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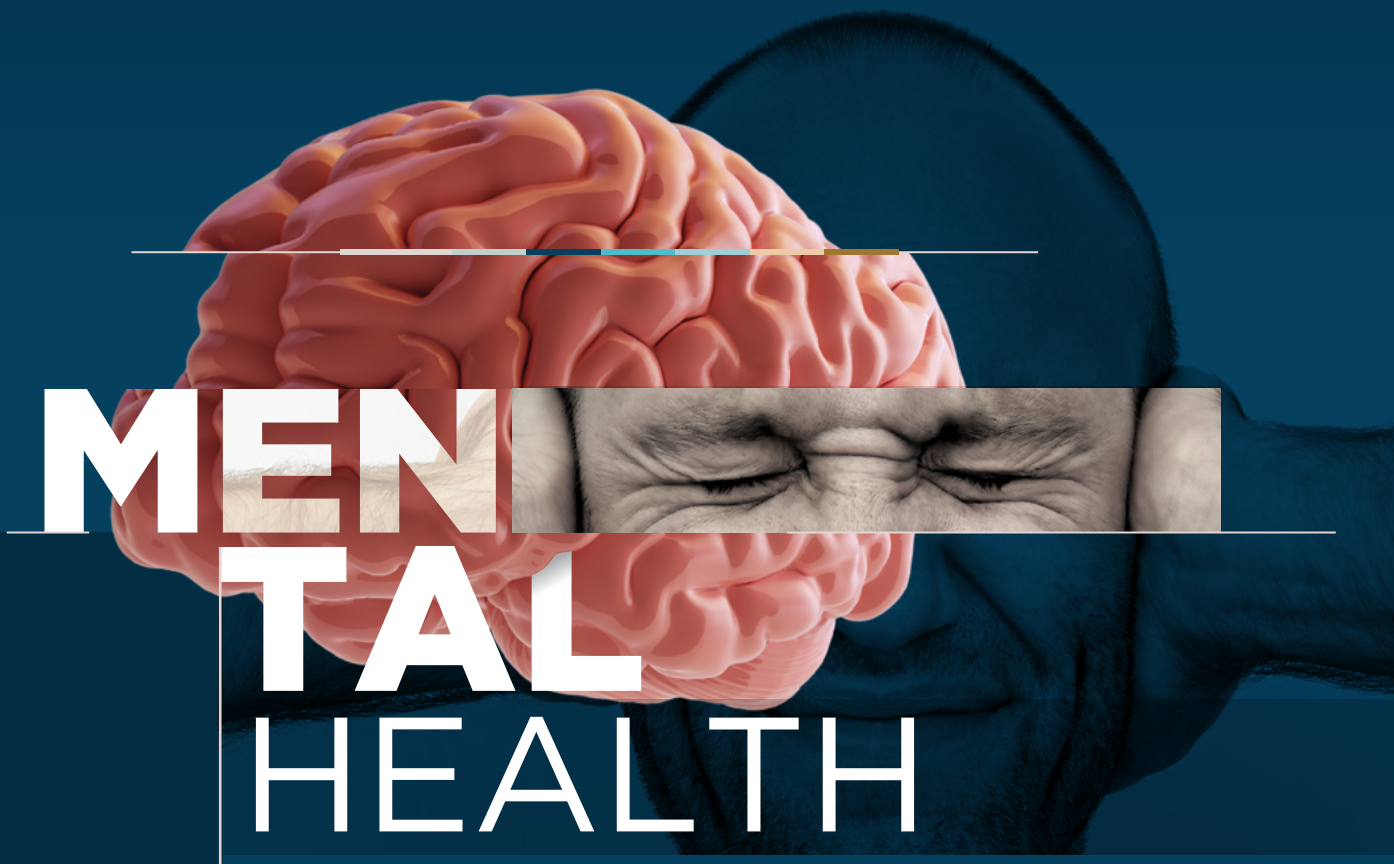

