated with poorer treatment outcomes and unacceptable human rights violations. In the Americas, 28% of all stays in psychiatric hospitals exceed five years, making it the WHO Region with the highest proportion of stays over five years (19).

Stigma and discrimination are a major barrier to care for people living with mental health conditions. The implementation of outdated mental health laws and policies in the Region that include stigmatizing language continues to reinforce stigma, discrimination, and exclusion. Additionally,

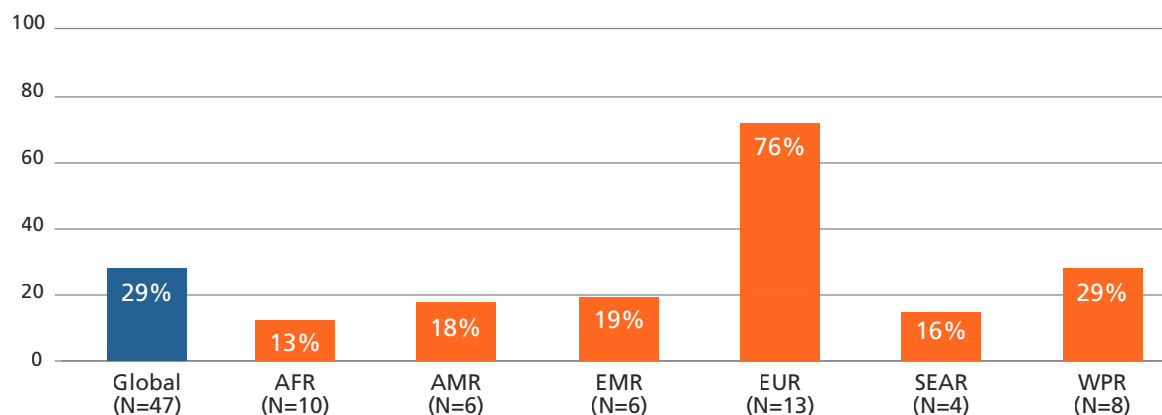
mental health stigma and discrimination is deeply embedded in many institutions and the health system, and even when this is unintentional, can prevent help-seeking behaviors and compromise effective treatment and recovery.

Another key challenge in the Americas that has hindered the strengthening of mental health care is a lack of mental health data and reporting. In 2020, one-quarter of countries reported that no mental health data had been compiled in the previous two years (19). Timely and quality mental health data that are systematically reported are essential for allocating appropriate resources according to need and developing mental health policies and services with an equity and human rights approach.

The COVID-19 pandemic: a mental health crisis exacerbated

The Region of the Americas has been disproportionately impacted by the COVID-19 pandemic. Nearly 3 million people in the Region have lost their lives as a result of COVID-19, the highest number of deaths of any WHO Region (2).

FIGURE 7
Service coverage for psychosis by WHO Region



Source: World Health Organization. Mental Health Atlas 2020. Geneva: WHO; 2021. Available from: <https://www.who.int/publications-detail-redirect/9789240036703>.

The pandemic has also produced devastating social and economic consequences for the Region. Subregional data for Latin America and the Caribbean shed light on this situation:

- Gross domestic product (GDP) decreased by 6.8%, its sharpest contraction since 1900 (20).
- The average employment rate fell from 57.4% to 51.7%, which equates to the loss of around 26 million jobs (21).
- The poverty rate is estimated to have reached 33.7%, and the extreme poverty rate 12.5%. This means that 209 million people are living in poverty (22 million more than in 2019) and 78 million in extreme poverty (up by 8 million) (20).
- Children in the subregion experienced some of the longest and uninterrupted COVID-19 school closures in the world. On average, students in the region fully or partially lost two-thirds of all in-person school days during the pandemic, with an estimated individual loss of 1.5 years of learning (22).
- During pandemic lockdowns, calls to domestic violence helplines increased in Latin America (23).

The COVID-19 pandemic magnified many well-established risk factors for mental health conditions, including grief and loss, financial insecurity, unemployment, feelings of isolation, and experiencing trauma and abuse. National studies confirmed a resulting worsening of mental health of the general population. It is estimated that in 2020, major depressive disorders rose by 35% and anxiety disorders by 32% in Latin America and the Caribbean (24). Post-COVID-19 condition, also known as “long COVID,” has also been linked to anxiety, depression, and other conditions (25).

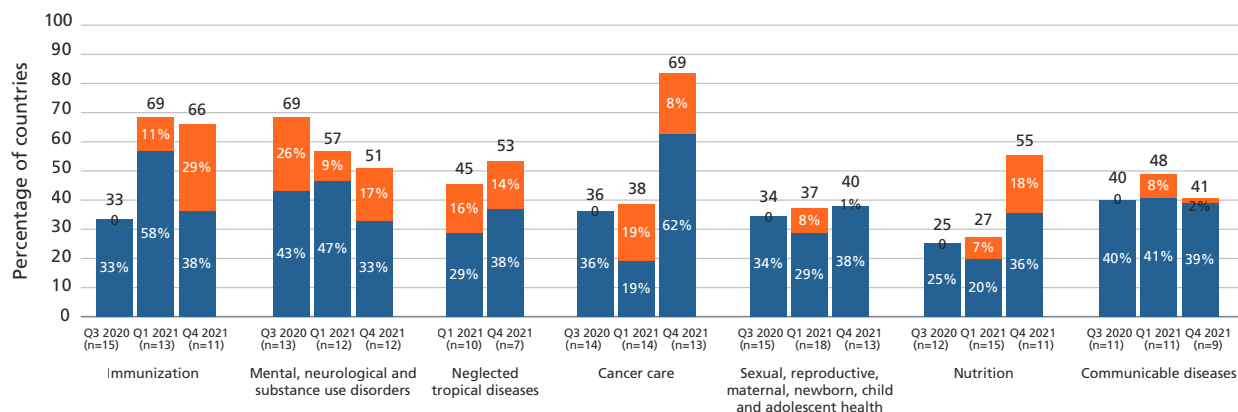
The COVID-19 pandemic magnified many well-established risk factors for mental health conditions, including grief and loss, financial insecurity, unemployment, feelings of isolation, and experiencing trauma and abuse.

While no one was immune from the mental health impact of the pandemic, some groups, including historically marginalized communities and those living in conditions of vulnerability, were disproportionately affected. Higher rates of mental health symptoms were documented in health and front-line workers; women; Indigenous peoples, people of African descent, and other ethnic groups; younger people; LGBTQ+ persons; people with preexisting mental health conditions; people diagnosed with COVID-19; and those living in poverty, among others (3).

The pandemic has also contributed to significant interruptions in mental health service delivery and care. In early 2022, 47% of countries in the Region that responded to the WHO Pulse survey on continuity of essential health services during the COVID-19 pandemic reported disruptions to services for mental, neurological, and substance use disorders. This compares with disruptions of these services reported by 60% of all responding countries one year earlier (when essential health services were experiencing the highest rates of disruption) (3). Figure 8 presents data on disruptions of essential health services.

FIGURE 8

Comparison of disruptions by tracer services in countries that responded to all three survey rounds: Q3 2020 (Round 1), Q1 2021 (Round 2), Q4 2021 (Round 3)



Source: Pan American Health Organization. Third round of the National Survey on the Continuity of Essential Health Services during the COVID-19 Pandemic: November-December 2021. Interim report for the Region of the Americas, January 2022. Washington, DC: PAHO; 2022. Available from: <https://iris.paho.org/handle/10665.2/56128>.

Key threats to mental health

People’s mental health is largely influenced by factors outside their control and outside the control of the health sector. In addition to the psychological and biological factors that may make an individual more vulnerable to mental health conditions, social, cultural, economic, political, and environmental elements all interact to influence an individual’s mental health. The social determinants of mental health conditions include the social, cultural, and economic factors that have a direct influence on the prevalence and severity of mental health conditions in men and women across the life course (26).

The Commission reviewed social determinants and their role in mental health in the Americas. Importantly, the impact of many of these determinants was exacerbated by the COVID-19 pandemic.

Poverty

The Americas is marked by high rates of poverty and extreme poverty, which grew during the pandemic. In Latin America and the Caribbean, poverty has increased over the past decade, rising from 27.8% in 2014 to 33.7% in 2022, and associated with 22 million more people living below the poverty line, of whom 8 million (36%) are in extreme poverty (27).

Poverty disproportionately affects different populations in the Region. In 2021, for every 100 men living in poor households in Latin America and the Caribbean, there were 116 women in a similar situation (28). In Latin America, poverty and extreme poverty are more severe among people of African descent (29), and Indigenous peoples, even who represent less than 8% of the overall population, currently account for around 17% of those living in extreme poverty (30). Children and adolescents also experienced significantly higher

rates of poverty. In 2021, nearly half (45.5%) of all people under 18 in Latin America were living in poverty (31). In the United States of America, 16.1% of children were living in poverty in 2021, up from 14.4% two years earlier (32).

Mental health conditions can be both a cause and consequence of poverty, generating a vicious cycle. The effects of poverty often start before birth and persist throughout the life course. The daily stresses of poverty increase the risk of mental health conditions through the inability to maintain basic living standards; reduced educational and employment opportunities; and low access to quality health care. Similarly, people experiencing severe mental health conditions are more likely to fall into poverty through loss of employment and increased health expenditures. This situation can also be aggravated by the lack of access to quality mental health services for people living in poverty.

Violence

Violence is a major public health challenge in the Americas, affecting a considerable proportion of the population. The Region has the highest homicide rate in the world (19.2 per 100 000) – more than three times the global average (33). Youth aged 10 to 29 years, particularly young men and boys, are especially vulnerable. One in three women aged 15 and older in the Region of the Americas has experienced physical and/or sexual violence by an intimate partner or nonpartner sexual violence (34). An estimated 58% of children in Latin America and 61% in North America experience physical, sexual, and/or emotional abuse every year (35). Femicide, the intentional killing of women with a gender-related motivation, claims the lives of thousands of women annually. In 2022, at least 4473 women were victims of femicide in 29 countries of Latin America and the Caribbean (36).

The effects of interpersonal violence are associated with a range of mental health conditions affecting survivors, including anxiety, depression, post-traumatic stress disorders, sleeping and eating disorders, self-harm, and suicidal behaviors. The mental health impact of violence is felt by survivors, their families and communities, including children witnessing violence in their homes, or witnesses of community violence.

Racism and racial discrimination

Racism, including prejudice and discrimination based on race, color, descent, or national or ethnic origin, is pervasive in the Americas. There are approximately 200 million people of African descent (37) and 62 million Indigenous people (38) in the Region. Indigenous peoples, people of African descent, and other ethnic groups in the Region continue to experience structural discrimination, exclusion, and inequality, which exposes them to chronic stress, anxiety, fear, and other factors that negatively impact their dignity, mental health, and well-being.

Political, economic, and social systems place Indigenous peoples and people of African descent in a condition of systemic exclusion, characterized by poverty, unemployment, and lack of access to adequate housing and essential services, such as drinking water and sanitation. This situation adversely affects their physical health and decreases their life expectancy, while also increasing their risk of new and worsening mental health conditions. These inequities are the legacy of colonialism and enslavement as well as institutional policies that limit their opportunities, resources, power, and well-being (39).

The murder of George Floyd in the United States in 2020 became a rallying cry for racial justice, but for many it also had profound mental health

impacts. According to research published in the Proceedings of the National Academy of Sciences of the United States of America, Black Americans reported significantly greater increases in symptoms of depression and anxiety after Floyd's death (40). This tragic episode also evidenced that racial discrimination and police brutality against people of African descent in the Americas places them at a disproportionate risk of reduced mental health, reflecting and reinforcing racial inequality and discrimination suffered historically and systematically. Adverse mental health impacts from common and pervasive exposure to racial discrimination, including following encounters with police, such as stops-and-searches and where force is used, were also highlighted in a 2021 Report of the United Nations High Commissioner for Human Rights (41).

Gender inequality

While gender² has implications for mental health across the course of every person's life, women and girls are disproportionately affected by gender inequality, which limits their opportunities to enjoy a dignified life, with optimal health and well-being. Women in the Americas continue to experience an unfair distribution of opportunities, power, resources, and responsibilities compared to men; they are underpaid, underrepresented in decisionmaking positions, and frequently experience gender-based discrimination, violence, and harassment (42). They also predominate in the informal sector (women shoulder most of the care for children, the sick, and people with disabilities, in their families and communities), limiting their access to resources and information for health care, and for pension and health-insurance coverage that accrue through employment in the formal sector (43).

Gender norms, values, and discrimination not only expose vulnerable individuals to mental health risks but also adversely affect their help-seeking behaviors, access to services, the responses they receive from the health sector, and ultimately their mental health outcomes (44). Women in the Region are 1.5 times more likely to suffer from depressive disorders than men and twice as likely to have an anxiety disorder (45). Moreover, men also experience mental health outcomes influenced by gender; the prevalence of alcohol use disorders in men in the Americas is more than double that of women (16), and men are more than three times as likely to die by suicide, although women are more likely to make suicide attempts (46).

It is also important to consider the mental health of diverse gender identities, expressions, and sexual orientations. The LGBTQ+ community is more likely to experience human rights violations including violence, torture, criminalization, involuntary medical procedures, and discrimination. They also face denial of care, discriminatory attitudes, and inappropriate pathologizing in healthcare settings (47). LGBTQ+ persons experience mental health disparities including higher rates of depression, anxiety, alcohol abuse, suicide, and suicidal ideation due to chronic stress, social isolation, and a lack of connection with various health and support services (48).

Humanitarian emergencies

The Americas is regularly exposed to a wide variety of health emergencies and disasters (natural, man-made, biological, chemical, radiological, and others) of increasing scale and frequency. For

² Gender refers to the socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for boys and men or girls and women.



The impacts of humanitarian emergencies can undermine mental health and psychosocial well-being of affected populations.

© PAHO/WHO

example, in the period between 2007 and 2016, around 24% of the disasters caused by natural phenomena that occurred worldwide took place in the Americas (49). The Region was also at the epicenter of the unprecedented COVID-19 pandemic, with the third-highest proportion of cumulative cases worldwide, but the highest percentage (43%) of deaths due to COVID-19 of all WHO Regions (2). Looking ahead, climate change, considered “the biggest global health threat of the 21st century” (50), is anticipated to amplify emergencies and disasters in the Americas as well as globally. Rising temperatures have already increased the number and intensity of tropical storms and floods in the Region, with 335 climate-related disasters occurring between 2005 and 2014, a 14% increase from the previous decade (50).

The impacts of humanitarian emergencies can undermine the long-term mental health and psychosocial well-being of affected populations. An estimated one in five people who have experienced war or other conflict in the previous 10 years will have a mental health condition, including depression, anxiety, post-traumatic stress disorder, bipolar disorder, or schizophrenia (51). The direct impact of climate change (heat waves, droughts, heavy storms, and rising sea-level), as well as its indirect impacts (vector-borne and airways diseases, food and water insecurity, undernutrition, and forced displacements) have been associated with adverse mental health outcomes as well as increased suicide rates (52). People with preexisting severe mental health conditions are especially vulnerable.



One in five people affected by conflict will suffer from a mental health condition, for which support is essential.

© PAHO/WHO, Arantxa Cayón

Migration and internal displacement

Migration³ and internal displacements are dramatically increasing in the Americas due to factors including social, political, and armed conflicts, the increase in violence and insecurity as a result of organized crime and drug trafficking, food insecurity, natural disasters, climate change, environmental degradation, economic hardship, violence, and other adverse drivers and structural issues. In 2020, Northern America was the destination for 59 million international migrants, while in Latin America and the Caribbean, the number of international migrants has more than doubled since 2005 to 15 million in 2021, making it the region with the highest increase in migration (53).

Throughout their migration journey, affected populations may be at a higher risk of developing mental health conditions due to risk factors such as concurrent physical health conditions; discriminatory treatment; experiencing sexual and gender-based violence, abuse, and trafficking; lacking adequate shelter, sanitation, and clean water; experiencing food insecurity; and lacking access to medication or care needs for those with preexisting conditions. These risks are exacerbated by barriers to accessing health services while in transit, in countries of destination, origin, or return (54).

³ Migration is defined as the movement of a person or a group of persons either across an international border or within a State. As such, migration encompasses any movement of people, no matter its length, composition, or cause. It includes the flow of refugees, displaced persons, economic migrants (voluntary or forced), temporal workers, students, undocumented migrants, and persons moving for other purposes, including family reunification, with different health determinants, needs, resources, capabilities, and levels of vulnerability (definition as contained in the PAHO Directing Council 2016 Resolution on Health of Migrants, Document CD55/11, Rev. 1).



DRA. D. HERNÁNDEZ



A New Agenda for Mental Health in the Americas: a call to action

What is A New Agenda for Mental Health in the Americas (NAMHA)?

A New Agenda for Mental Health in the Americas (NAMHA) is a call to action for countries in the Americas to seize the opportunity presented by the COVID-19 pandemic to prioritize and reform mental health care,⁴ both now and for the future. Together, as a Region, we can achieve momentous and lasting change in mental health for generations to come, but we must start now.

NAMHA presents the final recommendations developed by the PAHO High-Level Commission on Mental Health and COVID-19 for advancing mental health in the Region. It comprises 10 recommendations, each with corresponding action points and a case example. Importantly, the recommendations do not represent an exhaustive list of all improvements needed in mental health in the Region. Rather, they focus on key priority areas identified by the Commission which require urgent action for sustainable recovery from the COVID-19 pandemic and beyond.

The recommendations are intended to align with existing global and regional mental health and development objectives including the WHO Comprehensive Mental Health Action Plan 2013–2030, the PAHO Policy for Improving Mental Health, and the 2030 Agenda for Sustainable Development, while prioritizing actions specific to key mental health issues in the Region of the Americas. NAMHA is built on the premise of multisectoral partnership, where different sectors and actors work together in an integrated manner by pooling financial resources, knowledge, and expertise.

Who is NAMHA for?

The Commission recognizes the essential role that all actors, including governmental, nongovernmental, civil society, and the private sector, must play in advancing mental health. However, the Commission has focused its recommendations on high-level government authorities and decisionmakers in the Americas, recognizing that coordination with communities and the private sector is necessary for its

⁴ For the purpose of this report, mental health conditions will refer to both mental and substance use conditions. References to mental health services and care include services for both mental health and substance use conditions. It is recognized that additional actions specific to substance use, which go beyond the scope of the Commission's recommendations, will be needed to more comprehensively address this major public health issue in the Region.

effectiveness. The following were identified as key actors:

- Heads of State and Government (Presidents, Vice Presidents, Prime Ministers, and Chief Ministers);
- Ministers and Secretaries of Foreign Affairs, Finance, Health, Education, Social Welfare/ Development, Justice, Employment, and Labor, among others;
- Subnational government authorities including Governors, Mayors, Council members, etc.;
- Legislators and policymakers at all levels of government.

NAMHA recognizes that cooperation and joint work among various actors in society is essential for the generation, implementation, and monitoring of strategies and initiatives that positively impact people's mental health, promote their well-being, and allow them to have optimal health conditions for a dignified life.

How should NAMHA be used?

High-level government authorities in the Region are encouraged to read this report and integrate its recommendations into public policy and mental health planning and programming. This will entail working through existing multisectoral mechanisms (e.g., technical working groups, committees) to review the recommendations and determine how to implement those that are most relevant, depending upon context. Countries can also find an important resource for advancing NAMHA in PAHO's Mental Health and Substance Use Unit, which provides technical cooperation to Member States in strengthening their mental health capacity.

It is important to note that the diverse economies and cultures of the Region mean that no single plan can fulfill the needs of all countries. Countries and territories of the Region are at different stages of mental health reform. And there are differences among and within countries that necessitates tailoring the guidance to local opportunities as well as to overcome barriers and challenges. The Commission therefore emphasizes that the Recommendations will require contextual adaptation.

NAMHA cross-cutting principles

Six cross-cutting principles underly the Recommendations and action points (illustrated in Figure 9).

1. Universal health coverage

Universal health coverage (UHC) means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. As mental health is an essential component of health, it must be included in UHC, in parity with physical health, as part of all individuals' fundamental right to health.

2. Human rights

All people, including those living with mental health conditions, must be treated with dignity and respect and protected from all forms of abuse and discrimination. Mental health strategies, actions, and interventions should be compliant with the Convention on the Rights of Persons with Disabilities (CRPD) and other international and regional human rights instruments.

3. Equality and nondiscrimination

The principles of equality and nondiscrimination are at the core of human rights that lay the foundations for sustainable human development and the consolidation of just and prosperous

societies. Mental health services must be provided to all, without any discrimination. All services must incorporate diverse approaches such as gender, ethnicity, and cultural perspectives, as they are fundamental sources of inequality in the Region.

4. Life course approach

Diverse factors influencing mental health interact to influence mental health across a person’s life course, necessitating that all mental health policies, programs, and services consider the different risks and needs of people at all life stages, including infancy, childhood, adolescence, adulthood, and older age.

5. Empowerment of people with mental health conditions and their families

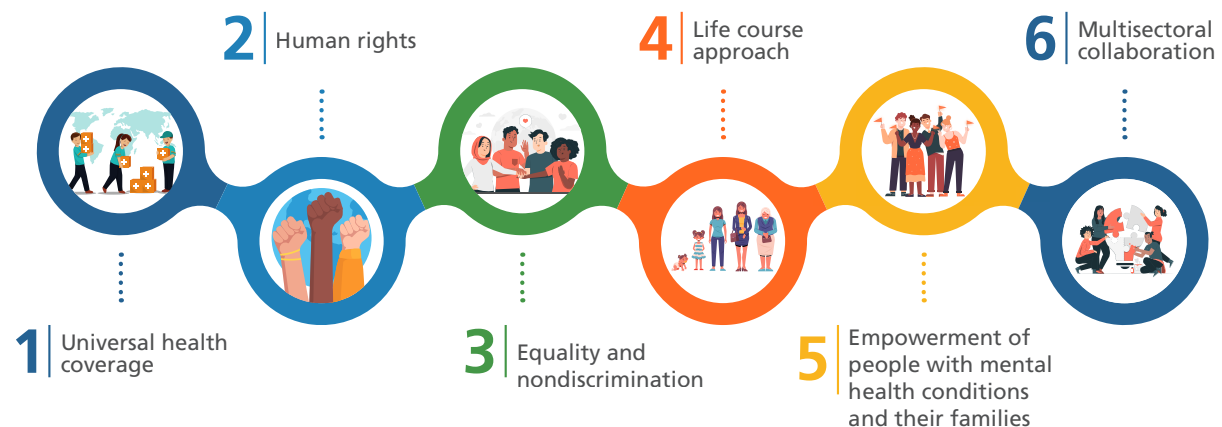
People with mental health conditions and their families have the right to participate actively

in shaping the social and health policies that affect their lives. This means that they should be empowered and actively involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research, and evaluation.

6. Multisectoral collaboration


A comprehensive and coordinated response for mental health requires partnership with several public areas such as health, education, employment, judicial, housing, social, and other relevant sectors, as well as the private sector, as appropriate to the country situation. The multisectoral approach is the most efficient and effective way of mainstreaming mental health promotion and the prevention and treatment of mental health conditions into the broad range of policy, planning, and services required.

FIGURE 9
NAMHA cross-cutting principles

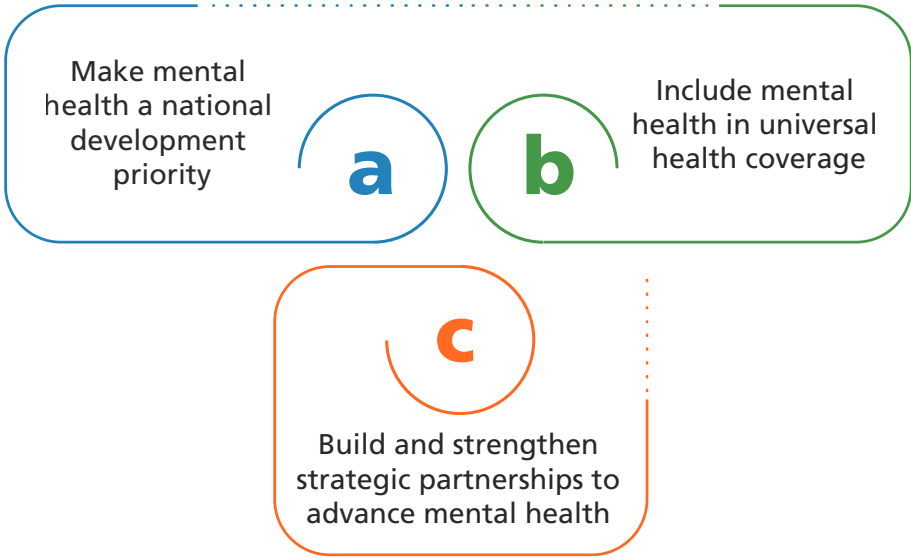




Recommendations

 **1. Elevate mental health at the national and supranational levels**

ACTION POINTS



NAMHA calls on all actors at the highest levels of government to spearhead significant and sustainable mental health reform at the national level and beyond. The COVID-19 pandemic has reminded us that we can no longer afford to neglect mental health without serious and

long-term consequences to society. Countries in the Americas must commit to elevating the prominence of mental health on national political agendas and demonstrate their commitment through bold and strategic action. While they may find themselves at different stages of mental

health reform and progress, each and every country in the Region, no matter its income level and national circumstances, has the potential and the obligation to transform its mental health systems and services.

a. Make mental health a national development priority

Mental health conditions can compromise not only the well-being and development of individuals but also that of communities and societies.

Prioritizing the improvement of mental health at the population level can generate positive social and economic outcomes and fuel development, which have all been significantly compromised by the COVID-19 pandemic. If countries are to fully recover from the impact of the pandemic and reach their long-term development goals, they must treat mental health as an essential component of pandemic recovery and national development.