MENTAL HEALTH

in Latin America
and the Caribbean

THE SILENT PANDEMIC

People you can *trust for life*

PAN AMERICAN LIFE INSURANCE GROUP

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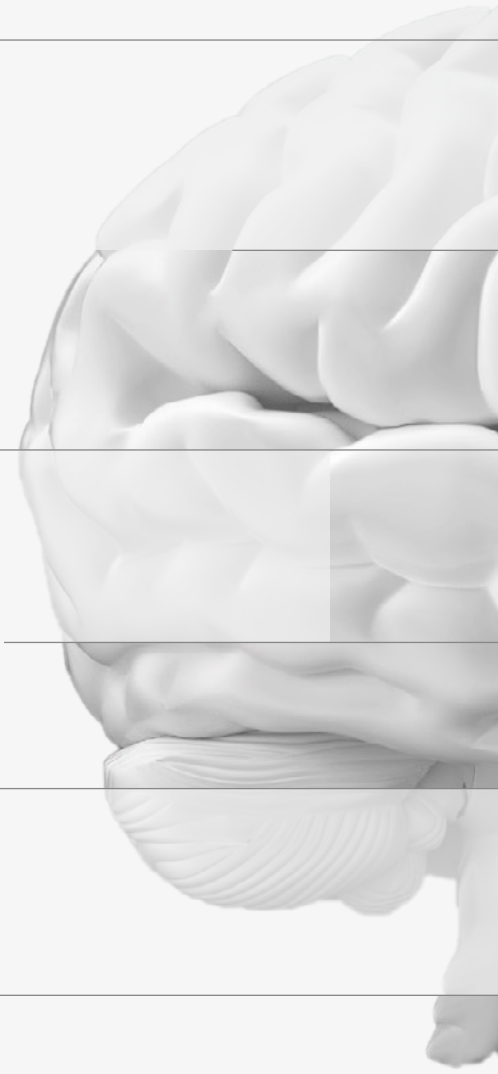


A PALIG White Paper

> There is no **health** without **mental** health

$3

Some countries in Central America allocate less than $3 per person per year for mental health programs and care.

Executive Summary

Mental, neurological and substance-use (MNS) disorders are widespread throughout Latin America and the Caribbean. These conditions account for about 20% of the total disability burden and are second only to noncommunicable chronic diseases (e.g. cardiovascular disease, diabetes).

Of the MNS disorders, depression, anxiety disorders and pain disorders are the most prevalent in the region, with wide variations in prevalence among Latin American and Caribbean countries.
Suicide rates, the most extreme outcome of MNS disorders, also vary widely among countries, with the highest rates seen in the U.S. and Canada and the lowest in Non-Latin Caribbean countries.

Mental, neurological and substance-use disorders place a tremendous financial burden on individuals, employers and the society at large. Costs are particularly high among the approximately one third of patients in Latin America that have "treatment resistant disorders". Workers with treatment resistant depression, for example, incur three times the medical expenses as workers without depression.

The causes of MNS disorders are complex and often multifactorial. The causes can include an individual's genetic makeup, life experiences (e.g. stress, especially in childhood), social issues (e.g. loneliness) and having another chronic disease such as diabetes. Due in part to the stigma related to MNS conditions, these conditions often are underdiagnosed and under-treated. This "treatment gap" between the need for services and their availability is particularly acute in many Latin American and Caribbean countries. Some countries in Central America, for example, allocate less than $3 per person per year for mental health programs and care.

The COVID-19 pandemic, which is still on going at the time of the writing of this report, has made the situation related to mental health in the region even worse. The pandemic has significantly increased the rates of conditions such as depression and anxiety, while simultaneously disrupting the availability of medications and in-person treatments. On a positive note, the pandemic also accelerated the use of telehealth and virtual care services for mental health disorders, which are generally effective and are well-received by patients.

Employers have an important role to play in the recognition and support of employees with mental health and substance use disorders. Employers in the region are encouraged to access the large and growing body of free bilingual educational materials (articles, videos) produced by PAHO as well as PALIG. Programs that assist employees with MNS disorders have been proven effective and allow for a more productive, loyal and lower cost workforce.

INTRODUCTION

The World Health Organization (WHO) defines mental health as a “state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”. Mental, neurological and substance-use (MNS) disorders are highly prevalent throughout Latin America and Caribbean, as well as the rest of the world, and are major contributors to morbidity, disability, and premature mortality.

MNS

(Mental, Neurological and Substance-use)

Among working-age populations, MNS disorders have a significant impact on worker productivity, absenteeism, and healthcare costs.[1] In addition to the patients themselves, these conditions places a tremendous burden on caregivers, and society at large. The stigma, social exclusion, and discrimination that are common around people with mental disorders living in Latin American and Caribbean cultures compound the situation. The COVID-19 pandemic has amplified the prevalence of mental-health and substance-use disorders throughout the region. Medication supply issues and travel restrictions have exacerbated mental health concerns, e.g. depression and anxiety, among people with existing chronic conditions that rely on consistent medication and treatments.

In this report, we provide an overview of mental health, neurological and substance use disorders in Latin America and the Caribbean. We also review statistics related to self-harm and suicide, which are two of the extreme consequences of these disorders. At the time of the writing of this report, the COVID-19 pandemic is having a major impact on mental-health and substance abuse disorders. We look at how COVID-19 has, or has not, affected the prevalence of these conditions, particularly among working age populations, and those with existing chronic conditions. In the last section of the report, we present steps that the medical community, employers and insurance companies can take to serve the needs of mental-health patients in spite of the challenges of the pandemic.

MENTAL HEALTH OVERVIEW

Mental, substance use, and specific neurological disorders and suicide form a subgroup of diseases and conditions that are a major cause of disability and mortality globally. In the Americas, these conditions and events are responsible for approximately a third of total years lived with disability (YLDs) and a fifth of total disability-adjusted life years (DALYs) (PAHO, 2018).

MNS
ARE A MAJOR CAUSE OF DISABILITY AND MORTALITY GLOBALLY.

There are many types of mental health disorders. These are grouped into categories or classes of disorders by clinicians. Some of the most common classes of mental health disorders, and specific examples within each class, are presented in the next section of this report.

A note about terminology and reporting

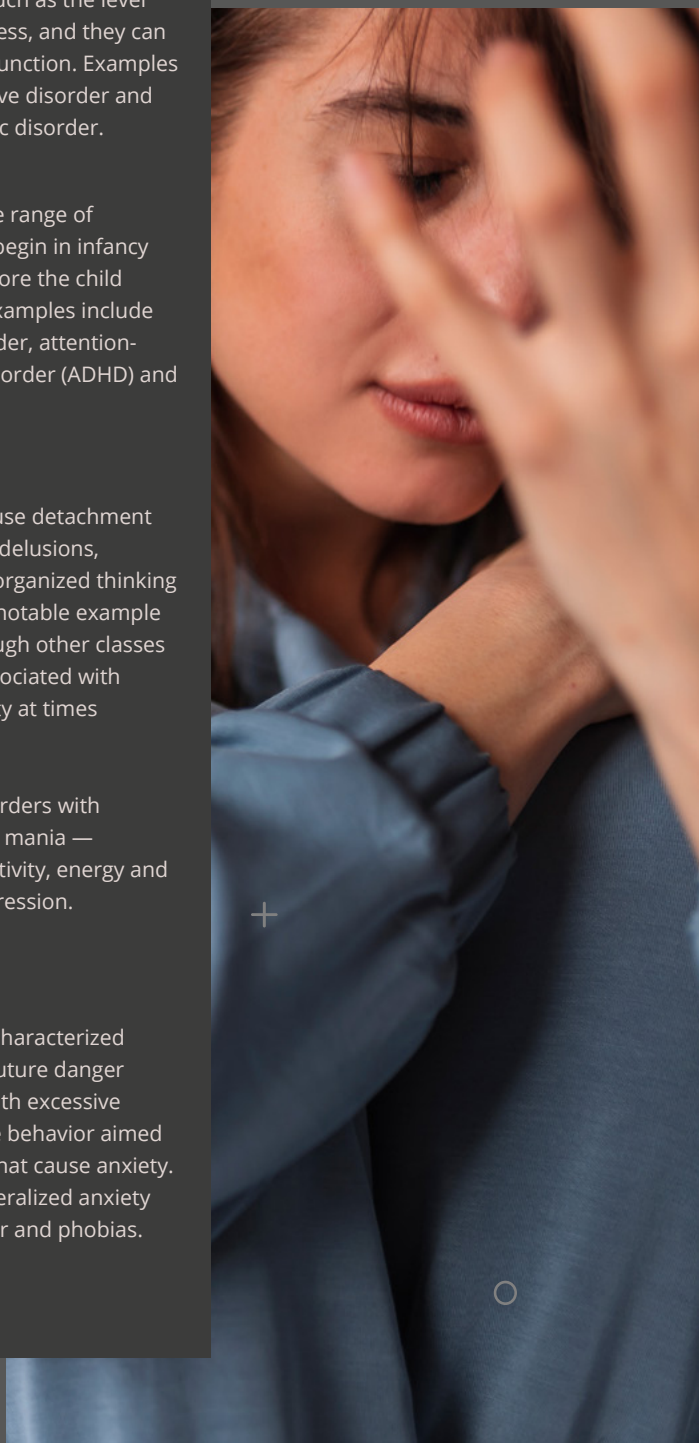
The manner in which researchers and medical personnel analyze and report on mental health and related disorders varies among publications and in practice. Many publications cluster "Mental health, Neurological and Substance use disorders" together and refer to this group of conditions using the acronym "MNS". Some organizations and researchers also include "self-harm" and/or "suicide" along with these other conditions and report on Mental health, Neurological, Substance use disorders and self-harm, or "MNSS". We note these definitions to alert the reader to the fact that some statistics included in this report are based on MNS, while others also include self-harm and suicide, i.e. MNSS.