Establishing mental health as a national post-pandemic development priority will require the integration of mental health into all COVID-19 pandemic recovery strategies and plans as well as broader national development strategies and action plans, to ensure that it is reflected in planning and programming. It also calls for increased financing (see **Recommendation 3**) and dedicated human resources trained in mental health policymaking and planning. There is an important need to build mental health leadership capacity at both the local and national levels, which requires the improvement of knowledge and skills in mental health policymaking; service planning and delivery; and monitoring and evaluation at the systems level. Governments can build local capacity in mental health leadership by investing in leadership training and educational

opportunities, mentorship, and knowledge-exchange programs, both within and between countries.

Some important examples of countries taking steps to make mental health a national priority include Chile's HealthyMind (see the **Case example** below), a presidential initiative for mental health launched by then President Sebastián Piñera in 2020 in response to the COVID-19 pandemic's impacts on mental health. The program, coordinated by a multisectoral panel of experts, aims "to support citizens and provide information to improve people's mental health and psychosocial well-being through coordinated actions." Additionally, in 2021, Canada appointed its first Minister of Mental Health and Addictions, Dr. Carolyn Bennett, who also serves as the country's Associate Minister of Health. Dr. Bennett works with the Ministry of Health to ensure that mental health care is treated as a full and equal part of Canada's universal health care system, with a particular focus on ensuring that health inequities are understood and addressed, including for Indigenous peoples, Black Canadians, and vulnerable Canadians (55).

b. Include mental health in universal health coverage

Universal health coverage (UHC) means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship (56). People have the right to attain the highest standard of health, which can only be achieved when their mental health and well-being is ensured, and their rights respected, requiring the full integration of mental health into UHC. In 2019, world leaders adopted the United Nations High-Level Political Declaration on Universal Health Coverage, which

recognized mental health and well-being as “an essential component of universal health coverage.” Governments must now honor this commitment.

All countries should work to ensure that: 1) mental health conditions are sufficiently and appropriately included within national UHC service packages; 2) that high-quality rights-based services are accessible to everybody who needs and wants care; and 3) that services are provided in such a way that does not cause service users financial hardship.

While every country’s approach to mental health in UHC will differ depending on the national context, key components should include (57):

- Integrating mental health into all UHC strategies and planning, and the inclusion of mental health services within the basic package of essential services.
- Increasing sustainable financing and human resources for mental health (see **Recommendation 3**).
- Strengthening mental health laws and policies aligned with international human rights standards (see **Recommendation 4**).
- Shifting service delivery toward non-specialized settings in the community (see **Recommendations 4 and 6**).
- People with lived experience are empowered to participate in the development and implementation of mental health

policies, strategies, laws, and services (see **Recommendation 6**).

To achieve mental health in UHC, a defined set of mental health conditions and evidence-based interventions, including both psychotropic medicines and psychosocial therapies, should be explicitly recognized and included in the essential list or package of health benefits offered to all citizens by governments, whether as part of the national tax-based health service or under the provisions of social or private insurance schemes (58). This should form part of a comprehensive set of benefit packages for mental health, including social protection as discussed in **Recommendation 5**. Financial risk protection for the care of mental health conditions is imperative. Even in countries with social health insurance, plans frequently do not cover mental health conditions, exacerbating inequalities through either a lack of access to care for those in need or high costs leading to catastrophic out-of-pocket expenditures.

c. Build and strengthen strategic partnerships to advance mental health

Advancing sustainable improvement in mental health calls for building partnerships and collaboration with diverse actors across sectors and entities both vertically (linking regional, subregional, national, and local institutions) and horizontally (linking government, civil society, and the private sector at each level). These partnerships can enhance available resources, both financial and human, for mental health, facilitate knowledge exchange and expertise, and expand the reach and impact of mental health initiatives.

Governments play a key role in driving partnerships for mental health at a variety of levels (see Table 1 for examples of key strategic actors and partners). At the national level, key partners should include a range of government ministries and sectors, local governments, civil society organizations, the private sector, academia, United Nations agencies, funds and other multilateral organizations, and the media, among others. Partnerships with organizations representing people living in conditions of vulnerability (such as Indigenous peoples, people of African descent, and other ethnic groups) are essential, as are those with mental health service users and family associations. People with lived experiences and their families have invaluable perspectives that can help to shape mental health planning, programming, and evaluation.

Partnerships at the subregional and regional levels can enable capacity-building, facilitate better linkages and coordination, and promote the sharing of knowledge and expertise between countries. Countries in the Region that have made less progress in advancing mental health can benefit from partnerships with countries that have made significant advancements and can provide various forms of guidance and support. Dialogue among countries can also facilitate the identification of priorities, exchange of best practices, and establishment of joint initiatives to address common challenges, such as strengthening data on mental health (see **Recommendation 10**), suicide prevention (see **Recommendation 7**), and the inclusion of mental health in national

and cross-border preparedness and mitigation efforts for natural disasters, climate change, and mass migration (see **Recommendation 2**). It is also important that national leaders capitalize on their membership and participation in subregional integration mechanisms and multilateral organizations, including international financial institutions, health and political organizations, to advocate for the prioritization of mental health on subregional and regional political and development agendas.

The United Nations recommends that partnerships should be characterized by six elements: inclusiveness (including all relevant stakeholders); experience-sharing (finding commonalities and comparing perspectives); strategy (linking stakeholders proactively to maximize outcomes and economies of scale); empowerment (building capacity of all stakeholders and in their interrelationships); consensus-building (developing mutually supportive policies, processes, and operations); and continuous improvement (establishing moving targets of success and measures of approaching success and building on successes) (59). To ensure that they are functional, partnerships should establish formal agreements or joint plans with stakeholders, allocate dedicated funding to the stakeholder or partnership, and carry out regular meetings with them. Transparency and accountability are also crucial to sustaining partnerships by building trust among stakeholders and the public as well as responsibility, fairness, and equality.

TABLE 1
Key strategic actors and partners

LEVEL	STRATEGIC ACTORS AND PARTNERS	
National	Ministry/Secretariat of Health; National SDG coordination mechanisms; Executive, legislative, and judicial bodies; Government sectors (education, finance, foreign affairs, environment, agriculture and livestock, work/labor, and others); Municipal or local governments; PAHO/WHO.	United Nations agencies; National and international civil society organizations; International cooperation agencies; Academic and scientific sectors; Private sector.
Subregional	Subregional integration mechanisms and, where applicable, their health-focused bodies.	Subregional mechanisms from other related sectors; PAHO/WHO subregional offices.
Regional	Epidemiology, statistics, planning, international health relations networks, and others; PAHO/WHO; United Nations Development Group for Latin America and the Caribbean (UNDG LAC); PAHO/WHO Collaborating Centers; Economic Commission for Latin America and the Caribbean (ECLAC).	Organization of American States (OAS); World Bank, Latin America and the Caribbean Region; Inter-American Development Bank (IDB) and other development banks; Other international agencies.

Source: Adapted from Pan American Health Organization. Sustainable Health Agenda for the Americas 2018-2030: A Call to Action for Health and Well-Being in the Region. Washington, DC: PAHO; 2017. Available from: <https://iris.paho.org/handle/10665.2/49170>.

Case example: Chile's Presidential HealthyMind Initiative

Chile's HealthyMind Initiative (Iniciativa SaludableMente) was launched by the Office of the President early in the COVID-19 pandemic. Officially established on 1 June 2020, the HealthyMind Committee included more than 30 academic experts, representatives of scientific societies and other civil society organizations, members of Congress, and representatives from a range of ministries (60).

The Committee was challenged to fulfill its mandate in 90 days. The Committee's first task was to review and expand the Ministry of Health's analysis of and plans for the likely mental health needs of the population. It identified six priority workstreams: (i) strengthening mental health services; (ii) protecting the mental health of vulnerable groups; (iii) community strengthening and communication strategies; (iv) care of healthcare professionals and overall workplace mental health; (v) prevention of substance and alcohol misuse; and (vi) a comprehensive virtual platform for mental health promotion, prevention, and treatment activities.

For each priority area, a working group developed a road map that included a summary of the current situation, actions, expected

results, monitoring activities, and a timeframe, to create an integrated strategy with clear deadlines to meet the 90-day requirement.

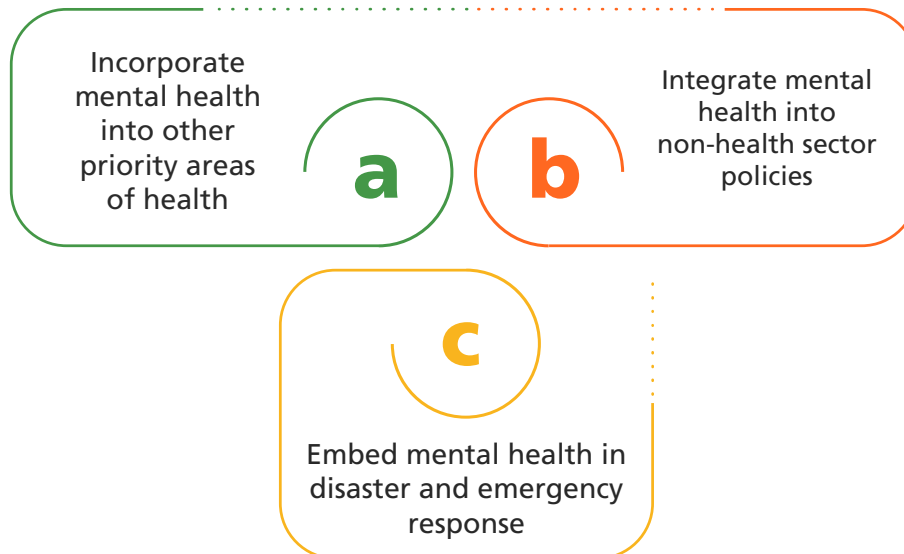
The HealthyMind digital platform was created as a one-stop destination for information and access to tele-mental health services (61). A suite of evidence-based resources was made available to promote the mental health of the general population, plus targeted information for priority groups such as children and adolescents, older adults, parents and caregivers, and individuals with COVID-19. The platform content has expanded over time to reflect the changing needs of the population. For women, this has included information on services for survivors of gender-based violence as well as advice on pregnancy and on promoting co-responsibility for care and domestic work (62).

The Presidential HealthyMind Initiative stimulated broad intersectoral collaboration on the mental health needs of the population, which has guided government actions within and beyond health services. The Initiative has been extended beyond its initial 90 days and continues to increase the visibility of mental health and to secure new resources (60).



2. Integrate mental health into all policies

ACTION POINTS



Mental health is a cross-cutting issue across both health and non-health areas. Integrating mental health into other relevant program areas can support mental health promotion and the prevention of mental health conditions, increase the accessibility of mental health care, and improve outcomes beyond mental health. Accordingly, NAHMA urges countries to implement a mental-health-in-all-policies (MHiAP) approach, which recognizes that mental health is determined by policies and programs outside of the sphere of solely mental health and even beyond the health sector, and to actively integrate mental health into all policies.

a. Incorporate mental health into other priority areas of health

Integrating mental health into other health services and programs can promote better treatment

outcomes for all health conditions. For example, the integration of mental health into services and care for physical health conditions, including cardiovascular diseases, diabetes, cancer, and HIV and tuberculosis (all of which commonly coexist with mental health conditions), can improve treatment adherence and reduce high-risk behaviors and stress, contributing to better management and outcomes for both physical and mental conditions (63). Maternal and child health programs can also benefit from integrated care, as many women experience mental health changes during pregnancy and in the first year postpartum, when as many as one in five will experience a mental health condition. Unmet mental health needs can negatively affect women's health and the well-being of their babies and families, and equally, poor health or difficult circumstances in

the lives of women, their babies, and families can negatively impact women’s mental health (64). Additionally, integrated mental health care can provide care in a less stigmatizing environment, improving access, as well as provide more whole-person care, where the entire person is treated, as opposed to a specific disease or body system.

Countries can facilitate and advance the integration of mental health into other relevant areas of health through the inclusion of mental health in other health strategies, policies, and plans of action at all levels of government. Additionally, building the capacity of health workers beyond the mental health sector, including primary care providers and non-mental health specialists (see **Recommendation 6**), can promote service integration. Another key opportunity is the integration of mental health data into other data collection efforts such as health information systems (see **Recommendation 10**). In lower-income countries, which are more likely to rely on external funding, it is important for health authorities to liaise with donors to plan and

operationalize embedding mental health services into aid programs, including priority areas (for donors) such as violence prevention, sexual and reproductive health, and maternal and child health.

b. Integrate mental health into non-health sector policies

Multisectoral policies and programs are central to addressing the social determinants of mental health, many of which fall outside the purview of the health sector. The multisectoral approach is the most efficient and effective way of mainstreaming mental health promotion, prevention, and treatment into the broad range of policy, planning, and services required. Non-health sectors can support mental health in a variety of ways, including through policies and programs that promote mental health and prevent mental health conditions (see Table 2); the provision of mental health services outside of the health sector, including in the workplace, schools, and prisons; and by providing social support such as housing, employment, education, and child

TABLE 2
Examples of non-health sector policies that can benefit mental health

POLICY AIM	POLICY TYPES AND AIMS	LINKAGE WITH MENTAL HEALTH
Reduce financial insecurity, poverty, and income inequality	Financial protection for mental health; social protection, pension systems, debt relief, economic empowerment, and other poverty alleviation programs, as well as livelihood support for people with disabilities.	Increasing evidence shows that cash transfer programs not only alleviate financial hardship but also benefit recipients’ mental health and well-being.
Increase access to labor markets	Active labor market policies and programs – such as vocational training courses, job search assistance, wage subsidies, or supported internships and work experiences – can support those looking for work, in particular the long-term unemployed, as well as those with psychosocial or other disabilities.	Overall, employment has a positive influence on mental health, while unemployment is a notable risk.
Enhance access to education	Initiatives to close the gender and intergenerational gaps in education, mitigate early school-leaving, increase school enrollment, and boost adult literacy can all serve to enhance access to education.	Education is vitally important for physical and mental health as well as economic growth and poverty reduction.
Improve housing safety and security	Policies to improve access to safe, affordable, and good quality housing for disadvantaged groups.	Overcrowded, insecure, and inadequate housing as well as homelessness all pose risks to mental health.

Source: Adapted from World Health Organization. World mental health report: Transforming mental health for all. Geneva: WHO; 2022. Available from: <https://www.who.int/publications-detail-redirect/9789240049338>.

protection. Multisectoral programs can take the form of joint programs led by the health sector as well as the integration of mental health into programming within the education, employment, judicial, housing, social, and other relevant sectors, as well as in the private sector and professional associations, as appropriate to the country situation.

Table 2 shows some examples of non-health sector policies that can benefit mental health. Analyses of emergency measures brought in during the COVID-19 pandemic measures may prove especially useful, such as the effect of financial support for economically disadvantaged families on parents' mental health (65).

To achieve this, countries will need formal mechanisms that facilitate and ensure multisectoral collaboration and action. These can take the form of working groups, commissions, or committees, and should include relevant government agencies, departments, and ministries, as well as local governments; nongovernmental organizations; people with mental health conditions and their representatives; and people living in conditions of vulnerability, as well as wider civil society.

c. Embed mental health in disaster and emergency response

As demonstrated by the COVID-19 pandemic, emergencies can precipitate or worsen mental distress and at the same time weaken a country's mental health infrastructure. Country responses to the COVID-19 pandemic highlighted the need for mental health to be embedded in all national disaster and emergency responses. The updated WHO Comprehensive Mental Health Action Plan 2013–2030 includes a new indicator proposing that 80% of countries will have a system in place for mental health and psychosocial preparedness for emergencies and/or disasters by 2030 (2).

Mental health and psychosocial support (MHPSS), which aims to protect or promote psychosocial well-being and/or prevent or treat mental health conditions, is a core component of all phases of an emergency: preparedness, response, and recovery. It must therefore be integrated into all emergency response efforts and included in national disaster/emergency strategies and plans. The NAMHA cross-cutting principles apply to mental health embedded in preparedness and response activities, including an approach to all interventions grounded in equity and human rights. Additionally, people affected by emergencies should be active participants in improving national emergency plans, rather than passive recipients of services designed by others.

Mental health should be represented in all emergency/disaster technical working groups and clusters in addition to health, social protection, education, human rights, community organization, human resources, food safety, and water and sanitation sectors. Multisectoral coordination is needed to ensure optimization of resource use and to avoid duplication of effort. Forming a single intersectoral MHPSS coordination group, including actors traditionally associated with both the health and protection sectors, is considered the most effective way to reduce fragmentation and to ensure that all aspects of MHPSS are addressed in an integrated manner (66).

Countries can utilize existing resources and guidelines for MHPSS that have been developed for emergencies, including the Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings (66), and the Mental Health and Psychosocial Support Minimum Service Package (67), making the necessary adjustments to the local context and specific needs.

Case example: Argentina's multisectoral approach to community-based mental health care

Argentina's National Mental Health Law was enacted in 2010, guaranteeing the right of all people to mental health protection and mandating a national transition of services from long-stay psychiatric institutions to community-based mental health care (68). The regulatory decree of the same law establishes the National Interministerial Commission on Mental Health and Addictions Policies (CONISMA) under the orbit of the Chief of Cabinet of Ministers, with the Ministry of Health playing a coordinating role. Recognizing that progress in the implementation of the legislation had stalled, on 22 April 2022 (69), the country launched a Federal Strategy for a Comprehensive Approach to Mental Health. This strategy proposes an overtly intergovernmental approach whereby different ministries partner with the Ministry of Health to fully realize the vision of the law.

For example, the Ministry of Territorial Development and Habitat has launched an inclusive living program to promote and fund the construction of community housing for people with mental health or psychosocial disabilities (70). The construction of the first 50 houses out of a planned total of 2000 is underway (71). This ministerial collaboration advances in the realization of the requirement of the Mental Health Act "... In no case may the hospitalization of persons with mental illness be

indicated or prolonged to solve social or housing problems, for which the State shall provide adequate resources through the competent public bodies" (68).

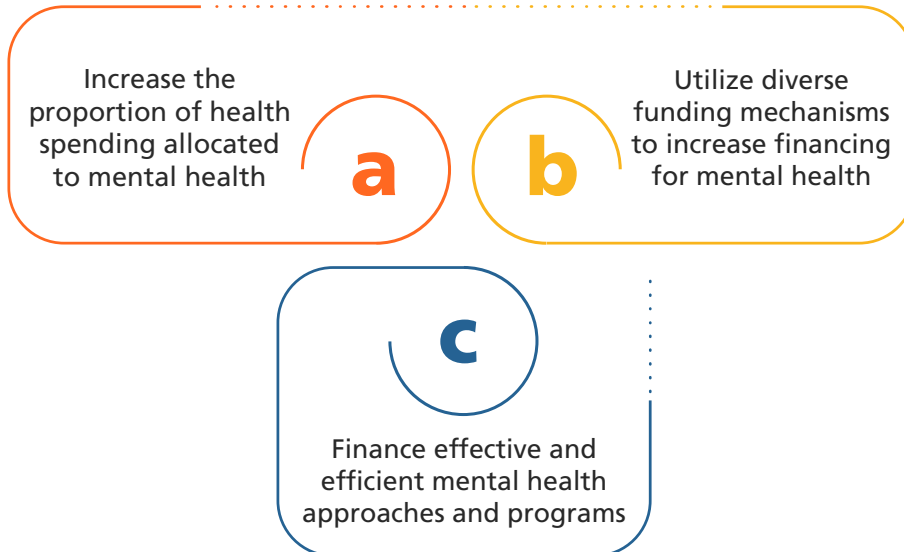
Through the Ministry of Public Works, the number of community mental health centers or Network Care Nodes is being increased by means of the construction of new buildings and mental health wards for brief hospitalizations in general hospitals and 24-hour emergency services. These new construction projects prioritize jurisdictions that to date have been characterized by a lack of services (69). The Ministry of Labor, Employment, and Social Security is implementing a program to promote the inclusion of people with mental health conditions/psychosocial disabilities in the workforce (69).

The strategy also advances the Mental Health Act's requirement that public and private universities expand training for professionals in rights-based mental health care. The initiative has already resulted in the creation of a new Diploma in Mental Health. In addition, the three-year paid postgraduate course, the Interdisciplinary Mental Health Residency, has been upgraded to become an accredited qualification for the mental health specialist (69), taking it from the hospital to the community setting in many jurisdictions.



3. Increase the quantity and improve the quality of financing for mental health

ACTION POINTS



Substantial, sustained investment in community-based mental health services and care is imperative to mitigate the current mental health crisis exacerbated by the COVID-19 pandemic and to achieve long-term sustainable development. While national and local governments may share responsibility for mental-health funding with nongovernmental and private entities, they have the sole responsibility for ensuring that financing is in place to meet the mental health needs of their populations. In addition to increasing the quantity of funding for mental health, countries must also ensure the equitable and efficient use of funds.

a. Increase the proportion of health spending allocated to mental health

Currently, funding for mental health falls far short of meeting the need for care, demonstrated by

the high burden of mental health conditions and the large gap in affected people receiving care. In the Americas, the average ratio of the mental health burden to expenditure on mental health is 6.1, meaning that the burden attributable to mental health conditions is six times the proportion of health funds allocated to mental health. Adequate investment in mental health services necessitates increasing funding to a level commensurate with the burden of mental ill-health and ensuring parity between physical and mental aspects of health care (15). In order to improve health system sustainability and enable a more efficient pooling of resources, it is important that financing for mental health comes primarily from domestic funds (58). Reallocating current government health spending to align with the health burden is one important opportunity.

The Lancet Commission on Mental Health and Sustainable Development recommends that a minimum of 5% of the health budget in low- and middle-income countries and 10% of the budget in high-income countries should be made available to mental health (72). It is estimated that this greater investment could lead to an increase in treatment coverage of 40% to 80% by 2030 (58). While it is understood that low-income countries are grappling with urgent, competing priorities which make substantially increasing their budgets for mental health seem out of reach, there are valuable steps that these governments can take with limited funding, including using incremental approach to investing and service delivery (73), which can produce large gains. An added benefit

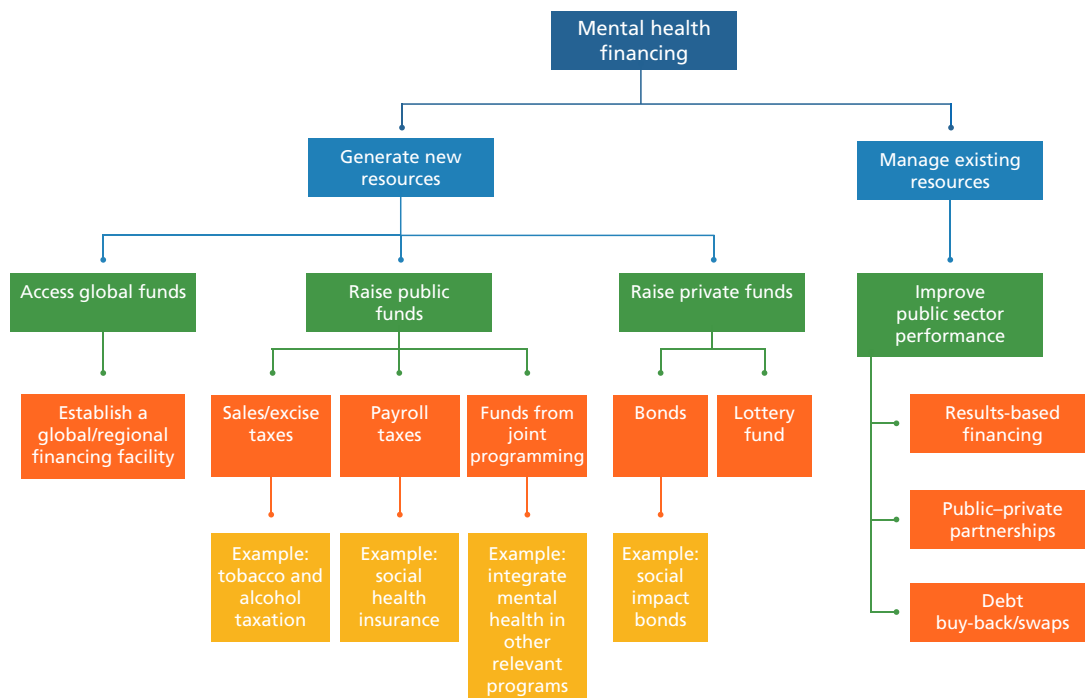
of increasing mental health budgets in lower-income countries is that by explicitly demonstrating that mental health is a local priority, it may attract more support from the wider donor community.

b. Utilize diverse funding mechanisms to increase financing for mental health

In order to increase financing for mental health, countries should consider mobilizing a variety of funding sources, which includes leveraging existing funding sources as well as establishing new ones and managing existing resources more effectively. This is illustrated in Figure 10.

One possible source of sustainable financing for mental health is through sales or excise taxes,

FIGURE 10
Conceptual framework for sustainable mental health financing



Source: Adapted from Chisholm D, Docrat S, Abdulmalik J, Alem A, Gureje O, Gurung D, et al. Mental health financing challenges, opportunities and strategies in low- and middle-income countries: findings from the Emerald project. *BJPsych Open*. 2019;5(5):e68. Available from: https://www.cambridge.org/core/product/identifier/S2056472419000243/type/journal_article.

including taxes on tobacco, alcohol, and sugary drinks. These health taxes can have the simultaneous benefits of reducing the consumption of harmful products that contribute to disease and premature mortality and while increasing domestic funding for mental health (74). Social impact bonds are another promising approach that rely on private funds. In social impact bond transactions, investors join donors to fund an organization that delivers a social program or services. The investors are remunerated, often with a return on their investment, from the same governments that would have funded the organization's program over many years and usually for smaller amounts. This type of bond has proved acceptable not only to commercial investors but also to charitable and philanthropic organizations and aid agencies. The bonds can allow the government or sponsor to raise larger amounts of money earlier – which relieves governments of the need to fund start-up costs and facilitates planning (75).

Integrating mental health into other national priority health and social welfare programs (addressed in **Recommendation 2**), including for HIV and tuberculosis; noncommunicable diseases; maternal, newborn, and child health programs;

violence prevention; occupational health; and emergency response, among others, can create sustainable funding opportunities for mental health while improving the quality of care and outcomes for both components of the program.