COMMON CONDITIONS

There are many types of mental, neurological and substance-use illnesses, which are often grouped into “classes” of disorders. The Mayo Clinic provides a good summary of the main classes of MNS disorders (Table 1).

Table 1. Main Classes of Mental, Neurological and Substance-Use Disorders

Depressive disorders.	These include disorders that affect how you feel emotionally, such as the level of sadness and happiness, and they can disrupt your ability to function. Examples include major depressive disorder and premenstrual dysphoric disorder.
Neurodevelopmental disorders.	This class covers a wide range of problems that usually begin in infancy or childhood, often before the child begins grade school. Examples include autism spectrum disorder, attention-deficit/hyperactivity disorder (ADHD) and learning disorders.
Schizophrenia spectrum and other psychotic disorders.	Psychotic disorders cause detachment from reality — such as delusions, hallucinations, and disorganized thinking and speech. The most notable example is schizophrenia, although other classes of disorders can be associated with detachment from reality at times
Bipolar and related disorders.	This class includes disorders with alternating episodes of mania — periods of excessive activity, energy and excitement — and depression.
Anxiety disorders.	Anxiety is an emotion characterized by the anticipation of future danger or misfortune, along with excessive worrying. It can include behavior aimed at avoiding situations that cause anxiety. This class includes generalized anxiety disorder, panic disorder and phobias.



COMMON CONDITIONS

Obsessive-compulsive and related disorders.

These disorders involve preoccupations or obsessions and repetitive thoughts and actions. Examples include obsessive-compulsive disorder, hoarding disorder and hair-pulling disorder (trichotillomania).

Trauma- and stressor-related disorders.

These are adjustment disorders in which a person has trouble coping during or after a stressful life event. Examples include post-traumatic stress disorder (PTSD) and acute stress disorder.

Dissociative disorders.

These are disorders in which your sense of self is disrupted, such as with dissociative identity disorder and dissociative amnesia.

Disruptive, impulse-control and conduct disorders.

A person with one of these disorders may have physical symptoms that cause major emotional distress and problems functioning. There may or may not be another diagnosed medical condition associated with these symptoms, but the reaction to the symptoms is not normal. The disorders include somatic symptom disorder, illness anxiety disorder and factitious disorder.

Substance-related and addictive disorders.

These include problems associated with the excessive use of alcohol, caffeine, tobacco and drugs. This class also includes gambling disorder.

Neurocognitive disorders.

Neurocognitive disorders affect your ability to think and reason. These acquired (rather than developmental) cognitive problems include delirium, as well as neurocognitive disorders due to conditions or diseases such as traumatic brain injury or Alzheimer's disease.

Personality disorders.

A personality disorder involves a lasting pattern of emotional instability and unhealthy behavior that causes problems in your life and relationships. Examples include borderline, antisocial and narcissistic personality disorders.

Table 1. Main Classes of Mental, Neurological and Substance-Use Disorders

STIGMA
AND CULTURAL ISSUES

Stigma can be defined as "a mark of disgrace or shame that sets a person apart from others." When a person is labeled by their illness they are no longer seen as an individual but as part of a stereotyped group. Negative attitudes and beliefs toward this group create prejudice that leads to negative actions and discrimination.

Stigma towards mental health, neurological and substance disorders is prevalent throughout Latin America and the Caribbean and remains as one of the main obstacles to improving care for those afflicted.[3] Traditional Latino cultural values have been associated with the stigma related to mental health and substance-use disorders. Gender-based differences in expectations related to seeking help rooted in cultural values such as ***machismo*** (men being able to handle their own problems without external help), ***marianismo*** (self-sacrifice for those one cares about even to the detriment of oneself), as well as ***familismo*** (successfully fulfilling family obligations before all else) and ***fatalismo*** (accepting God's will or fate) may further impact Latinos' perceptions of people with depression and also their willingness to seek professional help. Certain taboos, and various aspects of religion have also been associated with higher stigma related to mental health conditions in Latin American cultures.[4]

> **Stigma is the biggest killer out there.** Stigma kills more people than cigarettes, than heroin, than any other risk factor. Because it keeps people in the shadows, it keeps people from asking for help, it keeps good people from being willing to offer help.[2]
>
> Dr. Jerome Adams.
> Former U.S. Surgeon General 2017-21

In a comprehensive review article on the topic, Mascayano et al[5] classified the main types of stigma in mental health among Latin American and Caribbean populations into four categories: Public; Institutional; Self; and Family Stigma. Oftentimes, more than one type of stigma is often a reality for the individual with a mental-health and/or substance-use disorder (Table 2).

PUBLIC	The process in which the general public stigmatizes individuals with mental illness, consisting of processes of stereotyping, prejudice, and discrimination.
INSTITUTIONAL	Institutional practices that work to the disadvantage of the stigmatized group or person.
SELF	When an individual takes publically acknowledged stereotypes held by society and applies them to him or herself.
FAMILY	When stigma is experienced among those who are related by kinship to labeled individuals.

Table 2. Types of Stigma associated with a mental-health or substance use disorder among Latin American and Caribbean populations.

In another review article by Misra et al (2021), researchers found that Latin Americans more often conceal mental illness and treatments (therapy and medication) because they feel that it reflects personal weakness, that they're faulty, and/or a source of individual and familial shame.[6]

Stigma and bias towards people with mental health and substance use conditions is not limited to the general public – healthcare providers can also be at fault. A study from the Dominican Republic [7], found that stigmatizing attitudes among health care staff negatively influenced the care of patients with MNS-disorders. On a more positive note, some researchers have found that the traditional values of compassion and benevolence associated with Latin American culture can counter-act the tendency for stigma towards MNS patients.[8]

In the next section, we review some statistics and trends in the Americas Region for major mental-health, neurological and substance-use disorders, as well as those for self-harm and suicide. Of note, it is likely that the rates of some of these conditions are even higher than these official statistics, in part due to the stigma associated with these conditions.

STAT|ST|CS

Mortality data alone do not adequately capture the deaths caused by mental illness and substance-use; therefore, it is useful to look at metrics that incorporate the disability associated with these maladies. The PAHO and other international organizations use Disability-adjusted life years (DALYs) and Years lived with disability (YLDs).

In an analysis of the burden of disease across all conditions in the Americas, mental health, neurological, substance-use and suicide (MNSS) accounts for 19% of the total DALYs. This proportion is second only to noncommunicable diseases (e.g. cardiovascular disease, diabetes) which account for the largest percentage of DALYs at 59% in the region.