There are three main approaches, illustrated in Figure 11:

- Earmarked funding, where funds from new or existing revenue streams are set aside for a specific purpose and usually remain under the control of the (mental) health ministry.
- Delegated financing, where funds from one or more sources are allocated to an independent statutory organization such as a health promotion agency or foundation.
- Joint budgeting – also known as resource pooling or pooled budgets – where two or more sectors share their resources to address a specific issue; this may be a mandatory or voluntary process and can take different forms from the alignment of budgets to a fully integrated budget between two or more sectors.

FIGURE 11



Additional opportunities to leverage financing across sectors and programs for mental health include the sharing of in-kind resources, rather than funding, between sectors, including staff, equipment, or expertise, as well as the provision of space to host a joint project, and the creation of fiscal incentives, usually involving taxation or financial subsidies, to stimulate intersectoral activity (76). Fiscal incentives have shown particular promise in the area of workplace mental health.

Finally, by managing existing resources for mental health, countries can strengthen mental health financing. Results-based financing, which ensures that development funding is linked to pre-agreed and verified results, and that funding is provided when the results are achieved, can contribute to narrowing the funding gap by increasing the cost-effectiveness of existing funding and unlocking financing from the private sector. Through a range of mechanisms, results-based financing can help deliver development outcomes, improve accountability, and drive both innovation and efficiency (77). As described in the **Case example** below, Peru successfully mobilized results-based financing to scale up community-based mental health services.

c. Finance effective and efficient mental health approaches and programs

In common with all public sector financing, it is imperative that funds be directed toward establishing and enhancing effective and efficient mental health approaches and programs. As emphasized throughout these Recommendations, this means investing in community-based mental health services and care that are rights-based and tailored to the characteristics and needs of beneficiary populations. It is imperative that

funding for long-stay psychiatric hospitals be reduced in favor of financing mental health care delivered in the community. (**Recommendation 4** discusses in more detail the need to accelerate the transition from mental health services provided in long-stay psychiatric institutions to community-based services.) Financing of community-based mental health care must include investing in human resources, especially competency-based training, supervision, and coaching of diverse cadres of nonspecialist healthcare providers (see **Recommendation 6**). It also requires a greater prioritization of and investment in evidence-based mental health promotion and prevention to reduce the burden of mental health conditions.

The good news is that feasible, affordable, and cost-effective measures are available – an integrated package of cost-effective care and prevention can be delivered in community settings in low- and middle-income countries for USD 3–4 per capita (78). Resources such as the *WHO Menu of Cost-effective Interventions for Mental Health* can be useful in considering which interventions to finance, although it is important to keep in mind that other factors in addition to cost-effectiveness should be used in decisionmaking and resource allocation, including ensuring equity and respect for human rights; balancing potential benefits and harms of interventions; values and preferences related to the interventions and their outcomes; implementation capacity and acceptability; and the need to implement a combination of population-wide and individual-level interventions (79). Furthermore, effectiveness, cost-effectiveness and return on investment studies carried out at the local level are important to ensure that all decisions are evidence-based and contextualized (see **Recommendation 10**).

Case example: Innovative financing incentivizes service transformation in Peru

Over the past decade, Peru, a country with one of the smallest health budgets in Latin America, has tripled its budget for mental health, showing that even countries that invest little in health overall can increase resources for mental health and catalyze reform. The adoption of results-based financing has been a significant driver of the country's ongoing transformation of mental health services. Centralized psychiatric hospitals are being replaced by a decentralized network of health and social services anchored in the general health care system and community mental health centers, in accordance with the community mental health care model envisaged in the new legal framework.

In 2014, the Peruvian Ministry of Economy and Finance approved a stand-alone pay-for-performance budget and committed to 10 years financing of community-based mental health services, subject to the attainment of pre-set indicators (80). The results-based budgeting program began with the equivalent of USD 20 million allocated for fiscal year 2015 and the first 22 community mental health centers were launched. Funding was assessed each month. Any funds left unspent were

recouped by the government. Failure to reach the pre-set indicators – evidenced by the return of funds – could lead to a reduced budget allocation for the following month, although this has not occurred. Managers and providers were incentivized to achieve the pre-set indicators.

Investment in mental health in Peru grew 223.7% between 2015 and 2022. This investment has allowed an average per capita investment of USD 6.9, close to the average for the Americas (USD 7.9). About 85% of the funding for mental health is via the Ministry of Economy and Finance's results-based budgeting program. The remaining 15% comes from program budgets for gender-based violence, early childhood development, and drug use prevention.

The results-based financing proved successful in reorienting government budgets toward more effective services, including inpatient mental health and addiction units in general and regional hospitals. As of the end of 2022, a total of 248 community mental health centers were in operation, with 82% located in provinces outside the capital. Currently 1124 primary healthcare centers, located in all provinces, have psychologists on their staff.



4. Ensure the human rights of people living with mental health conditions

ACTION POINTS

Establish and implement legislation that guarantees the human rights of people with mental health conditions

a

Accelerate the transition from long-stay psychiatric institutions to community-based services

b

c

Build capacity in human rights for mental health across sectors

People with mental health conditions are among those living in the most vulnerable situations in society. They experience enormous prejudice, discrimination, and exclusion, which violate their basic and fundamental human rights and result in their further marginalization (81). It is imperative that countries honor the commitments they have made to international human rights standards and guarantee that everyone in the population, including people with mental health conditions, can experience all of their rights to the fullest.

a. Establish and implement legislation that guarantees the human rights of people with mental health conditions

The rights of people with mental health conditions are protected by a range of international human rights instruments (see Box 1), most notably the Convention on the Rights of Persons with Disabilities (CRPD),⁵ which “promotes, protects and ensures the full and equal enjoyment of all human rights and fundamental freedoms” by all people with mental health conditions, and “promotes respect for their inherent dignity” (82). These rights

⁵ The CRPD defines disabilities as “Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”

Box 1

International and Inter-American Instruments for Human Rights

International Instruments for Human Rights

- Universal Declaration of Human Rights (1948)
- International Convention on the Elimination of All Forms of Racial Discrimination (1965)
- International Covenant on Civil and Political Rights (1966)
- International Covenant on Economic, Social and Cultural Rights (1966)
- Convention on the Elimination of All Forms of Discrimination Against Women (1979)
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984)
- Convention on the Rights of the Child (1989)
- ILO Indigenous and Tribal Peoples Convention (1989)
- International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990)
- Declaration on the Elimination of Violence against Women (1993)
- Convention on the Rights of Persons with Disabilities (2006)
- Declaration on the Rights of Indigenous Peoples (2007)

Source: Adapted from the Office of the United Nations Commissioner for Human Rights. International standards on the right to physical and mental health. Geneva: OHCHR; 2021. Available from: <https://www.ohchr.org/en/core-international-human-rights-instruments-and-their-monitoring-bodies>.

Inter-American Instruments for Human Rights

- American Declaration of the Rights and Duties of Man (1948)
- American Convention on Human Rights (1969)
- Inter-American Convention to Prevent and Punish Torture (1985)
- “Protocol of San Salvador”: Additional Protocol to the Convention on Human Rights in the Area of Economic, Social and Cultural Rights (1988)
- “Convention do Belem do Pará”: Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (1994)
- Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities (1999)
- Inter-American Convention Against Racism, Racial Discrimination, and Related Forms of Intolerance (2013)
- Inter-American Convention on Protecting the Human Rights of Older Persons (2015)

Source: Adapted from the Organization of American States. Basic Documents in the Inter-American System. Washington, DC: OAS; 2023. Available from: https://www.oas.org/en/IACHR/jsForm?File=/en/iachr/mandate/basic_documents.asp.

depend on a number of key human rights principles in the mental health care context, including: the right of people with mental health conditions to exercise their legal capacity; freedom from coercive practices, including, for example, involuntary admission, involuntary treatment, and the use of seclusion; the right to participate in decisionmaking processes in society as a whole; community inclusion; and the right to a recovery approach (83).

To date, few countries in the Region have established mental health policies and legislation that fully comply with international human rights frameworks. Many countries still have mental health laws and policies that retain colonial, stigmatizing language. Furthermore, while the majority of countries have a dedicated authority or independent monitoring body to assess compliance with international human rights instruments, in many countries this body does not function well (e.g., there is no budget or staff) or carry out regular inspections of mental health services, systematically respond to complaints, and report its findings at least once a year (19).

In NAMHA, countries are urged to establish and implement mental health legislation that aligns with their obligations under international human rights instruments, including the CRPD. Where legislation already exists, it must be periodically reviewed and revised, and laws that perpetuate stigma and discrimination against people with mental health conditions, including the criminalization of suicide, should be repealed. In line with the cross-cutting principle of accountability, countries must also ensure the existence of a robust independent body to monitor compliance of mental health services with international human rights instruments. The United Nations Office of the High Commissioner for Human Rights and WHO are currently developing

a resource for countries on legislative measures to support the transformation of mental health systems in line with international human rights law. This also contains considerations on the core responsibilities of an independent monitoring body and its relevance to ensuring the establishment of community-based mental health services (84).

With respect to legislation and policy, the CRPD obliges States to ensure the participation of persons with mental health conditions/ psychosocial disabilities, including children and adolescents, in all public decisions affecting them. Their meaningful participation at all stages of policymaking – from design and implementation to monitoring and evaluation – is key to upholding a rights-based approach to mental health. This ensures that their valuable expertise and experiences inform the development of policy responses that are relevant and effective and prevent harmful practices.

b. Accelerate the transition from long-stay psychiatric institutions to community-based services

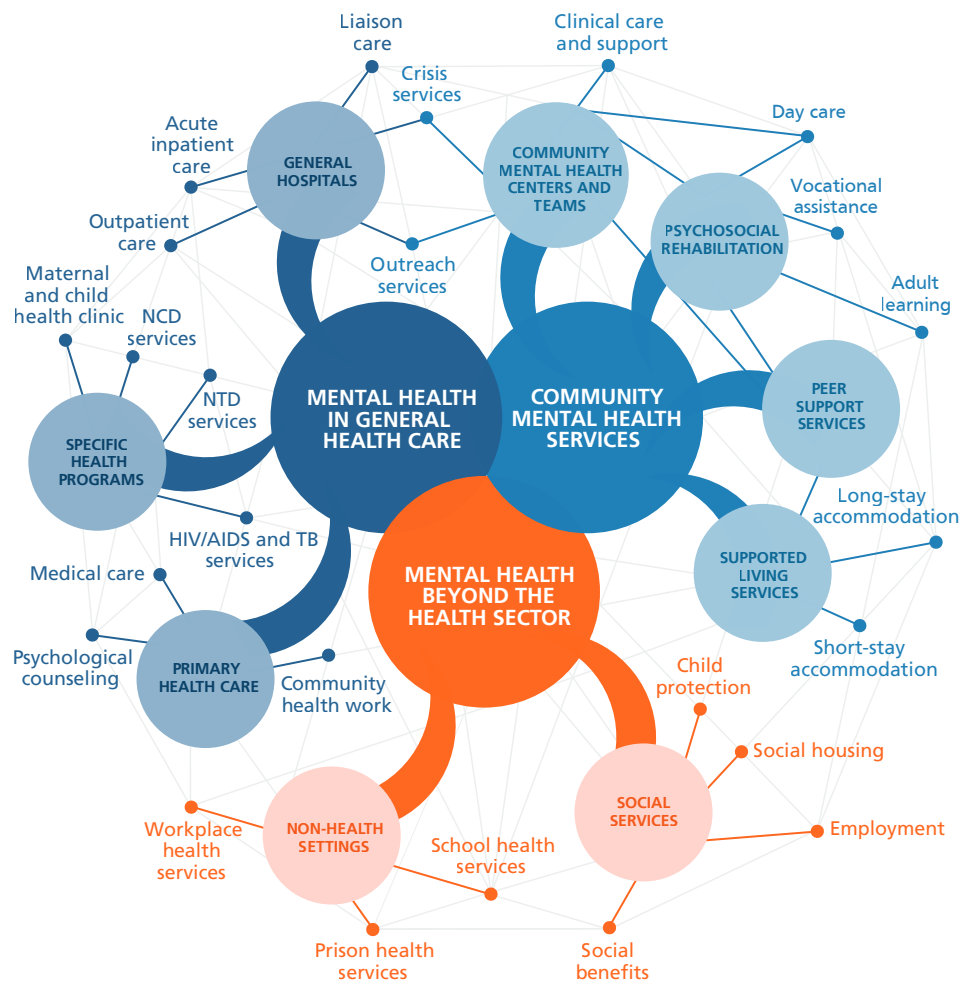
Three decades ago, the imperative to respect and protect the human rights of people living with mental health conditions/psychosocial disabilities catalyzed the transition from long-stay psychiatric institutions to community-based services in several countries in the Region. In 1990, the Caracas Declaration called for structural change from centralized services based on closed-door psychiatric hospitals with widespread human-rights violations to decentralized, rights-based services integrated in the community.

Since then, progress in many countries has stalled due to low prioritization of mental health in national health spending and political agendas. Some countries of the Region have yet to start

the transition and still have policies and laws that perpetuate institutionalization and coercive and/or harmful treatment. NAMHA urges countries to reignite the spirit of the Caracas Declaration by building up quality community-based care networks grounded in human rights and phasing out long-stay psychiatric institutions.

The transition process from long-stay institutions to community-based care involves (i) progressively reducing caseloads to close or repurpose long-stay psychiatric institutions; (ii) expanding community-based services to meet the health and social needs of former institutional residents (including community-supported housing and

FIGURE 12
Model network of community-based mental health services



Source: Adapted from World Health Organization. World mental health report: transforming mental health for all. Geneva: WHO; 2022. Available from: <https://www.who.int/publications/i/item/9789240049338>.

beds in general hospitals for acute cases); and (iii) special protections for people remaining in psychiatric facilities while suitable community-based services are being developed (85).

Community-based mental health services are well established as the most humane, effective, and efficient model of service delivery (86). The foundational principles of this model are a focus on person- and recovery-oriented care, a rights-based approach, and care delivered in non-institutional settings. As shown in Figure 12, the community-based mental health services model comprises a network of diverse and interconnected services built around three foundational service segments (86):

- Mental health services in general health care – through primary health care, general hospitals, and embedded in specific health programs, such as those for people living with HIV;
- Community mental health services – through community mental health centers and teams, rehabilitation services, peer support, and supported living services;
- Mental health beyond the health sector – services delivered in non-health settings, such as health services in prisons, schools, and workplaces, and via social services, such as supported housing.

While this model is adaptable and should be tailored to specific local contexts, it is important to note that every country, no matter its resource constraints, can and must take steps to restructure mental health service delivery and scale up community-based mental health services and care (86).

In Latin American and Caribbean countries where progress in the transition from institutionalized to community-based care has been made, high-level facilitators included the following (85):

- Robust, sustained political support – goodwill and enthusiasm are not enough. Significant reforms can be achieved in countries with fewer resources, as long as strong political support for mental health reform exists.
- Quality data showing the levels of need for mental health care to inform effective policy.
- A policy and plan that clearly define the road map, including workplans for legislation, organization, information systems, financing, and human resources.
- A mental health unit, usually part of the ministry of health, to coordinate implementation. Successful reform depends on the unit being close to political power, having authority over operation of services, and having technical capacity.
- Stakeholder alliances with other health services and social care. Representation by patients and family members is key, as is effective collaboration with staff of psychiatric hospitals to mitigate resistance to change.

c. Build capacity in human rights for mental health across sectors

Human rights violations of people with mental health conditions/psychosocial disabilities can take many forms. They can include instances of degrading treatment, abuse, and violence, which have tragically resulted in needless deaths. They also consist of violations spanning basic civil, cultural, economic, political, and social rights, such

as the denial or restriction of employment rights and opportunities or the inability to access quality mental health services. Addressing these violations, which occur in many environments, including in the community; the workplace; psychiatric hospitals and other mental health service settings; in prisons, police encounters, and the legal system; and in schools, and transforming the culture of public servants, will require increasing sensitization to mental health issues and building capacity in promoting and protecting human rights for mental health across sectors, especially in the health, social, judicial, and law enforcement sectors.

The WHO QualityRights Initiative (87), which aims to improve the quality of care and support in mental health and social services and to promote the human rights of people with psychosocial,

intellectual, or cognitive disabilities worldwide, is an excellent resource to support governments in carrying out human rights reform for mental health. It includes a comprehensive set of training and guidance tools, developed to enhance knowledge, skills, and understanding among key stakeholders on how to promote the rights of persons with psychosocial, intellectual, or cognitive disabilities and improve the quality of services and supports being provided in mental health and related areas, in line with international human rights standards. QualityRights training can benefit policymakers, relevant government ministries (e.g., health, social affairs, education), government institutions and services (e.g., law enforcement, the judiciary, prison staff, monitoring bodies that inspect mental and social service facilities), among other key stakeholders.



QualityRights training can benefit policymakers, relevant government ministries, government institutions and services, among other key stakeholders.

©PAHO/WHO

Case example: Mexico's mental health legislation prioritizes human rights

In 2022, Mexico updated the General Health Law to guarantee the rights of all people to community-based mental health services (88). Although Mexico was a signatory to the Caracas Declaration in 1990 (89), progress in transitioning from asylum-based services to services integrated with primary health care and general hospitals has been slow. As of 2017, psychiatric beds in general hospitals did not increase, while there was a reduction in the number of psychiatric hospital beds from 5.07 to 2.98 per 100 000 population (90).

The amended legislation establishes the prioritization of mental health within public health policies. It guarantees universal, nondiscriminatory, and equitable access to mental health and substance abuse care for all, in accordance with the Constitution and international human rights instruments. The law emphasizes that the ultimate goal of mental health services is recovery and wellness, according to the preferences of the individual. One of the most significant aspects of the law is that mental health care is prioritized in a community approach and that hospitalization is voluntary, with prior informed consent.

The legislation establishes primary care as the main community provider of mental health services, integrated into an integrated network

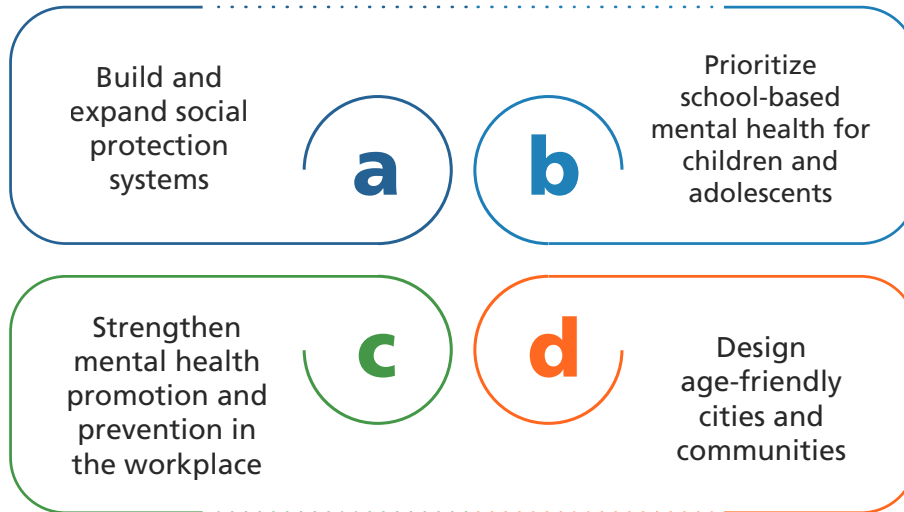
of health services. The construction of new psychiatric hospitals is prohibited, and existing facilities must be restructured as outpatient centers or general hospitals. Specifically, the law stipulates that the National Health System must provide mental health care close to the place of residence of service users that, in addition:

- Respects the dignity and human rights of individuals, with a focus on gender, equity, intersectionality, and interculturality, emphasizing prevention, early detection, and promotion of mental health;
- Promotes and develops awareness-raising measures on mental health and eradication of stigmas and stereotypes among the general population and health professionals;
- Mitigates the effects of risk factors experienced by service users;
- Prioritizes populations in conditions of vulnerability, such as youth, women, older adults, people with disabilities, Indigenous people, Afro-Mexicans, people living on the streets and in poverty, migrants, victims of violence, and people discriminated against because of their sexual orientation or gender identity.



5. Promote and protect mental health across the life course

ACTION POINTS



Many health promotion efforts and the prevention of mental health conditions across the life course are essential to targeting individual risk factors and social determinants of mental health and to strengthening protective factors and building resilience at key life stages including infancy, childhood, adolescence, adulthood, and older age. Promotion and prevention can reduce the burden due to mental health conditions and so prove to be cost-effective. In light of the COVID-19 pandemic's exacerbation of factors that jeopardize mental health, now more than ever, countries must invest in mental health promotion and prevention across the life course.

Note: The Commission considered suicide prevention a priority area of extreme importance

and therefore created a separate recommendation to address it (see **Recommendation 7**).

a. Build and expand social protection systems

An overarching policy imperative to promote and protect mental health across the life course is to build and expand universal social protection systems to address the social determinants of mental health, such as poverty, violence, and limited access to education and health care, among others, across the life course. Social protection is a set of policies and programs aimed at preventing or protecting all people against poverty, vulnerability, and social exclusion throughout their life, with emphasis on groups living in conditions of vulnerability (see Figure 13) (91). Universal

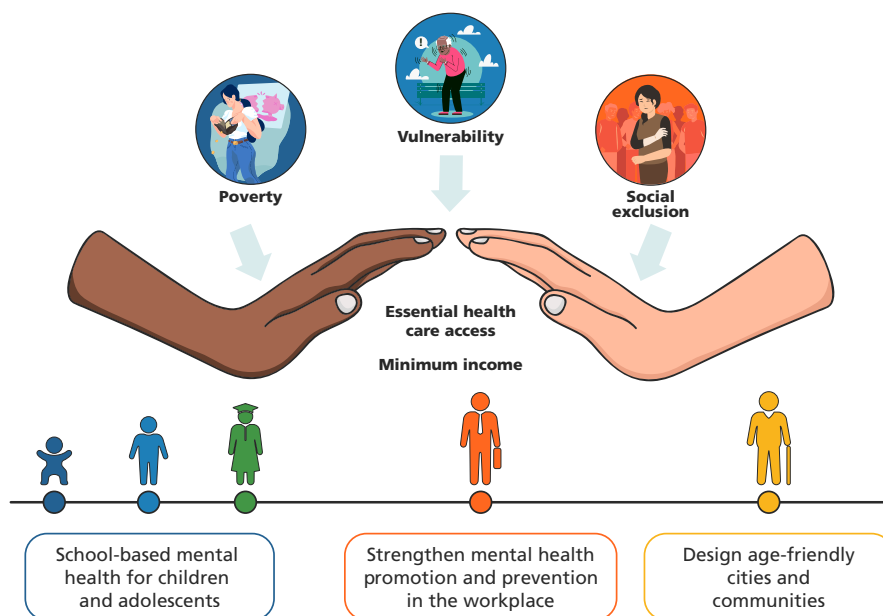
social protection coverage includes providing social assistance through cash transfers to those who need them; benefits and support for people of working age in case of maternity, disability, work injury, or for those without jobs; and pension coverage for older persons, and can be provided through social insurance, tax-funded social benefits, social assistance services, public works programs, and other schemes guaranteeing basic income security (92).

The right to social protection has been established by the Universal Declaration of Human Rights and also inscribed in core human rights conventions including the Convention on the Elimination of All Forms of Discrimination Against Women (see **Recommendation 8**), the Convention on the Elimination of All Forms of Racial Discrimination (see **Recommendation 9**), and the Convention on the Rights of the Child.

The social protection floor approach is an integrated set of social policies designed to guarantee income security and access to essential social services for all, paying particular attention to vulnerable groups and protecting and empowering people across the life course (93). The approach envisages countries implementing national social protection floors with basic social security guarantees that ensure universal access to essential health care and income security at least at a nationally defined minimum level, followed by a strategy of increasing levels of protection beyond basic to achieve comprehensive social security systems. Importantly, a social protection floor can contribute to reducing poverty in informal work related to the financial consequences of these risks (94).