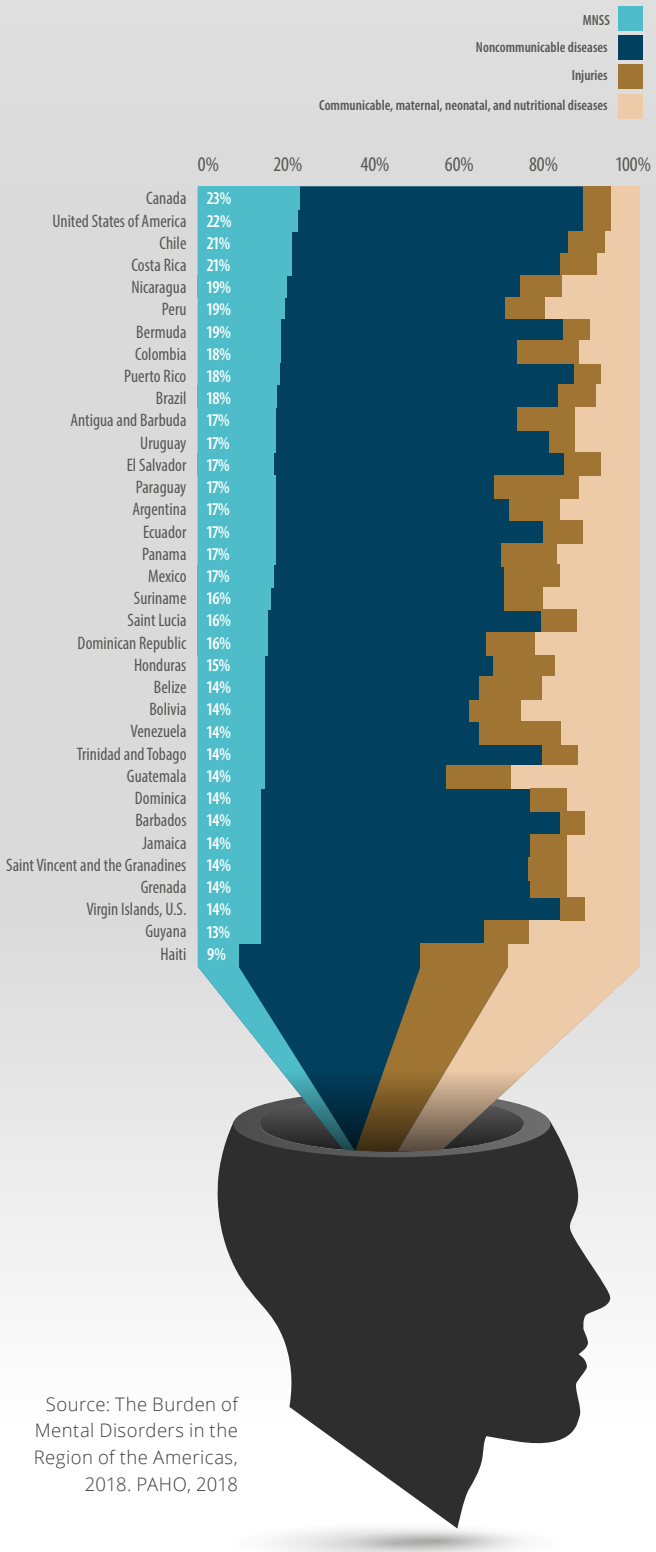
There are wide variations in the proportion of total DALYs that is accounted for by MNSS in the Americas region (Figure 1). MNSS accounts for 23% and 22%, of the total DALYs in Canada and the United States, respectively, but only 9%-14% among most Caribbean countries. Latin American countries generally fall in the middle, with a low of 14% in Guatemala and a high of 21% in Chile.

1in4

people in the Americas experiences mental illness and/ or substance use disorder in their lifetime