As gender and age play a disproportionately large role in how people experience risks, vulnerabilities,

FIGURE 13
Universal social protection systems

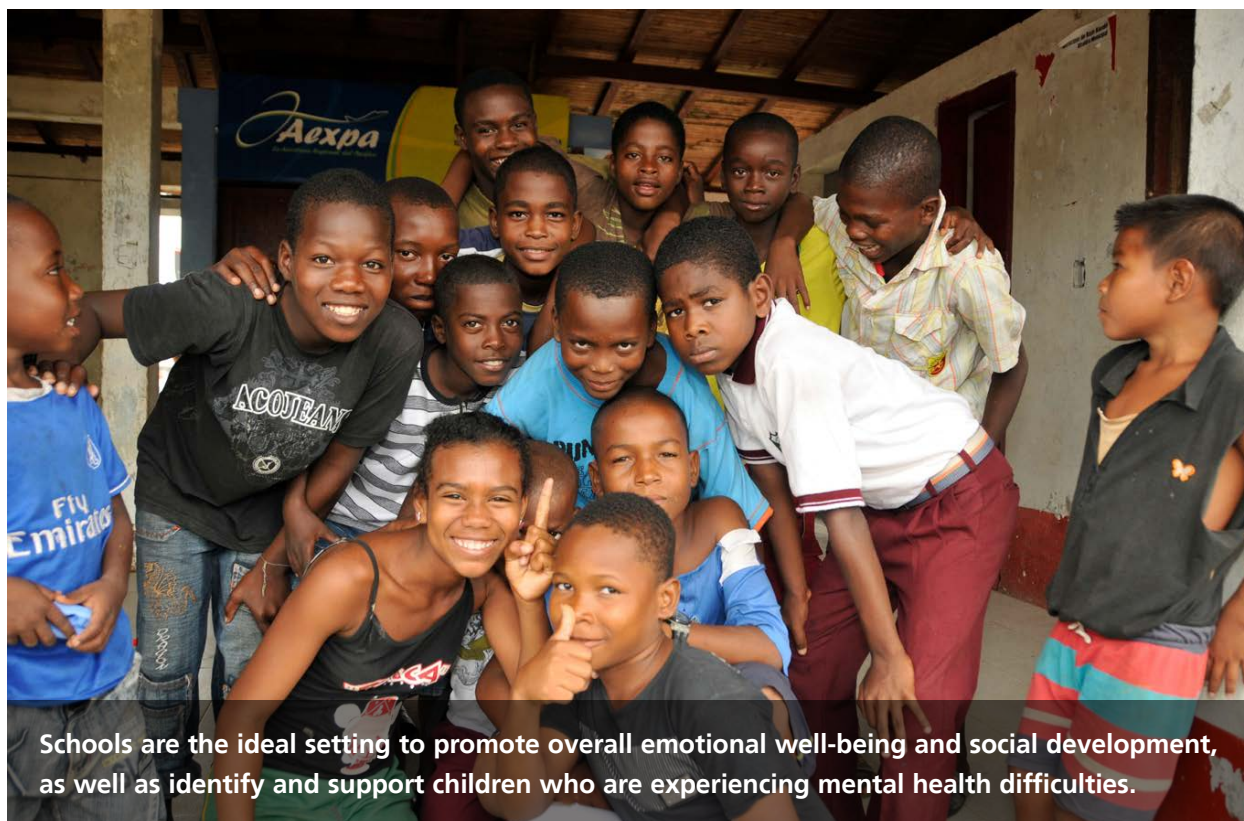


and opportunities, it is vital that social protection be gender-responsive and age-sensitive in order to address gender- and life course-related vulnerabilities and inequalities (95). For example, the first five years of life represent a critical period for brain development and future mental health, making comprehensive health care and social protection programs at this life stage essential.

b. Prioritize school-based mental health for children and adolescents

Childhood and adolescence is a critical time when valuable social and emotional skills can be learned. It is also a period when many mental health conditions first emerge. Global data show that among adults with mental health conditions, one-third experienced their first episode before age 14, and half before age 18 (96).

Schools are the ideal setting to promote overall emotional well-being and social development, to identify and support children who are experiencing mental health difficulties, and to prevent the development of mental health conditions. Mental health challenges in youth can have negative impact on interpersonal relationships, school performance, and productivity at work later in life (97). Countries should integrate mental health in all primary and secondary school curricula through activities such as classes on social-emotional learning and mental health literacy. Social-emotional learning helps students develop essential life skills, including how to regulate their own emotions, problem-solving techniques, and interpersonal skills and assertiveness (97). WHO's evidence-based guidance recommends that this type of learning should be provided for all



Schools are the ideal setting to promote overall emotional well-being and social development, as well as identify and support children who are experiencing mental health difficulties.

© PAHO/WHO

adolescents to promote positive mental health and to prevent mental health conditions, self-harm, and suicide (see **Recommendation 5**).

Educators, including teachers and classroom assistants to administrators and school management, play an essential role in child and adolescent mental health promotion and prevention. Building the capacity of educators to promote students' mental well-being, as well as to recognize and provide early support to children with mental health problems and their caregivers, is an important strategy. PAHO's recently developed handbook, *Promoting Wellbeing and Mental Health in Schools*, can support educators of primary school children in mental health literacy (98).

It should be noted that the COVID-19 pandemic forced a more intensive use of technology (e.g., smartphones and computers) to maintain social distance and avoid contagion while maintaining educational activities. However,

with the return to face-to-face activities, it is important to reduce the time children spend on these devices. The uncontrolled use of digital technologies, such as the Internet and social media, can expose young people to violent and age-inappropriate content, disinformation, unregulated advertising, and cyberbullying and cyberviolence, which generate significant risks to their mental health (98). Social and emotional learning programs can support the development of skills to help youth use the Internet responsibly and safely, reduce Internet-related risk exposure, educate them on cyberbullying, and promote online safety. It can also help to build protective factors against both perpetration of cyberbullying and victimization among adolescents, including empathy, self-esteem, and social skills (97). Guidelines for technology use in schools can also reduce these risks.

Returning children and adolescents to school and supporting them to recoup lost learning has



Educators play an essential role in child and adolescent mental health promotion and prevention.

© PAHO/WHO

been a priority for post-pandemic recovery. At the same time, it is recognized that the effects of the pandemic on young people's mental health can impair their readiness to learn and may increase school dropout, which is linked to subsequent unemployment, poverty, and social exclusion. A solution being implemented by several countries is integration of mental health in post-pandemic recovery packages for schools (99). In countries where social-emotional learning was not a feature in pre-pandemic education, recovery packages could form the basis from which sustainable integration of mental health into curricula can grow.

c. Strengthen mental health promotion and prevention in the workplace

People spend a significant portion of their adult lives at their place of work, making workplace mental health an area of great importance. The International Labour Organization and WHO have recently produced evidence-based guidance on a range of actions to improve mental health at work (100). For example, activities at the employer/organizational level can help reduce emotional distress and improve work-related outcomes such as job satisfaction, absenteeism, and work performance. These include providing flexible working arrangements, involving workers in decisions about their jobs, and modifying work schedules to enable work-life balance. They are most effective as part of a broader program of activities such as manager training in mental health and providing activities that support employees, including mindfulness and stress management. Programs to promote and protect mental health at work are most effective when planned and delivered with the meaningful participation of workers and/or their representatives.

In light of their difficult work experience during the pandemic, healthcare workers in particular are a priority. The COVID-19 HEalth caRe wOrkErS Study (HEROES) (101) found that between 14.7% and 22% of health personnel in countries of the Region of the Americas interviewed in 2020 presented symptoms consistent with depressive episodes, and 5–15% said they had thought about suicide. The study also reports that in some countries, only about a third of those who said they needed psychological care received it.

Governments play an important role advancing workplace mental health. They can create incentives for employers and workers' associations that take care of mental health in the workplace, such as awards and financial incentives. Additional government approaches recommended by the International Labour Organization and WHO to improve workplace mental health include (illustrated in Figure 14) (102):

- Work with employers' and workers' organizations to develop new, or review and revise existing, employment and occupational safety and health laws, policies, and guidance to include provisions on mental health in parity with those on physical health.
- Develop legal and policy frameworks to require or encourage the implementation of interventions to protect and promote mental health.
- Provide guidelines and quality assurance standards for training and psychosocial interventions.
- Ensure that employment laws align with international human rights instruments and provide for the nondiscrimination of workers

FIGURE 14

Governments' role advancing workplace mental health



with mental health conditions, including by covering key issues such as confidentiality, reasonable accommodations, and social protection.

- Establish policies and referral pathways between health, social, and employment services to facilitate supported employment initiatives and return-to-work programs, including to support employers to implement these.

In addition, governments must ensure that the rights of people living with mental health conditions to work are protected. Both governments and employers should uphold that right through person-centered, recovery-oriented strategies that support people living with mental health conditions to gain, sustain, and thrive in work. WHO guidelines recommend three evidence-based interventions to support people with mental health conditions at work: reasonable accommodations at work, return-to-work programs, and supported employment initiatives. All three can increase inclusivity at work and help those with mental health conditions to fulfill their potential (102).

d. Design age-friendly cities and communities

In 2019, 16% of the population of the Americas was above 60 years old, and it is projected that by 2100, this number will climb to 36% (103). In addition to life stressors experienced by other people, older adults may be more likely to experience added stressors such as a decline in functional ability, reduced mobility, chronic pain, bereavement, a drop in socioeconomic status with retirement, and elder abuse, placing them at greater risk of developing mental, neurological, or substance use conditions as well as other comorbid conditions (104). Dementia in particular affects more than 10 million people in the Americas.

Promoting active aging by optimizing opportunities for health, participation, and security in order to enhance quality of life as people age is a core strategy for promoting positive mental health and preventing mental health conditions in older adults (105). Age-friendly communities refers to communities that adapt their structures and services to be accessible to and inclusive of older people with varying needs and capacities. Eight core areas of age-friendly urban living were



Promoting active aging by optimizing opportunities for health in order to enhance quality of life as people age is a core strategy for promoting positive mental health.

© PAHO/WHO, Sandra Mallo

identified by the WHO Global Age Friendly Cities Project; they include outdoor spaces and buildings; transportation; housing; social participation; respect and social inclusion; civic participation and employment; communication and information; and community support and health services. For each core area, regional and local authorities can assess their communities' progress in achieving age-friendly features (105). They can also use a common framework and core indicators developed by WHO to monitor and evaluate communities' age-friendliness (106). This guide sets forth a framework and a set of core and supplementary indicators to inform the selection of a local indicator set to

monitor and evaluate progress in improving the age-friendliness of urban environments.

The Global Network of Age-Friendly Cities and Communities (GNAFCC) was established by WHO in 2010 with the mission of stimulating and enabling cities, communities, and other subnational levels of government around the world to become increasingly age-friendly (107). As of 2018, the Network includes 760 communities and cities, with the Region of the Americas becoming the fastest growing region in the Network. Subnational authorities are encouraged to become members (108).

Case example: Investing in Strong Families in Uruguay

Uruguay is the most recent country in the Americas to roll out the Strong Families parenting program (109). Building on a successful pilot of Strong Families in 2022, the government is expanding the program nationwide up to 2025. Strengthening families is increasingly accepted as a sound investment in building a country's social capital and economic development. A growing body of evidence indicates that parenting programs provide a good return on investment (110).

As with other countries in Latin America, family structure in Uruguay is undergoing significant changes. Changes in family dynamics are resulting from many external factors including demographic transition, the increased role of women in the labor market, migration, globalization, environmental changes, and new technologies. And behaviors that are harmful to physical and mental health are occurring at increasingly younger ages (111).

The Strong Families program works with young adolescents aged 10–14 years and their parents/

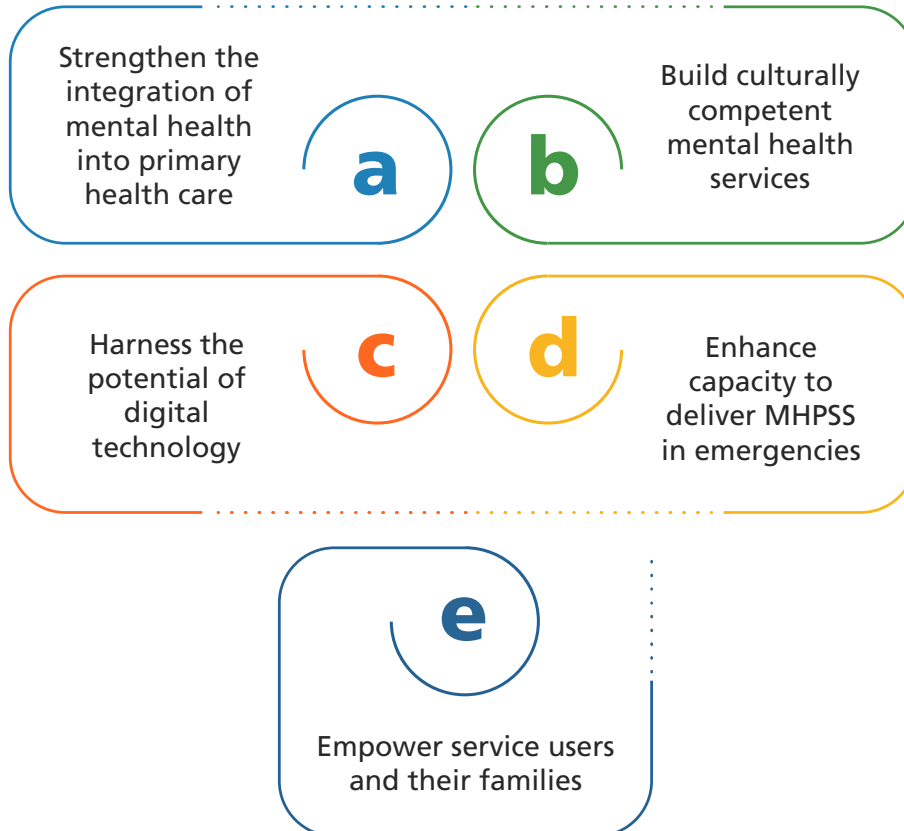
caregivers to strengthen family communication and cohesion. The original format was devised nearly four decades ago in the United States of America and has been revised, refined, and adapted since then. The longevity of the program has allowed evaluation of the effects over time, showing significant, cost-effective reductions in alcohol and drug use, violence, and unprotected sexual activity in adolescents in the short and long term. The program has also shown improved parenting styles and academic performance (111).

The program of seven sessions is delivered by a trained facilitator in groups in schools and other community-based settings. Strong Families was first adapted for the cultural norms of Latin America and has been deployed in 17 countries in the Region. It has recently been comprehensively updated and provides guidance and recommendations for planning, implementation, monitoring, and evaluation of this program at the national and local levels (111). In Uruguay, Strong Families has been further adapted and tailored to the country's culture (109).



6. Improve and expand community-based mental health services and care

ACTION POINTS



To urgently expand access to mental health care and reduce the treatment gap in the Region, NAMHA recommends that countries take important actions to further the integration of mental health into primary health care. Services must be respectful of and responsive to the unique needs and preferences of all people, particularly populations living in conditions of vulnerability. Lessons learned from the COVID-19 pandemic highlight the need to harness digital technology to scale up services and to build capacity in mental

health and psychosocial support in the face of new and growing emergencies. This cannot be done without the empowerment of people with lived experience, who must play a central role.

a. Strengthen the integration of mental health into primary health care

Integrating mental health care into primary health care (PHC) is an essential strategy for improving access to mental health and reducing the large mental health treatment gap. As a person's first

point of contact with the health system, primary care personnel are ideally situated to identify and provide support to people struggling with mental health conditions. PHC providers can be trained to assess, manage, and provide follow-up care for priority mental health conditions using tools such as the WHO Mental Health Gap Action Programme Intervention Guide (mhGAP-IG) (112) for priority mental health conditions, referring more complex cases to specialist care when necessary.

While many countries have made progress in integrating mental health into PHC, much work remains to strengthen this integration and ensure its sustainability. Governments can support the operationalization and scaling up of this process by ensuring that policies, plans, and laws incorporate primary care for mental health as part of universal health coverage efforts, and must dedicate greater human and financial resources to advancing it (113). There is also a need to enhance mental health capacity building in PHC. While tools including the mhGAP-IG are often implemented as part of nonspecialized professionals' in-service training, integrating these tools into all pre-service education and training for medical, nursing, social work, and psychology students before they enter their respective service roles can better prepare them early in their careers to assess and manage mental health conditions. It also has the potential to be more cost-effective than in-service training (114).

It is important to note that mental health specialists continue to play a fundamental role in this approach by providing ongoing supportive supervision and clinical mentoring to trained PHC workers, through a variety of different models including as part of collaborative care teams. Additionally, all tools to build the capacity of

primary care providers should be adapted to the local context.

b. Build culturally competent mental health services

Members of marginalized groups can have differing health practices, preferences, and beliefs and are more likely to experience discrimination when accessing mental health care services (19). Providing culturally competent mental care, which seeks to effectively deliver mental health care and services that meet the social, cultural, and linguistic needs of service users, can reduce discrimination, thereby improving care-seeking and service use, as well as the quality of care and treatment outcomes (115). It can also reduce mental health disparities and inequities based on factors such as race, ethnicity, nationality, language, gender, socioeconomic status, physical and mental ability, sexual orientation, and occupation.

Mental health services should strive to meet the unique needs of the communities and people that they serve through the delivery of culturally competent care, at the systems, organizational, and provider levels. Key strategies to improve the cultural competence of services and care include (116):

- The use of interpretation services to address linguistic barriers;
- Recruiting, hiring, retaining, and promoting qualified, diverse staff members;
- Staff training, professional development, and education on cultural awareness, knowledge, and skills;
- Incorporating culturally relevant treatment approaches, materials, and tools;



Mental health services should be implemented taking into consideration people's unique needs and cultural backgrounds.

© PAHO/WHO

- Improving the design and operation of facilities to improve their accessibility;
- Strengthening community outreach and involvement;
- Developing and implementing policies and procedures that support culturally competent service delivery.

To develop culturally competent mental health services, organizations should engage community members, staff, service users and their families, traditional healers and spiritual guides, and other relevant stakeholders in the assessment, planning, implementation, and evaluation phases of the process. Establishing a committee to support and

oversee the strategic planning and implementation can be helpful. As cultural groups are diverse and continuously evolving, it is important to see the development of culturally competent mental health services as a dynamic, ongoing process that builds on previous knowledge and experience (115).

At the provider level, cultural competency requires mental health service providers to practice curiosity, empathy, respect, and humility. In addition to awareness and knowledge of other cultures, they must develop an awareness of their own culture and values, their own assumptions and biases about other cultures, and how these assumptions affect their ability to provide culturally responsive services (116). Providers should collaborate with service users and their families, select culturally

appropriate screening and assessment tools, and integrate cultural factors into treatment planning, including traditional healing practices when appropriate.

c. Harness the potential of digital technology

During the pandemic, many countries scaled up use of digital technologies, such as telemental health services and distribution of mobile health applications, providing opportunities to blend these approaches into routine services. Digital technology has great potential to accelerate the expansion of community-based mental health services. A significant argument for accelerating digital mental health care is reaching sections of the population, such as young people, who were greatly affected by the COVID-19 pandemic but are less likely to consult primary care providers because of embarrassment and stigma. Digital solutions are also highlighted as a way to provide care to people with limited access, such as those living in rural areas. More broadly, technology has the potential to improve the dissemination of public education on mental health and sign-posting to relevant services; provide evidence-based self-care and self-help advice to patients; and enable direct patient care via video or phone.

Governments can support the advancement of digital technologies for mental health by setting national policies and priorities for the digital economy which include mental health; supporting research and development of promising technologies; regulating and complementing market forces to ensure affordable access to the Internet; investing in human and organizational complements and institutional learning across all sectors and divides (including continuous support to healthcare providers on

the use of new mental health technologies); leading public services transformation and governance; and creating state capabilities and institutions to plan, fund, and implement national digital transformation strategies (illustrated in Figure 15) (117). Public-private partnerships can enhance government efforts, especially in building necessary infrastructure.

Although a rapidly increasing number of digital interventions are being developed, it is important to keep in mind that these interventions are not a substitute for functioning health systems or services. Furthermore, digital interventions should meet the same standards of quality and effectiveness as any other health intervention. As with in-person care, digital interventions need to be guided by ethical principles and implemented in line with professional codes of conduct. Key areas include privacy, data protection, safety, and accountability.

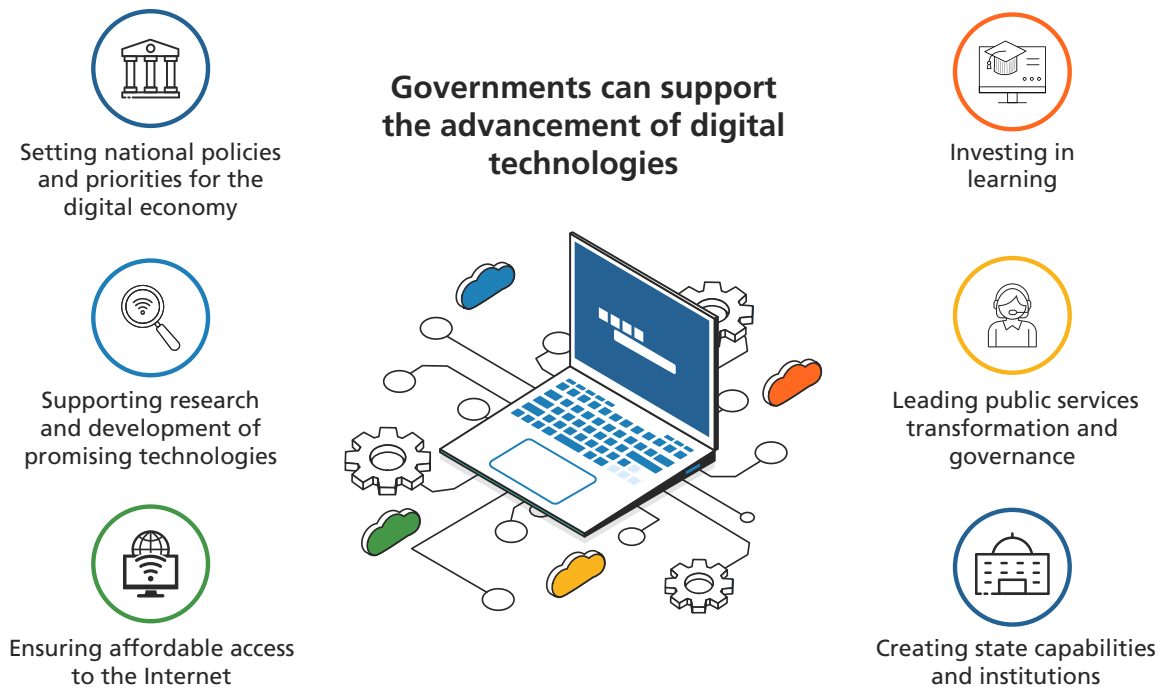
It is essential that all efforts to grow digital technologies for mental health must be underpinned by inclusivity and equity. These technologies must be made accessible and affordable to communities living in conditions of vulnerability. To help bridge the digital divide, the State must work with civil society and community organizations, local government, business associations, universities, and philanthropic organizations (117).

d. Enhance capacity to deliver MHPSS in emergencies

As emphasized in **Recommendation 2**, mental health and psychosocial support is essential to supporting people affected by emergency situations, where overall distress and the incidence of mental health conditions are likely to increase.

FIGURE 15

How governments can support the advancement of digital technologies

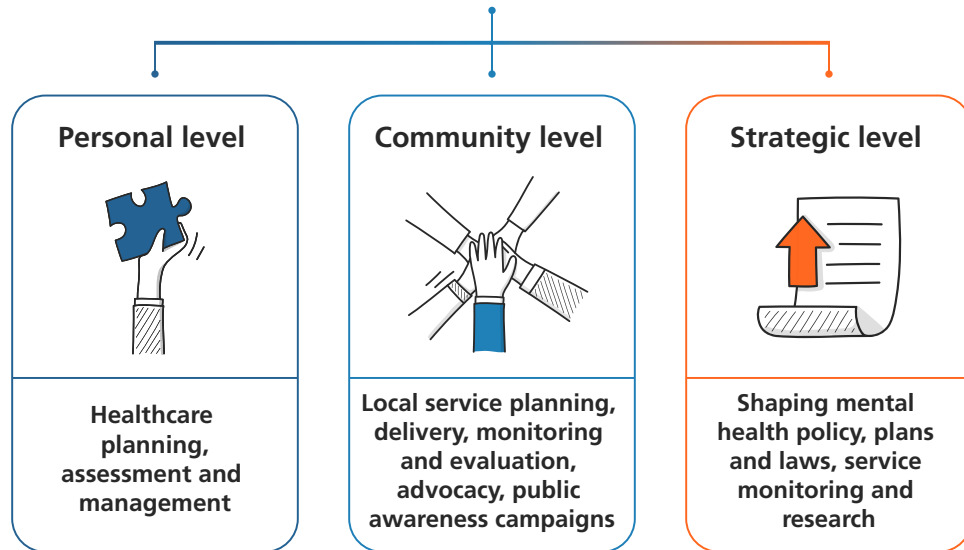


During an emergency, heightened demand for mental health services and care calls for increased capacity to deliver MHPSS. Primary care personnel and other nonspecialized health workers can be trained in the Mental Health Gap Action Programme Humanitarian Intervention Guide (mhGAP-HIG) (118), which was adapted from the mhGAP-IG and includes additional elements specific to humanitarian emergency contexts. The mhGAP-HIG contains additional modules on acute stress, grief, moderate-severe depressive disorder, and post-traumatic stress disorder. Building the capacity of front-line workers, including nurses, ambulance drivers, volunteers, case identifiers, teachers, and other community leaders on essential psychosocial care principles, psychological first aid, and how to make referrals when needed is also recommended in an emergency context.

Additionally, it is essential to ensure the mental well-being of those delivering MHPSS in the context of an emergency. Health and front-line workers are exposed to a variety of stressors in an emergency, such as difficult working conditions, possible fear of exposure to infectious diseases, and witnessing intense suffering and death. Among the biggest stressors reported by these workers is insufficient managerial and organizational support (66). Managers should facilitate healthy working environments for front-line staff and volunteers, address work-related stressors, and ensure access to health care and psychosocial support for staff, which can be achieved by training some staff to provide peer support. Providing front-line and health workers with tools and resources for self-care is also important.

FIGURE 16

How service users and their families can be involved in the health system



e. Empower service users and their families

Central to the design of community-based mental health services is the empowerment of service users and their families. Historically, people with mental health conditions and their families have lacked a voice. They have not been involved in decisionmaking on services, reinforcing their experience of discrimination and exclusion. Empowerment refers to the level of choice, influence, and control that users of mental health services can exercise over events in their lives. The key to empowerment is the removal of formal or informal barriers and the transformation of power relations between individuals, communities, services, and governments (119).

To date, empowerment and greater participation of people with lived experience has been mainly

restricted to those in high-income settings. The involvement can be at different levels within the mental health system (see Figure 16) (86):

- At the personal level: involvement in one’s own healthcare planning, assessment, and management, for example through shared decisionmaking, advanced planning, supported self-management, and person-centered recovery approaches to care.
- At the community level: involvement in local service planning, delivery, monitoring and evaluation, advocacy, public awareness campaigns – especially to reduce stigma – and training for mental health staff and others.
- At the strategic level: participation in shaping mental health policy, plans, and laws, service monitoring, and research.

Case example: Advancing mental health for Indigenous and Afro-descendant people in the Plurinational State of Bolivia, Guatemala, and Honduras

A year-long collaborative PAHO-led initiative, funded by the Public Health Agency of Canada, has strengthened approaches to mental health for Indigenous and Afro-descendant people affected by the COVID-19 pandemic in the Plurinational State of Bolivia, Guatemala, and Honduras. The two interlinked project priorities were to increase access to mental health services and increase demand for the new services.