PAHO, 2018

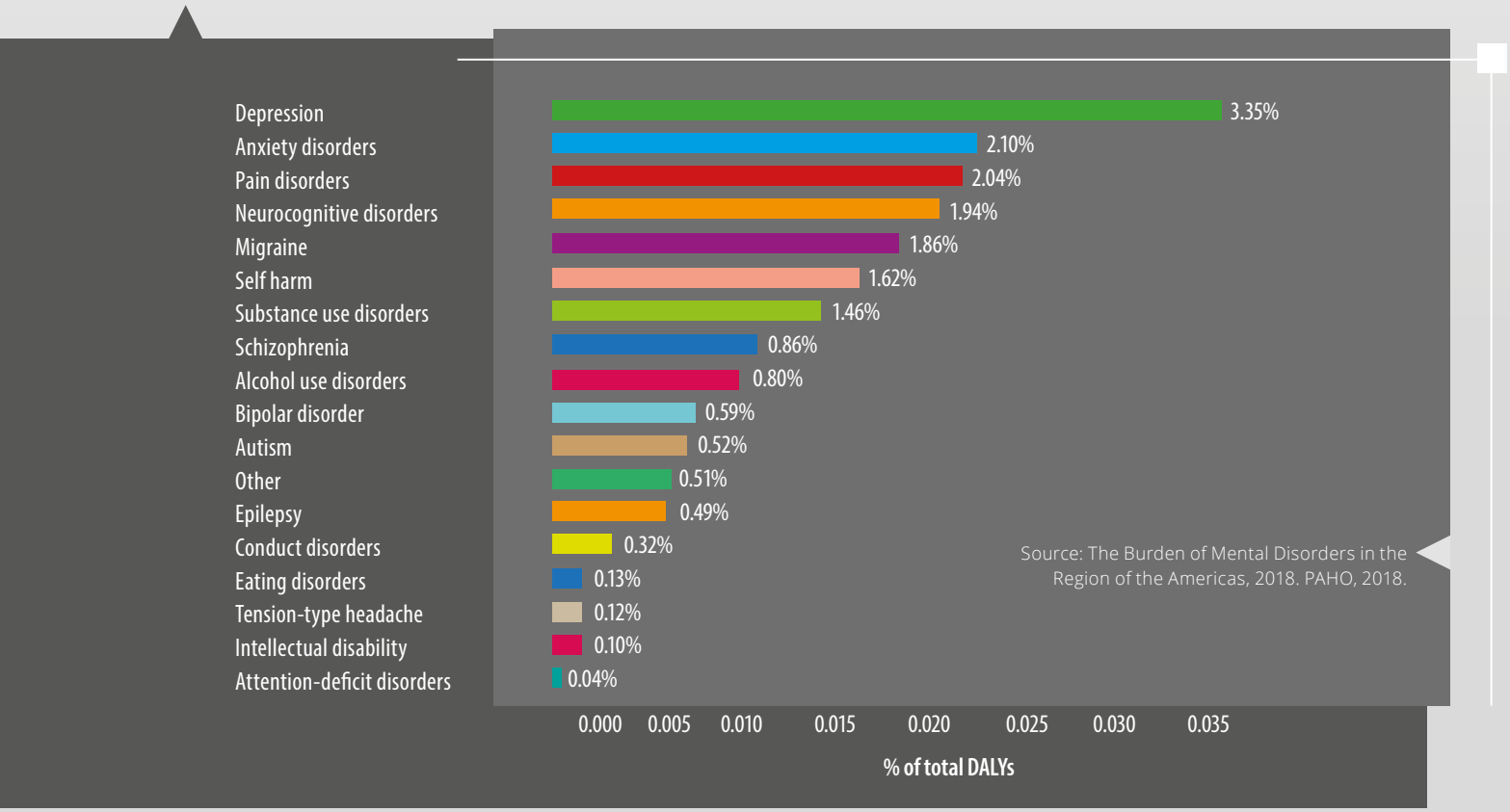
Figure 1. Disability-adjusted life years (DALYs) distribution by country (%)



Source: The Burden of Mental Disorders in the Region of the Americas, 2018. PAHO, 2018