As a result of the project, the three countries have strengthened national capacities to coordinate, plan, and provide mental health services to Indigenous and Afro-descendant communities that are contextualized to community culture and traditions. Indigenous communities and Afro-descendant populations have been empowered to utilize these new services and were key stakeholders and contributors to the initial situation analyses, project design, implementation, and evaluation.

In the Plurinational State of Bolivia, at a national-level meeting in La Paz, Afro-descendant community leaders outlined the

needs and priorities related to mental health. Their recommendations are shaping a new community-based mental health center that will serve the people of North and South Yungas, where most of the country's Afro-descendant population live (120).

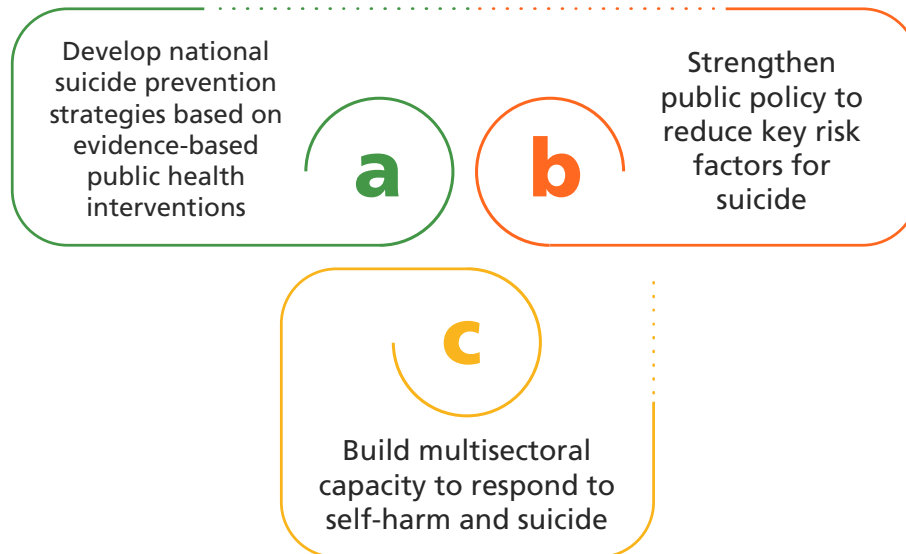
In Guatemala, the project targeted the San Marcos and Quiché departments, which have large populations of Indigenous Maya. Asociación IDEI, a local nongovernmental organization made up of Indigenous community members, acted as the main implementing partner for the project, supporting both the situation analysis and the implementation plan. In collaboration with the Ministry of Health and PAHO, Asociación IDEI also developed a communication strategy to raise awareness of mental health, tackle stigma, and increase use of services (121).

In Honduras, Indigenous community leaders acted as key informants for the situation analysis, and local nongovernmental organizations contributed to the development of the implementation plan and the strategy for capacity building (122).



7. Strengthen suicide prevention

ACTION POINTS



Suicide rates have continued to increase across the Region of the Americas. While the long-term impact of COVID-19 on suicide rates is still unknown, many established risk factors for suicide – financial insecurity, job losses, and trauma and abuse, among others – were significantly worsened by the pandemic, making suicide prevention a critical public policy priority. NAMHA emphasizes the urgent need for governments to take swift action to reduce suicides in their countries and engage all sectors and stakeholders in these efforts.

a. Develop national suicide prevention strategies based on evidence-based public health interventions

Government-led national suicide prevention strategies are critical tools to ensure that suicide

prevention is prioritized on national agendas, that prevention efforts are coordinated and monitored, and dedicated resources allocated. It is important for strategies to set clear objectives that can be translated into implementable action plans with objectives, indicators, targets, timelines, milestones, designated responsibilities, and budget allocations (123). Where there is no national strategy, conducting a situation analysis is an important first step to inform its development. In countries where suicide prevention strategies and plans have already been developed, they should be regularly monitored and evaluated, and revised and updated as appropriate.

Key components of national suicide prevention strategies should include effective interventions such as those outlined in the WHO *LIVE LIFE*

Implementation Guide for Suicide Prevention in Countries (see Figure 17) (124), including limiting access to the means of suicide; fostering social–emotional life skills in adolescents (see **Recommendation 5**); early identification, assessment, management, and follow-up care for anyone demonstrating suicidal behaviors or at risk; and interacting with the media on responsible reporting. Other components to be incorporated include awareness; stigma reduction; training and education; access to services; treatment; crisis intervention; postvention; surveillance; and oversight and coordination (125).

Addressing the many health and non-health factors that can increase suicide risk requires that all suicide prevention strategies promote

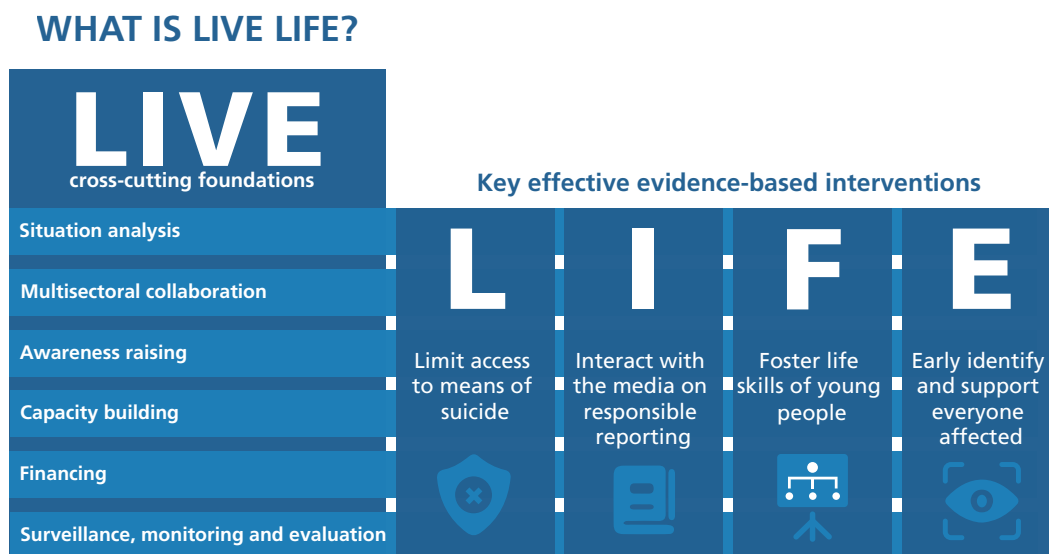
interventions across sectors, and that their development, implementation, and monitoring and evaluation involve multisectoral collaboration. A whole-of-government and whole-of-society approach that incorporates not only the health sector but other key sectors (e.g., education, labor, social welfare, agriculture, justice, law, the media); nongovernmental organizations; academic institutions; civil society; and especially people with lived experiences of suicide (e.g., who have experienced suicidal thoughts, made a suicide attempt, cared for a loved one during a suicidal crisis, or been bereaved by suicide), is vital.

b. Strengthen public policy to reduce key risk factors for suicide

Through public policy, governments can address some of the key risk factors for suicide, especially

FIGURE 17

LIVE LIFE cross-cutting foundations and key effective evidence-based interventions for suicide prevention



Source: Adapted from World Health Organization. LIVE LIFE: An implementation guide for suicide prevention in countries. Geneva: WHO; 2021. Available from: <https://www.who.int/publications/i/item/9789240026629>.

having direct access or proximity to means for suicide as well as harmful alcohol use.

Restricting access to the means of suicide is a universal evidence-based intervention for preventing suicide. The restriction of means, such as firearms, hazardous pesticides, etc., can give those contemplating suicide time to reconsider and/or seek help, as well as time for the acute crisis to pass (125). Means restriction may include (124):

- Limiting, banning, or regulating access to the means for suicide through national legislation and policy (e.g., banning acutely toxic highly hazardous pesticides or restricting and regulating firearms);
- Reducing the availability of the means (e.g., limiting the quantity of sales or size of packages for medications and poisonous substances);
- Reducing the lethality of the means by increasing availability of low-risk alternatives (e.g., reducing the lethality of pesticides); or
- Increasing the availability and effectiveness of antidotes and improving clinical management following acute intoxication or injury related to commonly used means of suicide.

In 2017, the most common category of suicide method in the Americas was hanging, strangulation, suffocation, drowning, and submersion, accounting for 47% of suicide deaths, followed by firearm-related self-harm (32% of deaths) and self-poisoning (13% of deaths) (126). However, significant variations by subregion and country make it essential for

countries to systematically collect and analyze national data to shape and revise policy based on the local context. Additionally, restricting access to means of suicide will require multisectoral collaboration among all relevant stakeholders. In the case of pesticide restriction, for example, this would include ministries of health, agriculture, regulators and registrars, as well as community leaders (125).

Another important risk factor for suicide that can be addressed through public policy is alcohol use. The risk of a suicide attempt is estimated to be around seven times greater soon after drinking alcohol, further increasing to 37 times after heavy use of alcohol (127). In 2018, WHO, in collaboration with international partners, launched the SAFER Initiative, to provide support for countries in reducing the harmful use of alcohol by strengthening the ongoing implementation of the Global Strategy to Reduce the Harmful Use of Alcohol and other WHO and United Nations instruments. The SAFER technical package identifies five key alcohol policy interventions that are based on accumulated evidence of their impact on population health and their cost-effectiveness:

1. Strengthen restrictions on alcohol availability.
2. Advance and enforce drink-driving countermeasures.
3. Facilitate access to screening, brief interventions, and treatment.
4. Enforce bans or comprehensive restrictions on alcohol advertising, sponsorship, and promotion.

5. Raise prices on alcohol through excise taxes and pricing policies.

SAFER can be used by government officials at the national, subnational, municipal, or local levels with responsibility for developing policy and action plans to reduce the harm done by alcohol. Implementing the interventions requires coordination across the many sectors relevant to alcohol control, including health, transportation, law enforcement, and the media. Importantly, the effectiveness of the policies will depend heavily on the degree to which governments are able to enforce them.

c. Build multisectoral capacity to respond to self-harm and suicide

Early intervention and care for people at risk of suicide and those who have made an attempt, are crucial to preventing suicide. As is the case for mental health conditions, the shortage of mental health specialists combined with the stigma that can be associated with specialist services makes delivering interventions for self-harm and suicide in alternative settings, such as primary health care, schools, and in the community, a viable alternative when capacities are strengthened.

Within the health sector, it is important to build the capacity of specific health departments or units likely to come into contact with at-risk individuals, such as those dealing with emergencies, mental health, alcohol use disorders, chronic pain, or chronic diseases (124). Primary care professionals, in particular, may be in a unique position to prevent suicide due to their frequent interactions with people at risk of suicide; studies suggest that nearly half of people who die by suicide will have been seen by a primary care

provider in the month before their death (128). These providers can be trained to identify early, assess, manage, and provide follow-up care to people as well as to refer individuals in need to follow-up support in the community, including social services, or specialist mental health care. The mhGAP-IG (discussed in **Recommendation 6**) includes a module on self-harm and suicide. Postvention support through health services (and in the community) should be available for people who have attempted suicide and those who have been bereaved by suicide.

Other sectors as well as the community can also play a valuable role in responding to people affected by suicide. The capacity of educators, law enforcement officers, and gatekeepers can also be built to identify at-risk individuals in schools, workplaces, and the community; assess and talk about self-harm, including in crises; deliver psychosocial interventions such as psychoeducation and mobilizing sources of social support; refer to specialists; and provide follow-up. It is essential that all capacity-building efforts be accompanied by continued support and supervision, appropriate to the role, in order to build knowledge, skills, and confidence, and to ensure quality delivery of the interventions.


Additionally, the response of the media to self-harm and suicide must be strengthened. Media reporting of suicide, especially high-profile suicides and where suicide methods are described, can contribute to additional suicides due to imitation. It can also reinforce stigma associated with mental health conditions and suicide. Responsible coverage of suicides can contribute to their prevention by reducing the risk of imitative behavior, challenging incorrect perceptions, and

encouraging help-seeking behaviors. Working with the media to promote improved reporting of suicide (see Figure 18), including through the capacity building of media professionals to report responsibly as well as through the implementation of policies for monitoring user content on digital media platforms, is therefore crucial (124). The development or revision and implementation of media policies and guidelines is an important

opportunity for intervention. Additionally, guidance or training for journalists and other members of the media, using tools such as the WHO and International Association for Suicide Prevention resource for media professionals on preventing suicide (129), can build capacity in responsible reporting of suicide. Having a mechanism through which to monitor and assess suicide reporting is key to the process.

FIGURE 18

Best practices for reporting on suicide



1. **Take the opportunity** to educate the public about suicide.
2. **Avoid** language which sensationalizes, normalizes suicide, or presents it as a solution to problems.
3. **Avoid** prominent placement and undue repetition of stories about suicide.
4. **Avoid** explicit description of the method used in a completed or attempted suicide.
5. **Avoid** providing detailed information about the site of a completed or attempted suicide.
6. **Utilize** words in headlines carefully.
7. **Exercise** caution in using photographs or video footage.
8. **Take** particular **care** in reporting celebrity suicides.
9. **Show** due **consideration** for people bereaved by suicide.
10. **Provide** information about where to seek help.
11. **Recognize** that media professionals themselves may be affected by stories about suicide.

Source: Adapted from World Health Organization. Preventing Suicide. A Resource for Media Professionals. Geneva: WHO; 2008. Available from: <https://apps.who.int/iris/handle/10665/43954>.

Case example: Suicide prevention in Trinidad and Tobago

As emphasized in the National Mental Health Policy 2019–2029, the Ministry of Health of Trinidad and Tobago has committed to reducing the lives lost by suicide (130). The work of the Ministry has laid the foundation for sustainable suicide prevention efforts aligned with other key public health initiatives. The National Suicide Prevention Strategy of Trinidad and Tobago was launched in 2019 (131). It is the result of the Ministry of Health, in collaboration with PAHO, leading an intersectoral, multistakeholder process to develop a strategy tailored to the needs of the country.

Although some progress has been made in reducing the suicide rate in Trinidad and Tobago, it remains high at 8.3 deaths per 100 000 population (132). The new National Suicide Prevention Strategy aims to engender a resilient, well-informed society where every human life is valued and it is rare for anyone to attempt suicide. The strategy is being implemented in two 5-year phases; the target of the current phase is a reduction in the national suicide rate by 10% in five years.

The key action areas for the first five years are: governance and coordination, health systems response, promotion and prevention, and surveillance. Work currently under way focuses

on constructing a robust surveillance system for a data-driven strategy (see Case example for Recommendation 10), building health systems capacity to respond to suicide attempts, and increasing public awareness of protective factors.

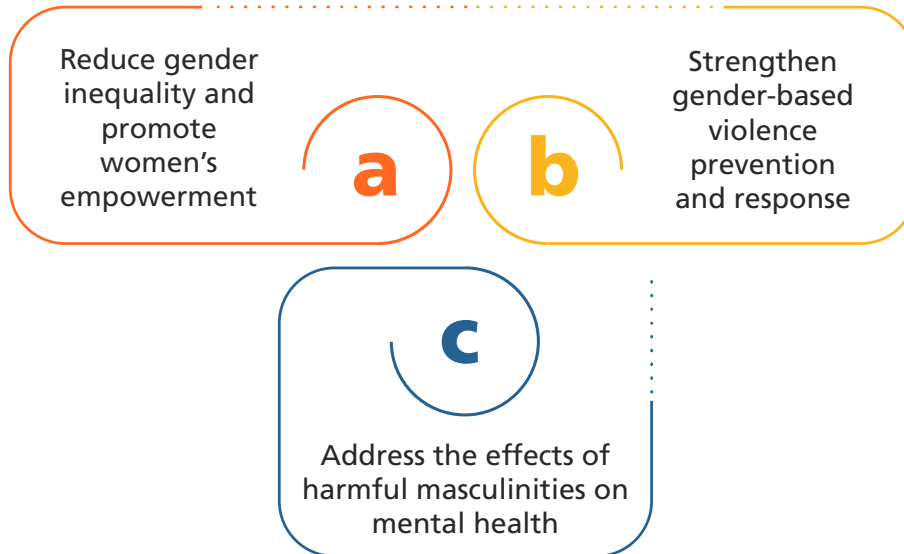
Several ongoing national efforts are supporting the strategy implementation. These include:

- Cabinet approval of a National Mental Health Committee and the establishment of Mental Health Unit at the Ministry of Health;
- National Media Guidelines for Responsible Reporting on Suicide (133);
- A national mental health awareness campaign “Paint De Town Green”;
- The availability of a confidential 24-hour helpline provided by the nongovernmental organization Lifeline;
- A Suicide Prevention Policy at the National Psychiatric Hospital, inclusion of suicide indicators in the National Health Surveillance, and roll-out of the mhGAP training for primary care professionals.



8. Adopt a gender transformative approach to mental health

ACTION POINTS



Addressing the profound gender inequalities that influence mental health in the Region will necessitate going beyond traditional approaches which have reinforced, ignored, or accommodated gender inequalities. Instead, NAMHA urges countries to implement gender transformative approaches, which actively strive to change harmful gender norms and imbalances of power to improve mental health for all. This cannot be achieved without the commitment of government leaders to challenge gender inequalities and take an unequivocal stand against violence and discrimination against all women and men in all their diversity and gender-diverse persons.

a. Reduce gender inequality and promote women's empowerment

Discriminatory policies, practices, and institutions in the Region continue to perpetuate social and economic inequalities for women in the Americas. Working to achieve gender equality and empowering women is essential to promoting women's mental health and well-being and preventing the development of mental health conditions. Addressing gender inequalities requires strengthening public policies that guarantee and promote the rights of women in all their diversity across all spheres of society, including in the home, in government, and in public spaces such as the workplace, schools, and in the community. However, it also calls for a cultural shift which



Promoting gender equality and empowering women is essential for preventing mental health conditions and promoting their well-being.

© PAHO/WHO

changes social norms and societal attitudes. Some key actions for governments to take include, but are not limited to (illustrated in Figure 19) (134):

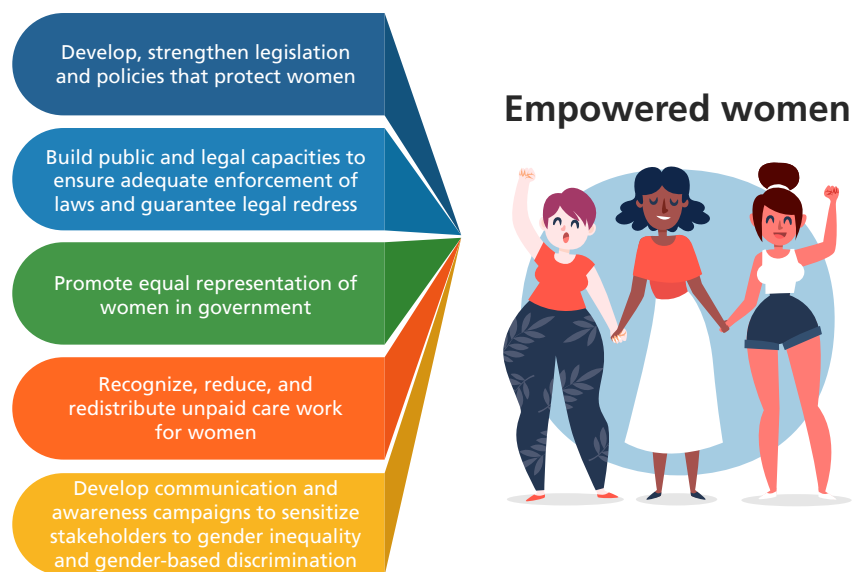
- Develop and strengthen legislation and policies that prohibit all forms of discrimination and violence against women in public and private spheres; protect women's workplace rights; set the minimum legal age for marriage at 18 years; guarantee women's sexual and reproductive rights; ensure women's rights to equality in marriage; and recognize their land and property rights, among others.
- Build public and legal capacities to ensure adequate enforcement of laws and investigations and guarantee legal redress to women who have been victims of violence and discrimination.

- Promote equal representation of women in government.
- Recognize, reduce, and redistribute unpaid care work for women through social protection programs and investment in time-saving technology and infrastructure (135).
- Develop communication and awareness campaigns to sensitize stakeholders to gender inequality and gender-based discrimination, violence, and to inform women about their integral health rights and opportunities.

A special focus must be given to marginalized women, including women who are migrants; women who are Indigenous, of African descent, or belong to other ethnic groups; and women

FIGURE 19

Key actions for governments to reduce gender inequality and promote women's empowerment



living in poverty or rural areas who are at the intersection of multiple, cumulated forms of discrimination (134).

b. Strengthen gender-based violence prevention and response

Gender-based violence (GBV) refers to harmful acts directed at an individual or a group of individuals based on their gender. All forms of violence against women and girls are gender-based, but gender-based violence goes further to include other forms of violence, including but not limited to violence targeting men and boys, including certain types of gang and armed violence, and LGBTQ+ persons. The mental health impacts of GBV, not only on those directly affected but on their loved ones and communities, are significant and enduring. Addressing GBV through a dual

approach that includes strengthening prevention and response is essential. Interventions should be implemented simultaneously across different levels. All sectors and the wider community have an important role to play (136).

GBV prevention (illustrated in Figure 20) must include the adoption and strengthening of legislation that prohibits violent behavior, holds perpetrators of violence accountable, and addresses major risk factors of violence, for example access to firearms and other weapons (137, 138). It is also critical to improve the enforcement of these laws, including through sanctions that challenge the impunity of violence, and supportive policy frameworks that bring different sectors and stakeholders together. For example, PAHO's regional *Strategy and Plan of Action on*

FIGURE 20

Approaches towards gender-based violence prevention



Strengthening the Health System to Address Violence against Women (139) specifically points to the development of national multisectoral policies on the prevention of violence against women and girls as well as the inclusion of violence against women and girls in national health policy.

Prevention efforts must also address gender and social inequalities, which permeate systems and institutions as well as the larger community (137, 138). Policies and guidelines can prohibit gender discrimination and promote the empowerment of women and girls in all their diversity across settings. This includes strengthening access to education and training for

all, as well as ensuring access to safe work and safe environments. Addressing gender biases and discrimination and improving gender sensitivity and cultural competency among the entire workforce are important at the organizational level. Community interventions that address social norms regarding the acceptability of violence can take the form of community mobilizing, workshops and training, and social marketing. To be successful, they should engage the entire community, including women and men in all their diversity and gender-diverse persons, although some approaches will engage these groups separately. Within the health sector, GBV prevention messages can be incorporated into standard health education and health promotion activities (140).



Community interventions that address social norms regarding the acceptability of violence can take the form of community mobilizing, workshops and training.

© PAHO/WHO, Sandra Mallo

Effectively responding to GBV should focus on building multisectoral capacity in helping to identify abuse early, providing survivors with care and support, referring those affected to appropriate and informed services, both within and outside the health system, and providing follow-up (139). Primary healthcare personnel are in a unique position to identify at-risk groups early and provide them with emphatic, nonjudgmental first-line support. When health services coordinate well with other essential services, including in the protection, justice, social, and education sectors, survivors can be provided with needed care and support in a timely manner, thus reducing the chance of retraumatization or revictimization (141). Within the health sector specifically, health system protocols and guidelines for GBV should be developed and strengthened in line with the evidence base and

implemented through clinical tools and health worker in-service and pre-service training (142).

c. Address the effects of harmful masculinities on mental health

The culture of patriarchy, which is part of the organizational and cultural structure of the Americas, has predominantly favored the socialization of men based on harmful masculinities. This situation has generated aggressive and discriminatory behaviors that deepen inequalities and promote and reinforce a masculine culture of lack of care, risk-taking, and reduced help-seeking behaviors (143).

In this way, men in the Region face risks of adverse mental health conditions, including suicide, alcohol use disorder and other addictions,



The impact of patriarchy on men's mental health has not received due attention from the Region's health services, which requires consideration of their vulnerabilities and effects.

© PAHO/WHO, Karen González

and psychosomatic illnesses. Behaviors rooted in socially constructed masculinities can also expose women to risk factors for mental health conditions including violence, substance abuse, sexually transmitted infections, unwanted pregnancies, absent father figures, and a lack of shared responsibility in housework and care (143).

The impact of patriarchy on men's mental health has not received due attention from the Region's health services, which requires consideration of their vulnerabilities and effects. Mental health laws, policies, and programs must incorporate an approach that recognizes harmful masculinities in order to improve the comprehensive well-being of men and societies in general.

Addressing gender norms such as masculinities necessitates the engagement of all, including men and boys. Childhood and adolescence provide an opportunity through which to influence socialization norms and shape gender

equality. Examples include health promotion and prevention programs for children and youth which incorporate an emphasis on nonviolence, gender equality, parenting, a comprehensive view of sexuality, and shared responsibility for care, and the integration of these topics into social and emotional learning programs in schools (143). Engaging boys and young men in familiar, safe, digital, school, or sport group-based settings can harness positive aspects of masculine socialization including friendship and connection through sport (144). It is important that this engagement avoids shaming and labeling.

Other opportunities to address masculinities include intersectoral public education efforts which discuss gender equality and new masculinities, as well as strengthening the capacity of health services, teachers, academia, and the media. In the case of health workers, this must be incorporated into pre-service education and training curricula.

Case example: Responding to gender-based violence among migrant women in Colombia

The health sector has a key role to play in preventing or mitigating the impact of violence against women. Health personnel who develop competencies to build trust are the ones who provide accompaniment and care to survivors of violence. Health professionals who have been trained in following evidence-based protocols, including mental health care, are key to early intervention and support (140).

Since 2015, more than 6 million migrants have left the Bolivarian Republic of Venezuela because of the political, human rights, and socio-economic situation. Migration exposes women and girls to the risk of trafficking, gender-based violence, and other forms of exploitation and abuse. The COVID-19 pandemic exacerbated the situation – border closures forced migrants to use more dangerous irregular routes and informal border crossings (145).

As part of the multilateral response, PAHO has been working in border areas and departments with a high concentration of refugees and migrants. This includes work in collaboration with four countries in the Region with significant migrant populations: Argentina, Brazil, Colombia, and Peru. The project is strengthening the health sector's capacity to prevent and respond to violence against migrant and refugee women and girls (146).

In Colombia, more than 400 healthcare providers have been trained by the program. They are based at health facilities located in areas with large levels of migrants and refugees and where the risk of gender-based violence and other threats such as trafficking are known to be high. The training enables healthcare professionals to recognize their role not only in front-line care but also in challenging the stereotypes and discrimination associated with gender-based violence (147).



9. Address racism and racial discrimination as a key determinant of mental health

ACTION POINTS

Work with Indigenous peoples, people of African descent, and other ethnic groups to understand and address racism and racial discrimination in all its forms and expressions

a

Develop national action plans against racism and racial discrimination

b

Strengthen legislation and policy to combat racism and promote equity

c

Implement multi-level interventions to create anti-racist environments

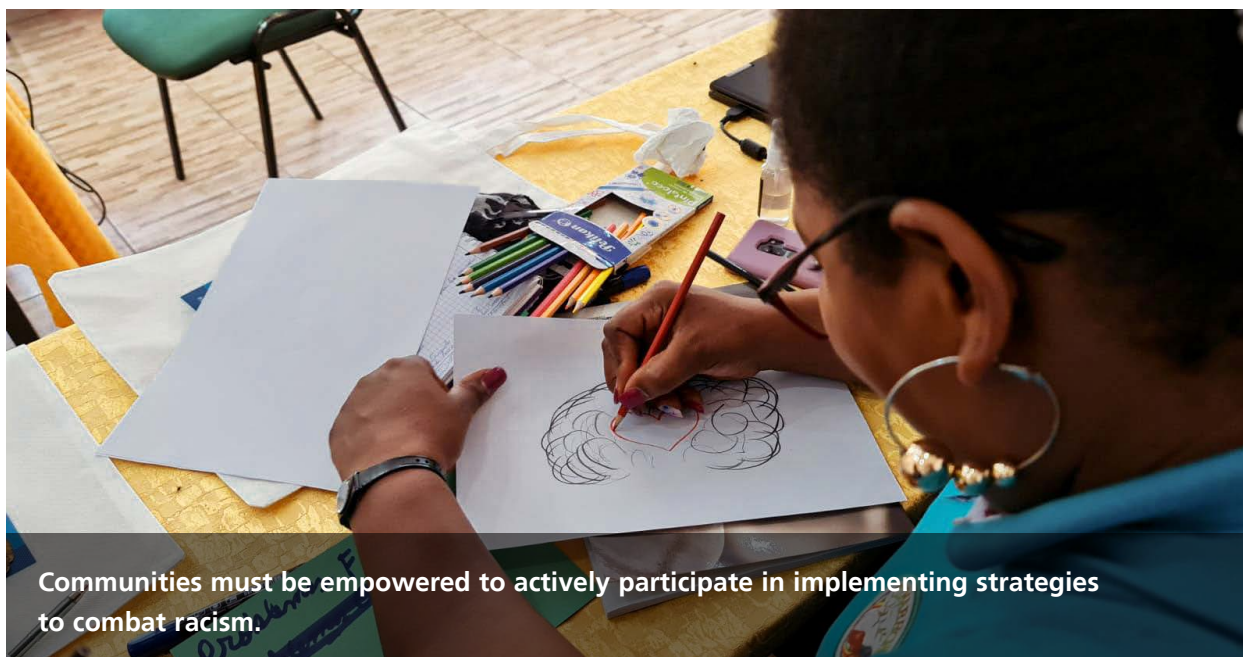
d

Racism in all its forms, including racist ideologies, prejudiced attitudes, discriminatory behavior, structural arrangements and institutionalized practices resulting in racial inequality (148), whether intentional or unintentional, is a violation of human dignity and rights, and unjustifiable. Governments have a legal obligation, under international human rights law, as well as a moral responsibility, to combat racism and racial discrimination. NAMHA urges countries in the Region to take a resolute stand against all racism to promote and protect the mental health and well-being of Indigenous peoples, people of African descent, and other ethnic groups. The road to recovery from the pandemic must address and reverse decades of exclusion and build systems and

institutions that work for all people while leaving no one behind.

a. Work with Indigenous peoples, people of African descent, and other ethnic groups to understand and address racism and racial discrimination in all its forms and expressions

Communities experiencing racism must be empowered to actively participate in setting priorities, making decisions, planning, implementing, and evaluating strategies to combat racism. Cultivating strategic partnerships and intercultural dialogues is essential to understanding and defining the problem, developing solutions, prioritizing actions, and improving policies and



Communities must be empowered to actively participate in implementing strategies to combat racism.

© PAHO/WHO

programs in practice. It is also a core principle of a human rights approach. In addition to fostering inclusion, effective participation, shared commitment, and joint action, engaging communities affected by racism can improve members' self-efficacy and perceived social support outcomes as well as reduce non-health inequalities through human and social capital gains (19).

The continued collection of information on lived experiences and history is essential for recognizing shared narratives, as a means to memorialize not only the suffering but also the resilience and dignity of victims through vigorous and respectful dialogues that provide everyone with the space needed to express themselves freely in a secure environment. Establishing the truth about the causes and impact of systemic racism and historical legacies is crucial for building support among policymakers and the public at large for reparations and transforming the discourse.

Dialogue should be grounded in equity and mutual respect, recognizing that these groups may experience deeply rooted fear and mistrust caused by a history of racism (149). It is important to respect the organizational structures of Indigenous peoples, people of African descent, and other ethnic communities and to take into account linguistic, geographic, financial, gender, and other barriers to participation that may be faced by populations experiencing different forms of discrimination. It should also be ensured that both women and men from these communities are represented.

b. Develop national action plans against racism and racial discrimination

A national action plan against racism and racial discrimination constitutes a comprehensive program of activities aimed at progressively bringing about improvements in the promotion of racial equality and can provide the basis for the

Primera Ayuda Psicológica

Caso 1

Prineipios:

1. Observar

- Heridas tanto de la nariz San grande y otros daños físicos
- Estado de crisis

2. Escuchar

Las Necesidades de la mujer

3. Conectar

- Detener la Hemorragia que lleva
- Limpiar dar cuidados de enfermería y tx.
- Conectar con Padres, líderes Comunitarios
- Referir al hospital de Nebaj por ser una agresión física
- Referir a Psicóloga del distrito

development of comprehensive public policy. The United Nations World Conference against Racism, the Durban Review Conference, the Committee on the Elimination of Racial Discrimination, and the Human Rights Council have all recommended that States adopt national action plans against racial discrimination (150).

While national action plans should be adapted to the political, cultural, historical, and legal circumstances of the countries where they are developed and implemented, key components of a plan include: the establishment of a national body or institution for racial equality; steps to adopt and revise legislation to prohibit racism and racial discrimination; the adoption of policies, plans, and strategies to protect and promote the rights of groups facing racism and racial discrimination; the adoption of special

measures to promote equal opportunity and overcome structural and systematic barriers faced by these populations (e.g., affirmative action or employment quotas); mechanisms to ensure justice, remedies, and accountability for victims of racial discrimination; and measures to raise public awareness about racial discrimination and provide education aimed at combating it (illustrated in Figure 21) (150).

Plans should set specific goals, objectives, and actions, as well as identify the responsible State bodies, target dates, performance indicators, and monitoring and evaluation mechanisms for each objective. Furthermore, there must be the appropriate allocation of human and financial resources to ensure the effective implementation of these plans. Countries have a responsibility to prevent racism and racial discrimination both by

FIGURE 21

Key components of a plan against racial discrimination



The establishment of a national body or institution for racial equality
Steps to adopt and revise legislation to prohibit racial discrimination
The adoption of policies, plans, and strategies to protect and promote the rights of groups facing racial discrimination
The adoption of special measures to promote equal opportunity and overcome structural disadvantages faced by specific groups
Mechanisms to ensure justice, remedies, and accountability for victims of racial discrimination
Measures to raise public awareness about racial discrimination and provide education aimed at combating it

State and non-State actors, making it important that plans apply to both the private sphere and the public sector.

As touched on in the previous action point, communities that experience racism must play a central role in the development, implementation, and evaluation of national action plans against racial discrimination.

c. Strengthen legislation and policy to combat racism and promote equity

While laws alone are insufficient to address racism, comprehensive national legislation that prevents, eliminates, prohibits, and punishes all acts and manifestations of racism and racial discrimination is crucial to combating it and to promoting racial equity and justice. Importantly, in addition to the laws themselves, enacting laws that prohibit racial discrimination can send a powerful message to society that racism is unacceptable and will not be tolerated.

Strengthening this type of legislation can take two forms: establishing legislation against racism and racial discrimination where it does not already exist or is incomplete; and revising existing

legislation to amend, rescind, or nullify laws that create or perpetuate racism. Legislation should meet international human rights standards and cover all four categories of law: constitutional (national constitutions should enshrine the principle of equal treatment, the commitment of the State to promote equality, as well as the right of individuals to be free from discrimination on grounds such as race, color, or ethnic origin), criminal (e.g., laws penalizing racially motivated violence and hatred, including hate speech), civil, and administrative (151). Specific laws can be focused on antidiscrimination or equality legislation that includes a duty for all public authorities to promote respect for diversity and equality and thus eradicate all forms of racism and discrimination.

Strong accountability mechanisms must be in place to effectively enforce anti-racism legislation. These mechanisms should be credible, independent, impartial, and transparent, and receive adequate financial and human resources to function. In order to be sustainable, they must be nationally owned (152). Punishment of those in violation of the law, without impunity, as well as assistance and protection to victims, is key to accountability and to restoring public confidence and trust (153).



Comprehensive national legislation that prevents, eliminates, and punishes all acts and manifestations of racism and racial discrimination is crucial to promoting racial equity and justice.

© PAHO/WHO

d. Implement multi-level interventions to create anti-racist environments

Racism is embedded in the laws, policies, practices, and attitudes of public institutions including government schools, hospitals, clinics, health centers, police stations, and other government offices. Transforming these spaces into anti-racist environments calls for a multi-level approach with interventions delivered at a variety of levels including systemic, organizational, interpersonal, and individual levels simultaneously, over an extended period of time (154). These include but are not limited to (154):

Systems level:

- Ensure equity-oriented budgeting approaches.
- Develop policies, codes of conduct, guidelines for and enforcement of antidiscrimination measures, including functional grievance redress mechanisms.
- Create transparent accountability mechanisms.
- Introduce and/or strengthen curricula of medical schools, educational institutions, and in-service training on the topics of intercultural health, discrimination-related health inequities, racism and exclusion, and the role of public institutions in exacerbating and alleviating these inequities.

Organizational level:

- Recruit, retain, and promote Indigenous peoples, people of African descent, and members of other ethnic groups at all levels in the workforce, ensuring leadership positions.
- Build supports for staff that are Indigenous, people of African descent, and members of other ethnic groups.
- Educate employees on anti-racism through several venues, grand rounds, newsletters,

public relations campaigns, ongoing curricula, workshops, and provide ongoing orientation for new workers.

- Collect data to identify racial disparities and their sources.

Interpersonal level:

- Provide workshops focusing on privilege, anti-racism, antidiscrimination, and cultural competency.

Individual level:

- Deliver training on providing culturally competent care (addressing concepts related to racism, unconscious or implicit bias, stereotype, prejudice).

Clearly defining the problem(s) and setting clear goals and objectives can greatly facilitate the process, along with establishing and incorporating shared anti-racism language. It is important that training go beyond diversity to address anti-racism and that it be mandatory and ongoing and regular at all levels of the organization, including management.

Anti-racism interventions will need to be tailored to the communities being served, which necessitates integrating the voices and experiences of staff and communities that are Indigenous, of African descent, and other ethnic groups. It is important for organizations to develop ongoing, meaningful partnerships with these communities and include them in developing interventions to ensure that they are culturally appropriate and address priority issues for the community. Additionally, memorialization, education, and awareness-raising in the community are catalysts for change and for debunking false narratives that have permitted a succession of racially discriminatory policies and systems to persist.

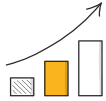
Case example: Redressing racism against Afro-Brazilians and Indigenous people through affirmative action in higher education

Afro-Brazilians make up more than half of the population of Brazil; however, they continue to face structural, institutional, and interpersonal racism, historically rooted in enslavement and colonialism (155). They experience a higher rate of unemployment and earned average wages below those of Whites in similar positions, and there has historically been a sizeable education gap (156).

In recent years, Brazil has established important legislation to improve educational opportunities for Afro-Brazilians. In 2012, the country passed Law No. 12711/12, known as the Quotas Law, which aims to promote equity in access to higher education by reserving vacancies for people who self-identify as Black, Multiracial, and Indigenous. The Law, which standardized quotas in all 59 of Brazil's federal universities, reserves 50% of vacancies at federal universities for Black, Multiracial, and Indigenous students who have completed secondary education in public schools. Additionally, 50% of these vacancies must be reserved for students from households with income equal to or less than 1.5 minimum wage per capita. The reservation of vacancies must also observe the proportion of Black, Multiracial, and Indigenous people in the population of the federative unit where the institution is located (157).

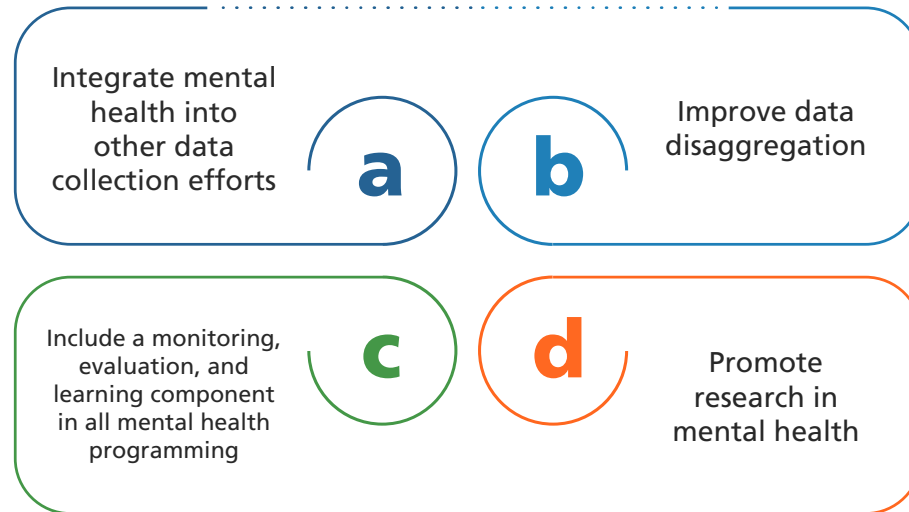
Compared to the period prior to the implementation of quotas, the number of self-declared Black, Multiracial, and Indigenous students in federal higher education institutions has grown. In 2020, 36.19% of students at these institutions declared themselves to be Multiracial, 10.68% Black, and 0.77% Indigenous. While in 2012, 15.02% declared themselves as Multiracial, 5.93% Black, and 0.22% Indigenous (158). Despite the success of Law No. 12711/12, it faces challenges. These include the continued existence of prejudice and discrimination against quota students, both by other students and teachers; a lack of student assistance resources and services for these students; and the continued concentration of low-income students in careers that generate lower remuneration (158).

Given that education and discrimination are important social determinants of mental health, it is expected that initiatives like this, if well documented, could bring important improvements in mental health outcomes for people of African descent and Indigenous people in the Region in parallel to many other social and health outcomes.



10. Improve mental health data and research

ACTION POINTS



Quality mental health data and research are needed by policymakers and program managers to make sound decisions based on need and informed by evidence and best practice. The COVID-19 pandemic highlighted major weaknesses in mental health data collection and reporting in the Region. As we build back from the pandemic, countries must strengthen mental health data and research and ensure that it is grounded in a human rights approach.

a. Integrate mental health into other data collection efforts

An efficient approach to mental health data collection is to integrate mental health into other health and non-health data collection efforts at the national, municipal, and local levels. Within health, mental health measures can be included in public health surveillance surveys or surveys of healthcare facilities, with one important opportunity to bring the integration of a minimum

set of mental health indicators into health information systems. Mental health can also be incorporated into non-health population surveys, such as censuses or household surveys, especially where data are being collected on the known social determinants of mental health.

Collecting data on mental health in surveys of non-health public services is especially relevant to policy and planning. Examples include surveys conducted to inform social protection systems and data collection in non-health sectors, such as routine evaluations of schools and prison services. Such data collection is important for the development of the type of multisectoral programming discussed in **Recommendation 2**. Although the national health information system would be the central repository, cross-ministerial ownership and responsibility for use in planning and monitoring will be essential. For example, the disaggregated



Collecting data on mental health in surveys of non-health public services is especially relevant to policy and planning.

© PAHO/WHO

data on school-aged children would be a joint resource informing and tracking the co-owned policy of the health and education ministries.

b. Improve data disaggregation

Ensuring that mental health data are disaggregated by a set of variables relevant to the local context is essential. Disaggregated data can contribute to a more accurate mental health situation analysis; help to identify patterns, problems, and needs; inform financing structures and plans for resource targeting; and support project monitoring and evaluation.

The PAHO Policy for Improving Mental Health emphasizes that policies to reduce mental health disparities and promote equity require data disaggregated by gender (this should use a nonbinary approach), sex, age, education, income/economic status and related measures (e.g., housing status, food security), race or ethnic

group, national origin, geographic location, disability status, sexual orientation, and other social, economic, and environmental determinants of health, where possible. Data that account for geographic mobility and migration are also needed.

Data disaggregated by a minimum set of variables are especially important for identifying populations in vulnerable conditions that are most likely to be left behind, as well as the factors keeping them in or moving them out of that position. These data can then support the development of nuanced policy to address their particular needs and promote increased resource allocation to these populations. Importantly, the availability and reporting of data on people living in vulnerable conditions makes these populations and the inequities they experience, which are often hidden, more visible to the general population and to political decisionmakers.

c. Include a monitoring, evaluation, and learning component in all mental health programming

Monitoring, evaluation, and learning (MEL) are an essential tool to measure progress, assess performance, and inform continuous improvement, which should be explicitly built into all mental health policies, plans, and services. On a larger scale, having strong and sustainable monitoring and evaluation systems in place can assist mental health policymakers and program managers to make well-informed decisions at the national and local levels that improve mental health services and care. To be successful, monitoring and evaluation systems require: engagement at the highest level of government; incentives that promote the use and generation of performance information; capacity to sustain the efforts of monitoring and evaluation; and access to good data and indicators (159).

While countries can develop their own monitoring and evaluation frameworks to monitor and evaluate mental health policies, plans, and programs, some tools exist to support them. The WHO Mental Health Policy and Service Guidance Package includes a module on Monitoring and Evaluating Mental Health Policies and Plans, which includes a checklist for evaluating a mental health plan (160). Additionally, the mhGAP Operations manual includes a framework for monitoring and evaluation of mhGAP operations, as well as indicators and means of verification (161). To support monitoring and evaluation of MHPSS programs in emergency settings, the Inter-Agency Standing Committee has developed a common Monitoring and Evaluation Framework (162).

d. Promote research in mental health

Beyond data collection, new research in mental health at the national and local levels is essential

to expanding the evidence base for mental health, improving the efficacy and effectiveness of interventions, and informing policy. This is especially important in low- and middle-income settings, which are often underrepresented in global mental health research. Some priority areas include the social determinants of mental health and their mechanisms, mental health financing (including cost-effectiveness and return on investment studies), and implementation science, although it will be important for countries to define their own research priorities based on local context.

Countries should ensure technical capacity-building and financial support for mental health research. The WHO Mental Health Action Plan 2013–2030 notes the need to improve research capacity and academic collaboration on national priorities for research in mental health, particularly operational research with direct relevance to service development and implementation and the exercise of human rights by persons with mental disorders, including the establishment of centers of excellence with clear standards, with the inputs of all relevant stakeholders including persons with mental health conditions and psychosocial disabilities.

Two movements in mental health research are proving especially promising. First is the recognition that a research community largely drawn from populations that are not marginalized is unlikely to identify the priority research questions relevant to the lives of those who are marginalized (163). This has led, for example, to initiatives to actively support racial and ethnic diversification in mental health researchers (164). Second, research on health services overall is emphasizing the need for full community participation in research design.

Case example: Toward quality self-harm surveillance in Guyana, Suriname, and Trinidad and Tobago

A prior suicide attempt is the single most important risk factor for suicide. Monitoring suicide attempts provides important information for development and evaluation of suicide prevention strategies. The registration of suicide attempts, and self-harm in particular, can add valuable information to guide the design of suicide prevention strategies (165).

Guyana, Suriname, and Trinidad and Tobago are partnering to develop a multi-country self-harm surveillance system. This initiative has grown out of a technical support and training program led by PAHO and the National Suicide Research Foundation (NSRF) in the Republic of Ireland, a WHO Collaborating Centre for Surveillance and Research in Suicide Prevention (166). Pilot regions were identified in each of the countries, and the program reviewed the existing self-harm surveillance approaches in general hospital settings. Training and workshops during 2021–2022 showed there was scope to combine efforts to create a multi-country system.

In 2022, standard operating procedures for monitoring self-harm were agreed upon,

allowing comparison of data among the three pilot countries. In accordance with WHO guidance, this included a common definition of self-harm and associated inclusion/exclusion criteria and agreement on the mandatory and optional data to be recorded (165). The three countries will ensure adherence to all requirements in terms of ethical approval, confidentiality, and data protection. Formal agreements are being drawn up with the participating general hospitals in the pilot areas to facilitate data access.

A major focus of the program has been the development of human resources. Staff involved in data collection have been trained during 2021–2022. Each pilot region has a dedicated data manager who is responsible for data management, analysis, and reporting, and the surveillance teams also have access to statistical support. Within the surveillance teams, staff have been allocated to assist in the preparation of communication materials such as monitoring reports; briefings for governments, policymakers, and stakeholders; and papers for peer-reviewed scholarly journals.



Conclusion

Humanitarian emergencies, in spite of the tragedy they produce, can also create the possibility of catalyzing change. The COVID-19 pandemic has shown the Region of the Americas the high cost of failing to prioritize mental health. But it has also presented us with an important opportunity to build back better mental health systems and care, aligned with our long-held vision of a Region where all people have access to quality mental health care, regardless of national or ethnic origin, color, gender, language, religion, or any other status. The choice is ours to seize this opportunity or let it pass.

The guidance of the PAHO High-Level Commission on Mental Health and COVID-19, presented in this report, gives countries a road map by which they

can not only scale up their mental health programs but transform them, in the context of the current pandemic and beyond. The 10 recommendations outlined by the Commission build on what we already know is needed to bring about mental health reform, while advocating for innovative approaches that emphasize action at the highest levels of government and confront the root causes of inequities in mental health in the Region.

Implementing these recommendations will require leaders and decisionmakers across the Americas to recognize the urgency of the current mental health crisis and unequivocally commit to prioritizing mental health like never before. Together we can reshape mental health in our Region, but we must act now.

References

1. Pan American Health Organization. COVID-19 - PAHO/WHO Response, Report 1 Washington, DC: PAHO; 2020 March [cited 31 March 2020]. Available from: <https://www.paho.org/en/documents/covid-19-pahowho-response-report-1-31-march-2020>.
2. World Health Organization. Weekly epidemiological update on COVID-19 - 22 February 2023. Geneva: WHO; 2023 February [cited 31 March 2023]. Available from: <https://www.who.int/publications/m/item/weekly-epidemiological-update-on-covid-19---22-february-2023>.
3. Tausch A, E Souza RO, Viciano CM, Cayetano C, Barbosa J, Hennis AJ. Strengthening mental health responses to COVID-19 in the Americas: A health policy analysis and recommendations. *Lancet Reg Health Am*. 2022;5(100118):100118. Available from: <https://doi.org/10.1016/j.lana.2021.100118>.
4. World Health Organization. Mental health. Geneva: WHO; 2022 [cited 22 March 2023]. Available from: <https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response>.
5. World Health Organization. Depression. Geneva: WHO; 2021 [cited 22 March 2023]. Available from: <https://www.who.int/news-room/fact-sheets/detail/depression>.
6. World Health Organization. Comprehensive Mental Health Action Plan 2013-2030. Geneva: WHO; 2021 [accessed 2 January 2023]. Available from: <https://www.who.int/publications/i/item/9789240031029>.
7. Fiorillo A, Sartorius N. Mortality gap and physical comorbidity of people with severe mental disorders: the public health scandal. *Ann Gen Psychiatry*. 2021;20(1):52. Available from: <https://doi.org/10.1186/s12991-021-00374-y>.
8. World Health Organization. Suicide worldwide in 2019. Geneva: WHO; 2021 [cited 22 March 2023]. Available from: <https://www.who.int/publications/i/item/9789240026643>.
9. Harvard School of Public Health and World Economic Forum. The Global Economic Burden of Non-communicable Diseases. Geneva: WEF; 2011 Sep [cited 22 March 2023]. Available from: https://www3.weforum.org/docs/WEF_Harvard_HE_GlobalEconomicBurdenNonCommunicableDiseases_2011.pdf.
10. World Health Organization. Mental health at work. Geneva: WHO; 2022 [cited 22 March 2023]. Available from: <https://www.who.int/news-room/fact-sheets/detail/mental-health-at-work>.
11. Chisholm D, Sweeny K, Sheehan P, Rasmussen B, Smit F, Cuijpers P, et al. Scaling-up treatment of depression and anxiety: a global return on investment analysis. *Lancet Psychiatry*. 2016;3(5):415-424. Available from: [https://doi.org/10.1016/s2215-0366\(16\)30024-4](https://doi.org/10.1016/s2215-0366(16)30024-4).
12. Pan American Health Organization. Prevención y control de las enfermedades no transmisibles y los trastornos mentales: El caso a favor de la inversión. Washington, DC: PAHO; 2021 [cited 22 March 2023]. Available from: https://iris.paho.org/bitstream/handle/10665.2/54306/OPSNMHRF210010_spa.pdf.
13. Pan American Health Organization. Care for mental health conditions in Jamaica: The case for investment. Evaluating the return on investment of scaling up treatment for depression, anxiety, and psychosis. Washington, DC: PAHO; 2019 [cited 22 March 2023]. Available from: <https://iris.paho.org/handle/10665.2/51834>.
14. Pan American Health Organization. Leading causes of death, and disability. Washington, DC: PAHO; 2021 [cited 21 March 2023]. Available from: <https://www.paho.org/en/enlace/leading-causes-death-and-disability>.

15. Pan American Health Organization. The burden of mental disorders in the Region of the Americas, 2018. Washington, DC: PAHO; 2018 [cited 22 March 2023]. Available from: <https://iris.paho.org/handle/10665.2/49578>.
16. Pan American Health Organization. Alcohol. Washington, DC: PAHO; 2023 [cited 21 March 2023]. Available from: <https://www.paho.org/en/topics/alcohol>.
17. Kohn R, Ali AA, Puac-Polanco V, Figueroa C, López-Soto V, Morgan K, et al. Mental health in the Americas: an overview of the treatment gap. *Rev Panam Salud Publica*. 2018;42:e165. Available from: <https://doi.org/10.26633/RPSP.2018.165>.
18. World Health Organization. Mental health atlas 2020. Geneva: WHO; 2021 [cited 2 January 2023]. Available from: <https://apps.who.int/iris/handle/10665/345946>.
19. World Health Organization. Strengthening primary health care to tackle racial discrimination, promote intercultural services and reduce health inequities. Geneva: WHO; 2022 [cited 22 March 2023]. Available from: <https://apps.who.int/iris/handle/10665/363854>.
20. Economic Commission for Latin America and the Caribbean. The recovery paradox in Latin America and the Caribbean. [Santiago]: ECLAC; 2021 Jul [cited 31 March 2023]. Available from: https://repositorio.cepal.org/bitstream/handle/11362/47059/S2100378_en.pdf.
21. International Labour Organization Regional Office for Latin America and the Caribbean. Overview of social protection systems in Latin America and the Caribbean: progress and setbacks in the face of the pandemic - Technical note. Lima: ILO Regional Office for Latin America and the Caribbean; 2021 [cited 8 March 2023]. Available from: https://www.ilo.org/caribbean/information-resources/publications/WCMS_824905/lang--en/index.htm.
22. World Bank Group. Two years after: saving a generation. Washington, DC: World Bank; 2022 [cited 30 January 2023]. Available from: <https://elibrary.worldbank.org/doi/book/10.1596/37586>.
23. Perez-Vincent SM, Carreras E. Domestic violence reporting during the COVID-19 pandemic: evidence from Latin America. *Rev Econ Househ*. 2022;20(3):799–830. Available from: <https://doi.org/10.1007/s11150-022-09607-9>.
24. COVID-19 Mental Disorders Collaborators. Global prevalence and burden of depressive and anxiety disorders in 204 countries and territories in 2020 due to the COVID-19 pandemic. *Lancet*. 2021 [cited 8 March 2023]; 398(10312):1700–1712. Available from: [https://doi.org/10.1016/S0140-6736\(21\)02143-7](https://doi.org/10.1016/S0140-6736(21)02143-7).
25. World Health Organization. A clinical case definition of post COVID-19 condition by a Delphi consensus, 6 October 2021. Geneva: WHO; 2021 [cited 30 January 2023]. Available from: https://www.who.int/publications-detail-redirect/WHO-2019-nCoV-Post_COVID-19_condition-Clinical_case_definition-2021.1.
26. Lund C, Brooke-Sumner C, Baingana F, Baron EC, Breuer E, Chandra P, et al. Social determinants of mental disorders and the Sustainable Development Goals: a systematic review of reviews. *Lancet Psychiatry*. 2018;5(4):357–369. Available from: [https://doi.org/10.1016/S2215-0366\(18\)30060-9](https://doi.org/10.1016/S2215-0366(18)30060-9).
27. Pan American Health Organization. Socioeconomic overview in the context of the pandemic. Health in the Americas+ portal. Washington, DC: PAHO; 2022 [cited 4 March 2023]. Available from: <https://hia.paho.org/en/covid-2022/socioeconomic>.
28. Economic Commission for Latin America and the Caribbean. Feminity index of poor households. Gender Equality Observatory. Santiago: ECLAC; 2016 [cited 31 March 2023]. Available from: <https://oig.cepal.org/en/indicators/feminity-index-poor-households>.
29. Economic Commission for Latin America and the Caribbean. Afrodescendants and the matrix of social inequality in Latin America: challenges for inclusion. Summary. Santiago: ECLAC; 2021 [cited 31 March 2023]. Available from: <https://www.cepal.org/en/publications/46871-afrodescendants-and-matrix-social-inequality-latin-america-challenges-inclusion>.
30. Pan American Health Organization. Plan of Action for Implementing the Gender Equality Policy of the Pan American Health Organization 2009–2014. Washington, DC: PAHO; 2010 [cited 8 March 2023]. Available from: <https://iris.paho.org/handle/10665.2/6036>.

31. Economic Commission for Latin America and the Caribbean. Social Panorama of Latin America and the Caribbean 2022: Transforming education as a basis for sustainable development. Santiago: ECLAC; 2022 [cited 31 March 2023]. Available from: <https://www.cepal.org/en/publications/48519-social-panorama-latin-america-and-caribbean-2022-transforming-education-basis>.
32. Congressional Research Service. Poverty in the United States in 2020. Washington, DC: CRS; 2022 Feb [cited 31 March 2023]. Available from: <https://crsreports.congress.gov/product/pdf/R/R47030>.
33. World Health Organization. World Health Statistics 2022. Geneva: WHO; 2022 [cited 31 March 2023]. Available from: <https://apps.who.int/iris/handle/10665/356584>.
34. Pan American Health Organization. Intimate partner violence against women in the Americas. Washington, DC: PAHO; 2018 [cited 31 March 2023]. Available from: <https://www.paho.org/en/documents/brochure-intimate-partner-violence-against-women-americas-data-and-action>.
35. Hillis S, Mercy J, Amobi A, Kress H. Global prevalence of past-year violence against children: a systematic review and minimum estimates. *Pediatrics*. 2016;137(3):e20154079. Available from: <https://doi.org/10.1542/peds.2015-4079>.
36. Economic Commission for Latin America and the Caribbean. ECLAC: At least 4,473 women were victims of femicide in Latin America and the Caribbean in 2021. Santiago: ECLAC; 2022 [cited 31 March 2023]. Available from: <https://www.cepal.org/en/pressreleases/eclac-least-4473-women-were-victims-femicide-latin-america-and-caribbean-2021>.
37. Department of International Law, Organization of American States. Afro-descendants. Washington, DC: OAS; [date unknown] [cited 4 March 2023]. Available from: <https://www.oas.org/dil/afrodescendants.htm>.
38. Pan American Health Organization. The Impact of COVID-19 on the Indigenous Peoples of the Region of the Americas: Perspectives and Opportunities. Report on the High-Level Regional Meeting, 30 October 2020. Washington, DC: PAHO; 2021 [cited 4 March 2023]. Available from: <https://iris.paho.org/handle/10665.2/53428>.
39. National Institute on Minority Health and Health Disparities. Structural racism and discrimination. Bethesda, MD: NIMHD; 2023 [cited 31 March 2023]. Available from: <https://www.nimhd.nih.gov/resources/understanding-health-disparities/srd.html>.
40. Eichstaedt JC, Sherman GT, Giorgi S, Roberts SO, Reynolds ME, Ungar LH, et al. The emotional and mental health impact of the murder of George Floyd on the US population. *Proc Natl Acad Sci U S A*. 2021;118(39):e2109139118. Available from: <https://doi.org/10.1073/pnas.2109139118>.
41. Human Rights Council. Promotion and protection of the human rights and fundamental freedoms of Africans and of people of African descent against excessive use of force and other human rights violations by law enforcement officers. New York: UN; 2021 Jun [cited 31 March 2023]. Available from: https://www.ohchr.org/sites/default/files/Documents/Issues/Racism/A_HRC_47_CRP_1.pdf.
42. World Health Organization. Ensuring gender-responsive health systems. Geneva: WHO; c2023 [cited 31 March 2023]. Available from: <https://www.who.int/activities/ensuring-gender-responsive-health-systems>.
43. Pan American Health Organization. Plan of Action for Implementing the Gender Equality Policy of the Pan American Health Organization 2009–2014. Washington, DC: PAHO; 2010 [cited 4 March 2023]. Available from: <https://iris.paho.org/handle/10665.2/6036>.
44. World Health Organization Regional Office for Europe. Evidence for gender responsive actions to promote mental health: young people’s health as a whole-of-society response. Copenhagen: WHO; 2011 [cited 31 March 2023]. Available from: <https://apps.who.int/iris/handle/10665/350013>.
45. World Health Organization. Depression and Other Common Mental Disorders: Global Health Estimates. Geneva: WHO; 2017 [cited 8 March 2023]. Available from: <https://apps.who.int/iris/handle/10665/254610>.

46. Pan American Health Organization. Suicide prevention. Washington, DC: PAHO; c2023 [cited 31 March 2023]. Available from: <https://www.paho.org/en/topics/suicide-prevention>.
47. World Health Organization. Improving the health and well-being of LGBTIQ+ people. Geneva: WHO; c2023 [cited 31 March 2023]. Available from: <https://www.who.int/activities/improving-the-health-and-well-being-of-lgbtqi-people>.
48. Pan American Health Organization. Report of the director on addressing the causes of disparities in health services access and utilization for lesbian, gay, bisexual, and trans (LGBT) persons. Washington, DC: PAHO; 2018 [cited 31 March 2023]. Available from: <https://www.paho.org/en/node/61784>.
49. Pan American Health Organization. Emergencies. Washington, DC: PAHO; c2023 [cited 31 March 2023]. Available from: <https://www.paho.org/en/topics/emergencies>.
50. Pan American Health Organization. As talks get underway at COP24, MERCOSUR Ministers of Health commit to prioritize health in climate change adaptation plans. Washington, DC: PAHO; 2018 [cited 4 March 2023]. Available from: https://www3.paho.org/hq/index.php?option=com_content&view=article&id=14861:as-talks-get-underway-at-cop24-mercosur-ministers-of-health-commit-to-prioritize-health-in-climate-change-adaptation-plans&Itemid=0&lang=en.
51. World Health Organization. Mental health in emergencies. Geneva: WHO; 2022 [cited 4 March 2023]. Available from: <https://www.who.int/news-room/fact-sheets/detail/mental-health-in-emergencies>.
52. Lawrance E, Thompson R, Fontana G, Jennings N. The impact of climate change on mental health and emotional wellbeing: current evidence and implications for policy and practice. London: Grantham Institute – Climate Change and the Environment; 2021 [cited 8 March 2023]. Available from: <https://www.imperial.ac.uk/grantham/publications/briefing-papers/>.
53. Pan American Health Organization. WHO report shows poorer health outcomes for many vulnerable refugees and migrants. Washington, DC: PAHO; 2022 [cited 31 March 2023]. Available from: <https://www.paho.org/en/news/20-7-2022-who-report-shows-poorer-health-outcomes-many-vulnerable-refugees-and-migrants>.
54. Pan American Health Organization. Guidance document on migration and health. Washington, DC: PAHO; 2019 [cited 4 March 2023]. Available from: <https://www.paho.org/en/documents/guidance-document-migration-and-health>.
55. Hon. Carolyn Bennett. About Carolyn Bennett. Toronto: libparl.ca; c2020 [cited 31 March 2023]. Available from: <https://carolynbennett.libparl.ca/about/>.
56. World Health Organization. Special initiative for mental health (2019–2023). WHO; 2019 May [cited 31 March 2023]. Available from: [https://www.who.int/publications/i/item/special-initiative-for-mental-health-\(2019-2023\)](https://www.who.int/publications/i/item/special-initiative-for-mental-health-(2019-2023)).
57. United Nations. Political Declaration of the High-level Meeting on Universal Health Coverage “Universal health coverage: moving together to build a healthier world”. New York: UN; 2019 [cited 4 March 2023]. Available from: <https://www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf>.
58. United for Global Mental Health. “NO HEALTH WITHOUT MENTAL HEALTH”: THE URGENT NEED FOR MENTAL HEALTH INTEGRATION IN UNIVERSAL HEALTH COVERAGE. [place unknown]: United for Global Mental Health; 2020 Dec [cited 31 March 2023]. Available from: <https://unitedgmh.org/knowledge-hub/uhc/>.
59. World Health Organization. Investing in Mental Health: Evidence for action. Geneva: WHO; 2013 [cited 31 March 2023]. Available from: <https://apps.who.int/iris/handle/10665/87232>.
60. Irarrazaval M, Norambuena P, Montenegro C, Toro-Devia O, Vargas B, Caqueo-Urizar A. Public Policy Responses to Address the Mental Health Consequences of the COVID-19 Pandemic: Evidence From Chile. *Front Public Health*. 2021;9. Available from: <https://doi.org/10.3389/fpubh.2021.590335>.

61. Government of Chile. HealthyMind. Santiago: Government of Chile; 2020 [cited 4 March 2023]. Available from: <https://www.gob.cl/saludablemente>.
62. UN Women. In Chile, data on women's paid and unpaid work prompt subsidy for working caregivers and inform upcoming national care policy. New York: UN Women; 2021 [cited 4 March 2023]. Available from: <https://data.unwomen.org/features/chile-data-womens-paid-and-unpaid-work-prompt-subsidy-working-caregivers-and-inform>.
63. Patel V, Chatterji S. Integrating mental health in care for noncommunicable diseases: An imperative for person-centered care. *Health Aff (Millwood)*. 2015;34(9):1498–1505. Available from: <https://doi.org/10.1377/hlthaff.2015.0791>.
64. World Health Organization. Guide for integration of perinatal mental health in maternal and child health services. Geneva: WHO; 2022 [cited 31 March 2023]. Available from: <https://apps.who.int/iris/handle/10665/362880>.
65. Batra A, Jackson K, Hamad R. Effects Of The 2021 Expanded Child Tax Credit On Adults' Mental Health: A Quasi-Experimental Study. *Health Aff (Millwood)*. 2023 Jan;42(1):74–82. Available from: <https://doi.org/10.1377/hlthaff.2022.00733>.
66. Inter-Agency Standing Committee. IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC; 2007 [cited 4 March 2023]. Available from: <https://interagencystandingcommittee.org/iasc-task-force-mental-health-and-psychosocial-support-emergency-settings/iasc-guidelines-mental-health-and-psychosocial-support-emergency-settings-2007>.
67. Inter-Agency Standing Committee. Minimum service package mental health and psychosocial support. Geneva: IASC; 2022 [cited 30 January 2023]. Available from: <https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/iasc-minimum-service-package-mental-health-and-psychosocial-support>.
68. Ministry of Justice and Human Rights. Law 26,657: National Mental Health Law. Buenos Aires: Ministry of Justice and Human Rights; 2010 [cited 30 January 2023]. Available from: <http://servicios.infoleg.gob.ar/infolegInternet/anexos/175000-179999/175977/norma.htm>.
69. Ministry of Health. Federal Strategy for a Comprehensive Approach to Mental Health. Buenos Aires: Ministry of Health; 2022 [cited 30 January 2023]. Available from: <https://www.argentina.gob.ar/salud/mental-y-adicciones/estrategia-federal-de-abordaje-integral-de-la-salud-mental>.
70. Ministry of Territorial Development and Habitat. Resolution 365/2022. Buenos Aires: Ministry of Territorial Development and Habitat; 2022 [cited 30 January 2023]. Available from: <https://www.argentina.gob.ar/normativa/nacional/resoluci%C3%B3n-365-2022-375815/texto>.
71. Ministry of Health. Vizzotti and Maggiotti launched the inclusive living program and announced the construction of 50 semi-detached houses in Luján for a community approach to mental health. Buenos Aires: Ministry of Health; 2022 [cited 30 January 2023]. Available from: <https://www.argentina.gob.ar/noticias/vizzotti-y-maggiotti-lanzaron-el-programa-habitar-inclusion-y-anunciaron-la-construccion-de>.
72. Patel V, Saxena S, Lund C, Thornicroft G, Baingana F, Bolton P, et al. *Lancet*. 2018 Oct 27;392(10157):1553–1598. Available from: [https://doi.org/10.1016/S0140-6736\(18\)31612-X](https://doi.org/10.1016/S0140-6736(18)31612-X). Epub 2018 Oct 9. Erratum in: *Lancet*. 2018 Oct 27;392(10157):1518.
73. Mackenzie J, Caddick H. ODI Insights. How low-income countries can invest in mental health. London: Overseas Development Institute; 2026 Dec [cited 4 March 2023]. Available from: <https://cdn.odi.org/media/documents/11183.pdf>.
74. Marquez PV, Saxena S. Making mental health a global priority. *Cerebrum*. 2016 Jul 1 [cited 4 March 2023];2016. Available from: <https://www.ncbi.nlm.nih.gov/pubmed/28058091>.

75. Patricia O. Sulser JM. Innovative finance in health care: Scaling up the use of impact bonds - convergence resources. Toronto: Convergence; 2022 Jun [cited 30 January 2023]. Available from: <https://www.convergence.finance/resource/innovative-finance-in-health-care:-scaling-up-use-of-impact-bonds-in-public-health-care-in-developing-countries/view>.
76. McDaid D, Park A-L. Evidence on financing and budgeting mechanisms to support intersectoral actions between health, education, social welfare and labour sectors. Copenhagen: World Health Organization Regional Office for Europe; 2016 [cited 4 March 2023]. Available from: <https://apps.who.int/iris/handle/10665/326309>.
77. The World Bank. Banking on impact: What You Need to Know about Results-based financing. Washington, DC: World Bank Group; 2019 [cited 31 March 2023]. Available from: <https://www.worldbank.org/en/news/feature/2019/06/28/banking-on-impact-what-you-need-to-know-about-results-based-financing>.
78. World Health Organization, United Nations Development Programme. Mental health investment case: a guidance note. Geneva: WHO; 2021 [cited 30 January 2023]. Available from: <https://apps.who.int/iris/handle/10665/340246>.
79. World Health Organization. WHO menu of cost-effective interventions for mental health. Geneva: WHO; 2021 [cited 31 March 2023]. Available from: <https://apps.who.int/iris/handle/10665/343074>.
80. Toyama M, Castillo H, Galea JT, Brandt LR, Mendoza M, Herrera V, et al. Peruvian Mental Health Reform: A Framework for Scaling-up Mental Health Services. *Int J Health Policy Manag.* 2017;6(9):501–508. Available from: <https://doi.org/10.15171%2Fijhpm.2017.07>.
81. Pan American Health Organization. Mental health: A Human Rights-based approach. Washington, DC: PAHO; 2022 [cited 28 December 2022]. Available from: <https://iris.paho.org/handle/10665.2/55797>.
82. United Nations. United Nations Convention on the Rights of Persons with Disabilities. New York: UN; 2006 [cited 28 December 2022]. Available from: https://www.un.org/disabilities/documents/convention/convention_accessible_pdf.pdf.
83. World Health Organization. Guidance and technical packages on community mental health services. Geneva: WHO; 2021 [cited 28 December 2022]. Available from: <https://apps.who.int/iris/handle/10665/341648>.
84. Office of the United Nations High Commissioner for Human Rights. Call for inputs: Draft guidance on Mental Health, Human Rights, and Legislation published jointly by WHO and OHCHR. Geneva: OHCHR; 2022 [cited 28 January 2022]. Available from: <https://www.ohchr.org/en/calls-for-input/calls-input/draft-guidance-mental-health-human-rights-legislation-who-ohchr>.
85. Pan American Health Organization. Deinstitutionalization of Psychiatric Care in Latin America and the Caribbean. Washington, DC: PAHO; 2021 [cited 28 December 2022]. Available from: <https://iris.paho.org/handle/10665.2/53207>.
86. World Health Organization. World mental health report: Transforming mental health for all. Geneva: WHO; 2022 [cited 28 December 2022]. Available from: <https://apps.who.int/iris/handle/10665/356119>.
87. World Health Organization. QualityRights materials for training, guidance and transformation. Geneva: WHO; 2019 [cited 28 December 2022]. Available from: <https://www.who.int/publications-detail-redirect/who-qualityrights-guidance-and-training-tools>.
88. Chamber of Deputies, LXV Legislature. From the Health Commission, a draft decree that reforms, adds and repeals various provisions of the General Health Law, regarding mental health and addictions. Mexico City: Parliamentary Gazette; 2021 [cited 2 February 2023]. Available from: <http://gaceta.diputados.gob.mx/PDF/65/2022/mar/20220331-IV.pdf>.
89. Pan American Health Organization. Caracas Declaration. Adopted in Caracas, Venezuela, on 14 November 1990 at the Conference on the Restructuring of Psychiatric Care in Latin America within the Local Health Systems. Washington, DC: PAHO; 1990 [cited 28 December 2022]. Available from: http://www.paho.org/hq/dmdocuments/2008/Declaracion_de_Caracas.pdf.

90. Oropeza MC, Berenzon S, Robles R, Real T, Mora MEM. Community-Based Mental Health Services in Mexico. Consortium Psychiatricum. 2021;2(3):53–62. Available from: <https://doi.org/10.17816/CP86>.
91. United Nations High Commissioner for Refugees. Social Protection. Geneva: UNHCR; c2021–2022 [cited 31 March 2022]. Available from: <https://www.unhcr.org/en-us/social-protection.html>.
92. World Bank. The World Bank in Social Protection. Overview. Washington, DC: World Bank Group; 2023 [cited 3 April 2023]. Available from: <https://www.worldbank.org/en/topic/socialprotection/overview>.
93. International Labour Organization. Social protection floor for a fair and inclusive globalization: report of the Social Protection Floor Advisory Group. Geneva: ILO; 2011 [cited 3 March 2023]. Available from: http://www.ilo.org/global/publications/ilo-bookstore/order-online/books/WCMS_165750/lang-en/index.htm.
94. International Labour Organization. Social Protection for Workers in the Informal Economy. Frequently asked questions (FAQ). Geneva: ILO; [2020?] [cited 3 April 2023]. Available from: https://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/---ilo-beijing/documents/publication/wcms_761053.pdf.
95. UNICEF Office of Research-Innocenti. Gender-responsive and age-sensitive social protection. Florence: UNICEF-IRC; c2023. [cited 3 April 2023]. Available from: <https://www.unicef-irc.org/research/gender-responsive-and-age-sensitive-social-protection/>.
96. Solmi M, Radua J, Olivola M, Croce E, Soardo L, Salazar de Pablo G, et al. Age at onset of mental disorders worldwide: large-scale meta-analysis of 192 epidemiological studies. *Mol Psychiatry*. 2022;27(1):281–295. Available from: <https://doi.org/10.1038/s41380-021-01161-7>.
97. World Health Organization. Helping Adolescents Thrive Toolkit. Geneva: WHO; 2021 [cited 2 January 2023]. Available from: <https://apps.who.int/iris/handle/10665/341344>.
98. Pan American Health Organization. Promoting wellbeing and mental health in schools. Washington, DC: PAHO; 2022 [cited 3 April 2023]. Available from: <https://iris.paho.org/handle/10665.2/56984>.
99. The World Bank, UNICEF, UNESCO. Two years after: Saving a generation. New York: UNICEF; 2022 [cited 3 April 2023]. Available from: <https://www.unicef.org/lac/en/reports/two-years-after-saving-a-generation>.
100. World Health Organization. Guidelines on mental health at work. Geneva: WHO; 2022 [cited 3 January 2023]. Available from: <https://apps.who.int/iris/handle/10665/363177>.
101. Pan American Health Organization. The COVID-19 Health caRe wOrkErs Study (HEROES): Regional Report from the Americas. Washington, DC: PAHO; 2022 [cited 2 February 2023]. Available from: <https://iris.paho.org/handle/10665.2/55972>.
102. World Health Organization and International Labour Organization. Mental health at work: policy brief. Geneva: WHO; 2022 [cited 2 February 2023]. Available from: <https://apps.who.int/iris/handle/10665/362983>.
103. Pan American Health Organization. Healthy Aging. Washington, DC: PAHO; c2023 [cited 31 March 2023]. Available from: <https://www.paho.org/en/healthy-aging>.
104. World Health Organization. Mental health of older adults. Geneva: WHO; 2017 [cited 31 March 2023]. Available from: <https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults>.
105. World Health Organization. Global age-friendly cities: a guide. Geneva: WHO; 2007 [cited 3 April 2023]. Available from: <https://apps.who.int/iris/handle/10665/43755>.
106. World Health Organization. Measuring the age-friendliness of cities. Geneva: WHO; 2015 [cited 3 April 2023]. Available from: <https://apps.who.int/iris/handle/10665/203830>.
107. World Health Organization. The global network for age-friendly cities and communities. Geneva: WHO; 2018 [cited 3 April 2023]. Available from: <https://apps.who.int/iris/handle/10665/278979>.

108. WHO Global Network for Age-friendly Cities and Communities. Membership in the Global Network of Age-friendly Cities and Communities (GNAFCC). Geneva: WHO; 2019 Dec. Available from: <https://extranet.who.int/agefriendlyworld/wp-content/uploads/2022/04/GNAFCC-membership-en.pdf>.
109. Ministry of Public Health. Strong Families Program will be implemented between 2022 and 2025. Montevideo: Ministry of Public Health; 2022 [cited 4 March 2023]. Available from: <https://www.gub.uy/ministerio-salud-publica/comunicacion/noticias/programa-familias-fuertes-se-implementara-entre-2022-2025>.
110. Sampaio F, Nystrand C, Feldman I, Mihalopoulos C. Evidence for investing in parenting interventions aiming to improve child health: a systematic review of economic evaluations. *Eur Child Adolesc Psychiatry*. 2022; Epub ahead of print. Available from: <https://doi.org/10.1007/s00787-022-01969-w>.
111. Pan American Health Organization. Strong Families: Love and Limits. Guide for the management and application of the program. Washington, DC: PAHO; 2021 [cited 4 March 2023]. Available from: <https://iris.paho.org/handle/10665.2/53696>.
112. World Health Organization. MhGAP intervention guide - version 2.0. Geneva: WHO; 2019 [cited 28 December 2023]. Available from: <https://www.who.int/publications/item/9789241549790>.
113. World Health Organization. Mental health in primary care: Illusion or inclusion?. Geneva: WHO; 2018 [cited 3 April 2023]. Available from: <https://apps.who.int/iris/handle/10665/326298>.
114. Iversen SA, Ogallo B, Belfer M, Fung D, Hoven CW, Carswell K, et al. Enhancing mental health pre-service training with the WHO mhGAP Intervention Guide: experiences learned and the way forward. *Child Adolesc Psychiatry Ment Health*. 2021;15(1):1. Available from: <https://doi.org/10.1186/s13034-020-00354-2>.
115. Georgetown University Health Policy Institute. Cultural Competence in Health Care: Is it important for people with chronic conditions?. Washington, DC: Health Policy Institute; 2014 [cited 31 March 2023]. Available from: <https://hpi.georgetown.edu/cultural/>.
116. Substance Abuse and Health Services Administration. TIP 59: Improving Cultural Competence. Rockville, MD: SAMHSA; 2014 [cited 31 March 2023]. Available from: <https://store.samhsa.gov/product/TIP-59-Improving-Cultural-Competence/SMA15-4849>.
117. Hanna N. A role for the state in the digital age. *J Innov Entrep*. 2018;7(1). Available from: <https://doi.org/10.1186/s13731-018-0086-3>.
118. World Health Organization. MhGAP humanitarian intervention guide (mhGAP-HIG): Clinical management of mental neurological and substance use conditions in humanitarian emergencies. Geneva: WHO; 2015 [cited 4 March 2023]. Available from: <https://apps.who.int/iris/handle/10665/162960>.
119. World Health Organization Regional Office for Europe. User empowerment in mental health – a statement by the WHO Regional Office for Europe. Copenhagen: WHO Regional Office for Europe; 2010 [cited 2 February 2023]. Available from: <https://apps.who.int/iris/handle/10665/107275>.
120. Pan American Health Organization. Responding to MHPSS needs during COVID-19 in Indigenous and Afro-Descendant Communities in the Americas: Bolivia. Washington, DC: PAHO; 2022 [cited 4 March 2023]. Available from: <https://www.paho.org/en/responding-mental-health-and-psychosocial-support-mhpss-needs-during-covid-19-indigenous-and-afro-0>.
121. Pan American Health Organization. Responding to MHPSS needs during COVID-19 in Indigenous and Afro-Descendant Communities in the Americas: Guatemala. Washington, DC: PAHO; 2022 [cited 4 March 2023]. Available from: <https://www.paho.org/en/responding-mental-health-and-psychosocial-support-mhpss-needs-during-covid-19-indigenous-and-afro-1>.
122. Pan American Health Organization. Responding to MHPSS needs during COVID-19 in Indigenous and Afro-Descendant Communities in the Americas: Honduras. Washington, DC: PAHO; 2022 [cited 4 March 2023]. Available from: <https://www.paho.org/en/responding-mental-health-and-psychosocial-support-mhpss-needs-during-covid-19-indigenous-and-afro-3>.

123. World Health Organization. National suicide prevention strategies: progress, examples and indicators. Geneva: WHO; 2018 [cited 4 March 2023]. Available from: <https://apps.who.int/iris/handle/10665/279765>.
124. World Health Organization. LIVE LIFE: An implementation guide for suicide prevention in countries. Geneva: WHO; 2021 [cited 4 March 2023]. Available from: <https://apps.who.int/iris/handle/10665/341726>.
125. World Health Organization. Preventing Suicide: A Global Imperative. Geneva: WHO; 2014 [cited 4 March 2023]. Available from: <https://apps.who.int/iris/handle/10665/131056>.
126. Pan American Health Organization. Suicide Mortality in the Americas. Regional Report 2015-2019. Washington, DC: PAHO; 2021 [cited 4 March 2023]. Available from: <https://iris.paho.org/handle/10665.2/55297>.
127. Pan American Health Organization. Alcohol and Suicide. Washington, DC: PAHO; 2021 [cited 4 March 2023]. Available from: <https://iris.paho.org/handle/10665.2/55083>.
128. Stene-Larsen K, Reneflot A. Contact with primary and mental health care prior to suicide: A systematic review of the literature from 2000 to 2017. *Scand J Public Health*. 2019;47(1):9–17. Available from: <https://doi.org/10.1177/1403494817746274>.
129. World Health Organization, International Association for Suicide Prevention. Preventing suicide: a resource for media professionals. Geneva: WHO; 2017 [cited 4 March 2023]. Available from: <https://apps.who.int/iris/handle/10665/258814>.
130. Ministry of Health of Trinidad and Tobago. National Mental Health Policy 2019–2029. Port of Spain: Ministry of Health; 2019.
131. Ministry of Health of Trinidad and Tobago. National Suicide Prevention Strategy of Trinidad and Tobago. Port of Spain: Ministry of Health; 2023.
132. Pan American Health Organization. The burden of suicide in the Region of the Americas. ENLACE data portal. Washington, DC: PAHO; 2021 [cited 4 March 2023]. Available from: <https://www.paho.org/en/enlace/burden-suicide>.
133. Ministry of Health. Guidelines for Reporting on Suicide. Port of Spain: Government of the Republic of Trinidad and Tobago; 2021 [cited 4 March 2023]. Available from: <https://health.gov.tt/sites/default/files/2021-12/Reporting%20guidelines%20FINAL.pdf>.
134. Organisation for Economic Co-operation and Development. SIGI 2020 Regional Report for Latin America and the Caribbean. Paris: OECD; 2020 [cited 4 March 2023]. Available from: <https://doi.org/10.1787/cb7d45d1-en>.
135. Ferrant G, Pesando LM, Nowacka K. Unpaid Care Work: The missing link in the analysis of gender gaps in labour outcomes. Paris: OECD; 2014 Dec [cited 4 March 2023]. Available from: https://www.oecd.org/dev/development-gender/Unpaid_care_work.pdf.
136. World Health Organization. Global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children. Geneva: WHO; 2016 [cited 31 March 2023]. Available from: <https://apps.who.int/iris/handle/10665/252276>.
137. World Health Organization. RESPECT women: Preventing violence against women. Geneva: WHO; 2021 [cited 31 March 2023]. Available from: <https://www.paho.org/en/documents/respect-women-preventing-violence-against-women>.
138. World Health Organization. INSPIRE: Seven strategies for Ending Violence Against Children (Full report and Executive summary). Geneva: WHO; 2016 [cited 31 March 2023]. Available from: <https://www.paho.org/en/documents/inspire-seven-strategies-ending-violence-against-children>.

139. Pan American Health Organization. Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women. Washington, DC: PAHO; 2015 [cited 2 April 2023]. Available from: <https://www.paho.org/en/documents/strategy-and-plan-action-strengthening-health-system-address-violence-against-women>.
140. Pan American Health Organization. Addressing Violence Against Women in Health Policies and Protocols in the Americas. A regional status report. Washington, DC: PAHO; 2022 [cited 2 April 2023]. Available from: <https://iris.paho.org/handle/10665.2/56750>.
141. UN Women. Essential services package for women and girls subject to violence. New York: UN; 2015 [cited 31 March 2023]. Available from: <https://www.unwomen.org/en/digital-library/publications/2015/12/essential-services-package-for-women-and-girls-subject-to-violence>.
142. World Health Organization. Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: a manual for health managers. Geneva: WHO; 2017 [cited 31 March 2023]. Available from: <https://apps.who.int/iris/handle/10665/259489>.
143. Pan American Health Organization. Masculinities and health in the Region of the Americas. Executive summary. Washington, DC: PAHO; 2019 [cited 4 March 2023]. Available from: <https://iris.paho.org/handle/10665.2/51666>.
144. Rice S, Oliffe J, Seidler Z, Borschmann R, Pirkis J, Reavley N, et al. Gender norms and the mental health of boys and young men. *Lancet Public Health*. 2021;6(8):e541–542. Available from: [https://doi.org/10.1016/s2468-2667\(21\)00138-9](https://doi.org/10.1016/s2468-2667(21)00138-9).
145. International Organization for Migration. Regional Refugee and Migrant Response Plan for Refugees and Migrants from Venezuela 2022. Geneva: IOM; 2022 [cited 4 March 2023]. Available from: <https://crisisresponse.iom.int/response/regional-refugee-and-migrant-response-plan-refugees-and-migrants-venezuela-2022>.
146. Pan American Health Organization. Strengthening health system responses to violence against migrant and refugee women and girls. Washington, DC: PAHO; 2022 [cited 4 March 2023]. Available from: <https://www.paho.org/en/topics/violence-against-women/strengthening-health-system-responses-violence-against-migrant-and>.
147. Pan American Health Organization. [Humanized health care: opportunities to strengthen the response to gender violence and resilience processes in migrant women]. Washington, DC: PAHO; 2022 [cited 4 March 2023]. Available from: <https://www.paho.org/es/noticias/24-11-2022-atencion-humanizada-salud-opportunidades-para-fortalecer-respuesta-violencias>
148. United Nations. Declaration on Race and Racial Prejudice. Paris: UNESCO; 1978 [cited 4 March 2023]. Available from: https://www.un.org/en/genocideprevention/documents/atrocities-crimes/Doc.11_declaracion%20on%20race%20and%20racial%20prejudice.pdf.
149. Pan American Health Organization. Considerations on Indigenous Peoples, Afro-Descendants, and Other Ethnic Groups during the COVID-19 Pandemic. Washington, DC: PAHO; 2020 [cited 4 March 2023]. Available from: <https://iris.paho.org/handle/10665.2/52251>.
150. United Nations Office of the High Commissioner for Human Rights. Developing National Action Plans Against Racial Discrimination. New York: UN; 2014 [cited 31 March 2023]. Available from: <https://www.ohchr.org/sites/default/files/Documents/Publications/HR-PUB-13-03.pdf>.
151. European Commission against Racism and Intolerance. ECRI GENERAL POLICY RECOMMENDATION No. 7 ON NATIONAL LEGISLATION TO COMBAT RACISM AND RACIAL DISCRIMINATION. Strasbourg: ECRI; 2002 [cited 31 March 2023]. Available from: <https://rm.coe.int/ecri-general-policy-recommendation-no-7-revised-on-national-legislatio/16808b5aae>.
152. United Nations. Establishing effective accountability mechanisms for human rights violations. *UN Chronicle*. New York: UN; 2012 [cited 4 March 2023]. Available from: <https://www.un.org/en/chronicle/article/establishing-effective-accountability-mechanisms-human-rights-violations>.

153. United Nations Office of the High Commissioner for Human Rights. UN human rights chief lists tackling discrimination and impunity among top priorities. Geneva: OHCHR; 2009 [cited 4 March 2023]. Available from: <https://www.ohchr.org/en/press-releases/2009/10/un-human-rights-chief-lists-tackling-discrimination-and-impunity-among-top>.
154. Hassen N, Lofters A, Michael S, Mall A, Pinto AD, Rackal J. Implementing anti-racism interventions in healthcare settings: A scoping review. *Int J Environ Res Public Health*. 2021;18(6):2993. Available from: <https://doi.org/10.3390/ijerph18062993>.
155. United Nations Office of the High Commissioner for Human Rights. Dismantling discrimination against Afro-Brazilians remains slow despite official commitment. Geneva: OHCHR; 2013 [cited 4 March 2023]. Available from: <https://www.ohchr.org/en/press-releases/2014/01/dismantling-discrimination-against-afro-brazilians-remains-slow-despite>.
156. United States Department of State. Brazil 2020 Human Rights Report. Washington, DC: State Department; 2020 [cited 31 March 2023]. Available from: <https://www.state.gov/wp-content/uploads/2021/10/BRAZIL-2020-HUMAN-RIGHTS-REPORT.pdf>.
157. UNESCO. Education Profiles. Brazil: Inclusion. [Paris]: UNESCO; 2021 [cited 31 March 2023]. Available from: <https://education-profiles.org/latin-america-and-the-caribbean/brazil/~inclusion>.
158. UNESCO. Brazil: tracing good and emerging practices on the right to higher education. UNESCO: Paris; 2023 [cited 31 March 2023]. Available from: <https://unesdoc.unesco.org/ark:/48223/pf0000384290>.
159. World Bank. Monitoring and evaluation for better development results. Washington, DC: World Bank Group; 2016 [cited 4 March 2023]. Available from: <https://www.worldbank.org/en/news/feature/2013/02/14/monitoring-and-evaluation-for-better-development-results>.
160. World Health Organization. Monitoring and evaluation of mental health policies and plans: Mental health policy and service guidance package. Geneva: WHO; 2007 [cited 4 March 2023]. Available from: <https://apps.who.int/iris/handle/10665/43631>.
161. World Health Organization. mhGAP operations manual. Geneva: WHO; 2018 [cited 31 March 2023]. Available from: <https://apps.who.int/iris/handle/10665/275386>.
162. Inter-Agency Standing Committee. IASC common monitoring and evaluation framework for mental health and psychosocial support in emergency settings: With means of verification (Version 2.0). New York: IASC; 2021 [cited 31 March 2023]. Available from: <https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/iasc-common-monitoring-and-evaluation-framework-mental-health-and-psychosocial-support-emergency>.
163. Hastings PD, Guyer AE, Parra LA. Conceptualizing the Influence of Social and Structural Determinants of Neurobiology and Mental Health: Why and How Biological Psychiatry Can Do Better at Addressing the Consequences of Inequity. *Biol Psychiatry Cogn Neurosci Neuroimaging*. 2022;7(12):1215–1224. Available from: <https://doi.org/10.1016/j.bpsc.2022.06.004>.
164. Folorunso OO, Burns White K, Alonso-Caraballo Y, Nowicki GP, Olson EA, Pizzagalli DA, et al. Building an intentional and impactful summer research experience to increase diversity in mental health research. *Neuropsychopharmacology*. 2022;47(13):2189–2193. Available from: <https://doi.org/10.1038/s41386-022-01461-8>.
165. World Health Organization. Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm. Geneva: WHO; 2016 [cited 4 March 2023]. Available from: <https://apps.who.int/iris/handle/10665/208895>.
166. Arensman E, Malik A. WHO tools for strengthening suicide and self-harm monitoring and surveillance systems. Cork: WHO Collaborating Centre on Surveillance and Research in Suicide Prevention; 2019 [cited 4 March 2023]. Available from: https://www.nsr.ie/wp-content/uploads/2021/04/Workshop-WHO-tools-for-strengthening-Suicide-and-Self-Harm-Monitoring-and-Surveillance_IASP-Symposium_2-3rd-May-2019.pdf.

Annexes

Annex 1. List of official Commission meetings and participants

PAHO High-Level Commission on Mental Health and COVID-19

List of official meetings and participants

MEETING	DATE	PARTICIPANTS
First plenary meeting (virtually)	6 May 2022	Commission Members
Meeting of Working Group on Social and Economic Determinants of Mental Health and Populations in Need of Special Attention	25 July 2022	Commission Members Special guests: <ul style="list-style-type: none"> • Michael Pietrus, Director of Opening Minds, Mental Health Commission of Canada. • Keith Dobson, Professor, Department of Psychology, University of Calgary.
Meeting of Working Group on Social and Economic Determinants of Mental Health and Populations in Need of Special Attention	27 July 2022	Commission Members Special guests: <ul style="list-style-type: none"> • Dévora Kestel, Director of the Department of Mental Health and Substance Use, World Health Organization. • Daniel Elia, Mental Health Coordinator, Government of State of Rio de Janeiro, Brazil. • Suzana Guerrero, Psychiatrist, professor and researcher, Dominican Republic.
Meeting of Working Group on Social and Economic Determinants of Mental Health and Populations in Need of Special Attention	28 July 2023	Commission Members Special guests: <ul style="list-style-type: none"> • Yuri Cutipé, Executive Director of Mental Health, Ministry of Health, Peru.

(continued)

List of official meetings and participants *(continued)*

MEETING	DATE	PARTICIPANTS
Virtual Stakeholder Consultation: People with Lived Experience	19 September 2022	<p>Commission Members</p> <p>Special guests:</p> <ul style="list-style-type: none"> • María Divina O’Brien, Chairwoman of Mindwise Project, Trinidad and Tobago. • Karen Santo Athié, Executive Committee Member at Global Mental Health Peer Network, Brazil. • Cecilia Guillén, Project Lead, En Primera Persona A.C., Mexico.
Second plenary meeting (Washington, D.C.)	13–14 October 2022	Commission Members
Virtual Stakeholder Consultation: Women from the Region	13 October 2022	<p>Commission Members</p> <p>Special guests:</p> <ul style="list-style-type: none"> • Alejandra Acuña Navarro, Executive Secretary of the Council of Ministers of Health of Central America and the Dominican Republic (COMISCA). • Evalinda Barrón, General Director of the National Commission Against Addictions from Mexico. • Carmen Correa, Executive Director of Pro Mujer. • María Inés Re, Latin American and Caribbean Women’s Health Network (RSMLAC). • Margareth Arilha, PAHO Latin American Center of Perinatology, Women’s and Reproductive Health (CLAP/SMR).
Virtual Stakeholder Consultation: Indigenous Peoples, People of African Descent, and other Ethnic Groups from the Region	13 October 2022	<p>Commission Members</p> <p>Special guests:</p> <ul style="list-style-type: none"> • Jessie Schutt-Aine, Chief, Equity, Gender and Cultural Diversity Unit, Pan American Health Organization. • Humberto Brown, Director, Health Disparities Initiatives, Medical Center Downstate from the State University of New York. • Otilia Lux de Cotí, Activist for the human rights of women and Indigenous people (Guatemala). • Jose Yac Huix, Director, IDEI Association (Guatemala).

(continued)

List of official meetings and participants *(continued)*

MEETING	DATE	PARTICIPANTS
Virtual Stakeholder Consultation: Regional Experts in Mental Health Systems and Services	13 October 2022	<p>Commission Members</p> <p>Special guests:</p> <ul style="list-style-type: none"> • Denise Razzouk, psychiatrist, researcher and affiliated professor at the Universidade Federal de Sao Paulo (Unifesp) of Brazil. • Luciano Grasso, psychologist and former National Director of Mental Health of Argentina. • Lourdes Trigueros, psychiatrist and consultant, Guatemala.
Third plenary meeting (Bogota, Colombia)	30 November–1 December 2022	Commission Members
Virtual consultation with specialists in mindfulness, yoga, and other meditation practices	10 March 2023	<p>Commission Members</p> <p>Special guests:</p> <ul style="list-style-type: none"> • Beatriz Goyoaga, General Coordinator of the Art of Living Foundation for Latin America • Alexandra Salzedo: Yoga, mindset, and spiritual coach • David Corbera, Academic Director, Enric Corbera Institute.
Virtual consultation. Public–Private Alliances to Promote Mental Health Services Based on Community Strategies: The Case of RENOVAR Clinics in Colombia	24 March 2023	<p>Commission Members</p> <p>Special guests:</p> <ul style="list-style-type: none"> • Rosario Lozano Peña, founder and CEO of RENOVAR Clinics, Colombia

Annex 2.

Key recommended resources

Recommendation 1: Elevate mental health at the national and supranational levels

- World Mental Health Report: Transforming mental health for all (WHO): <https://www.who.int/publications/item/9789240049338>.
- Comprehensive Mental Health Action Plan 2013-2020 (WHO): <https://www.who.int/publications/item/9789240031029>.
- Out of the Shadows: Making mental health a global development priority (World Bank Group & WHO): <https://documents1.worldbank.org/curated/en/270131468187759113/pdf/105052-WP-PUBLIC-wb-background-paper.pdf>.

Recommendation 2: Integrate mental health into all policies

- Mental health in all policies (Joint Action for Mental Health and Wellbeing): <https://mentalhealthandwellbeing.eu/mental-health-in-all-policies/>.
- From Awareness to Change in Integrated Mental Health, Skills and Work Policies (OECD): <https://www.oecd-ilibrary.org/sites/c9ee4f29-en/index.html?itemId=/content/component/c9ee4f29-en>.
- Guidelines on mental health and psychosocial support in emergency settings, 2007 (IASC): <https://interagencystandingcommittee.org/mental-health-and-psychosocial-support-emergency-settings-0/documents-public/iasc-guidelines-mental>.
- Mental health and climate change: policy brief (WHO): <https://apps.who.int/iris/handle/10665/354104>.

Recommendation 3: Increase the quantity and improve the quality of financing for mental health

- Investing in mental health: evidence for action (WHO): https://apps.who.int/iris/bitstream/handle/10665/87232/9789241564618_eng.pdf.
- Mental health funding and the SDGs (MHIN + Grand Challenges Canada): <https://www.mhinnovation.net/resources/mental-health-funding-and-sdgs>.
- Menu of cost-effective interventions for mental health (WHO): <https://www.who.int/publications/item/9789240031081>.

Recommendation 4: Ensure the human rights of people living with mental health conditions

- Quality Rights (WHO): <https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools>.
- Convention on the Rights of Persons with Disabilities (United Nations): https://www.un.org/disabilities/documents/convention/convention_accessible_pdf.pdf.

- Deinstitutionalization of psychiatric care in Latin America and the Caribbean (PAHO): <https://www.paho.org/en/node/76244>.
- Long-stay mental health care institutions and the COVID-19 crisis: identifying and addressing the challenges for better response and preparedness (WHO EURO): <https://apps.who.int/iris/handle/10665/333964>.

Recommendation 5: Promote and protect mental across the life course

- Promoting Wellbeing and Mental Health in Schools (PAHO): <https://www.paho.org/en/node/90276>.
- Helping Adolescents Thrive Toolkit (WHO & UNICEF): <https://www.who.int/publications/i/item/9789240025554>.
- Mental Health at Work (WHO/ILO): https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---safework/documents/publication/wcms_856976.pdf.
- Global age-friendly cities: A guide (WHO): <https://apps.who.int/iris/handle/10665/43755>.

Recommendation 6: Improve and expand community-based mental health services and care

- Guidance and technical packages on community mental health services (WHO): <https://www.who.int/publications/i/item/guidance-and-technical-packages-on-community-mental-health-services>.
- Mental Health Gap Action Programme (mhGAP) (WHO): <https://www.who.int/teams/mental-health-and-substance-use/treatment-care/mental-health-gap-action-programme>.
- Enhancing mental health pre-service training with the mhGAP-Intervention Guide: experiences and lessons learned (WHO): <https://www.who.int/publications/i/item/9789240007666>.
- Remote delivery of MHPSS interventions (PAHO): <https://iris.paho.org/handle/10665.2/52638>.

Recommendation 7: Strengthen suicide prevention

- Suicide Mortality in the Americas. Regional report 2014-2019 (PAHO): <https://iris.paho.org/handle/10665.2/55297>.
- LIVE LIFE: An implementation guide for suicide prevention in countries (WHO): <https://www.who.int/publications/i/item/9789240026629>.
- National suicide prevention strategies: Progress, examples and indicators (WHO): <https://apps.who.int/iris/bitstream/handle/10665/279765/9789241515016-eng.pdf>.
- Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm (WHO): <https://apps.who.int/iris/handle/10665/208895>.

Recommendation 8: Adopt a gender transformative approach to mental health

- Strategy and Plan on Ethnicity and Health 2019-2025 (PAHO): <https://iris.paho.org/handle/10665.2/51744>.

- Gendered health analysis: COVID-19 in the Americas (PAHO): <https://iris.paho.org/handle/10665.2/55432>.
- Masculinities and health in the Region of the Americas. Executive summary (PAHO): <https://iris.paho.org/handle/10665.2/51666>.

Recommendation 9: Address racism and racial discrimination as a key determinant of mental health

- Strategy and Plan of Action on Ethnicity and Health 2019-2025 (PAHO): <https://iris.paho.org/handle/10665.2/51744>.
- Considerations on Indigenous peoples, Afro-descendants and other Ethnic Groups during the COVID-19 Pandemic (PAHO): <https://iris.paho.org/handle/10665.2/52251>.
- Developing national action plans against racial discrimination (UNHCR): <https://www.ohchr.org/sites/default/files/Documents/Publications/HR-PUB-13-03.pdf>.
- Strengthening primary health care to tackle racial discrimination, promote intercultural services and reduce health inequities (WHO): <https://www.who.int/publications/i/item/9789240057104>.

Recommendation 10: Improve mental health data and research

- Mental health information systems (WHO): http://apps.who.int/iris/bitstream/handle/10665/43210/9241546719_eng.pdf?sequence=1.
- Mental Health Atlas 2020 (WHO): <https://www.who.int/publications/i/item/9789240036703>.
- Countdown Global Mental Health 2030. Making Mental Health Count (United for Global Mental Health): <https://unitedgmh.org/app/uploads/2023/02/Countdown-Mental-Health-Report-2030-FINAL.pdf>.
- A Human Rights-Based Approach to Data. Leaving no one Behind in the 2030 Agenda for Sustainable Development (United Nations): <https://hlpf.un.org/tools/a-human-rights-based-approach-to-data-leaving-no-one-behind-in-the-2030-agenda-for>.



Unmet mental health needs in the Region of the Americas are a leading source of morbidity and mortality, which result in tremendous health, social, and economic consequences. The COVID-19 pandemic has exacerbated the mental health crisis in the Region, necessitating urgent action at the highest levels of government and across sectors to build back better mental health now and for the future.

This landmark report is the result of the PAHO High-Level Commission on Mental Health and COVID-19. It provides an analysis of the mental health situation in the Region, followed by a series of recommendations and corresponding actions to support countries in the Americas to prioritize and advance mental health using human rights and equity-based approaches.

PAHO

www.paho.org



Pan American
Health
Organization



World Health
Organization
REGIONAL OFFICE FOR THE
Americas