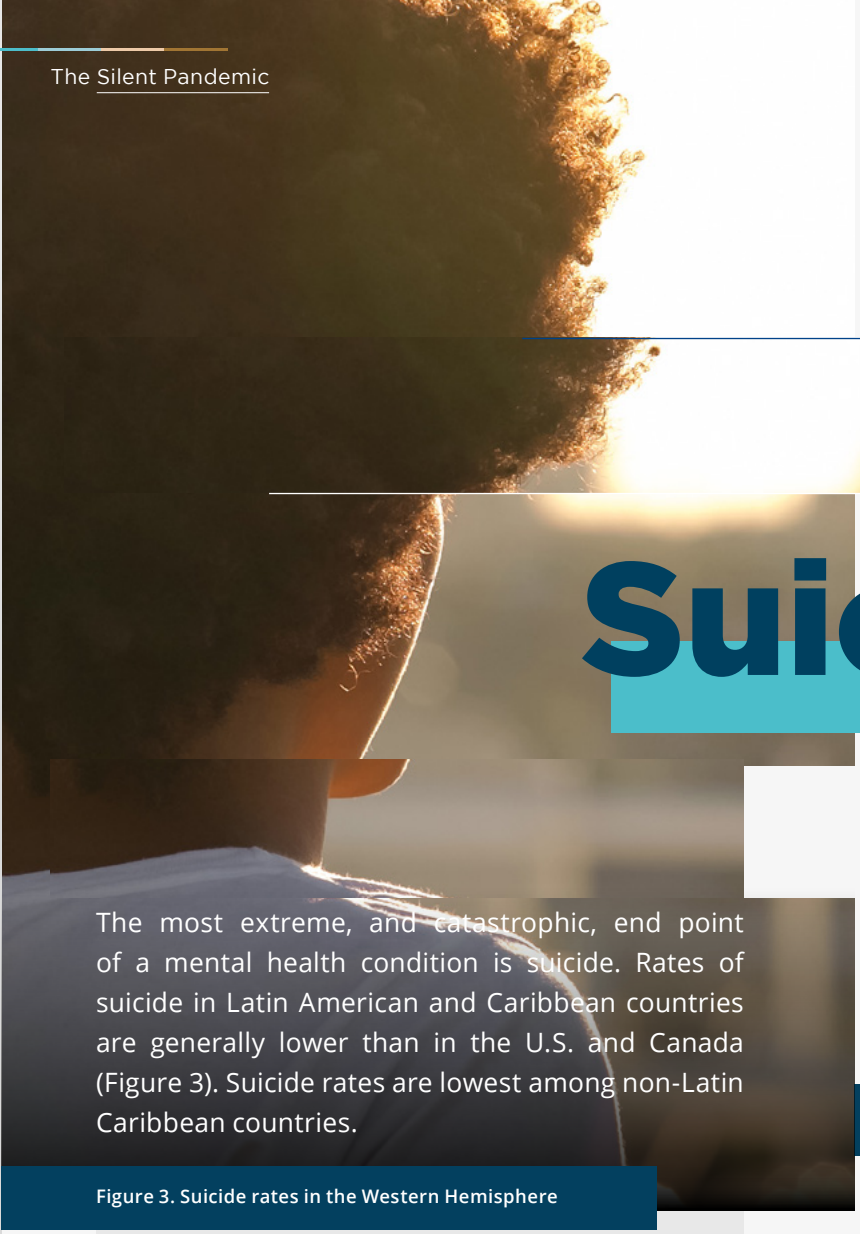
Depression, anxiety and pain disorders top the list of MNSS conditions in Latin America and the Caribbean (Figure 2).

Figure 2. Ranking of mental, neurological, and substance use disorders, and suicide (DALYs)



The most prevalent condition, depressive disorders, is associated with age and has very large impact on the total years of life with disability. Depressive disorders among working age populations in the Americas is responsible for nearly 10 million years lived with disability (YLDs).

The countries with the highest burden and years lost due to depressive disorders are in South America: Paraguay, Brazil, Peru, Ecuador and Colombia. Countries with the lowest YLDs due to depressive disorders tend to be in Central America (i.e. El Salvador, Guatemala, and Panama) while Caribbean countries are in the middle. Notably, Canada has the lowest YLDs due to depressive disorders.

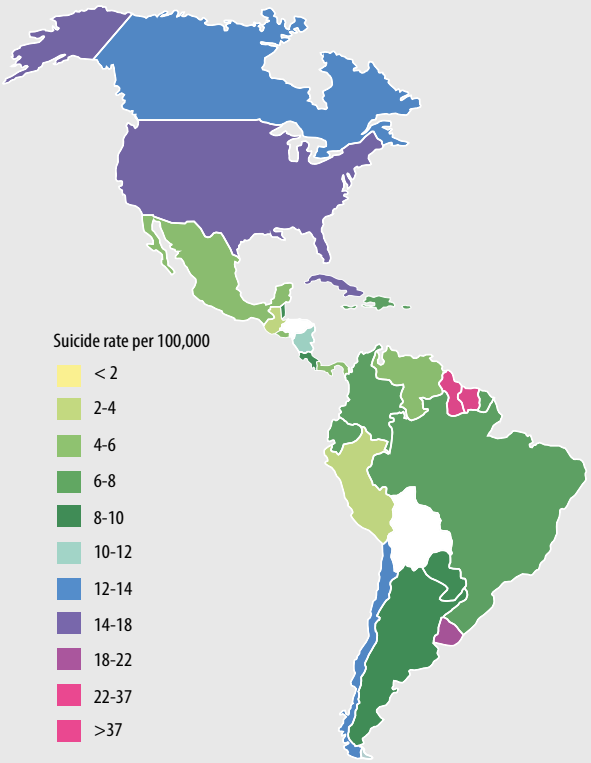


Suicide

The most extreme, and catastrophic, end point of a mental health condition is suicide. Rates of suicide in Latin American and Caribbean countries are generally lower than in the U.S. and Canada (Figure 3). Suicide rates are lowest among non-Latin Caribbean countries.

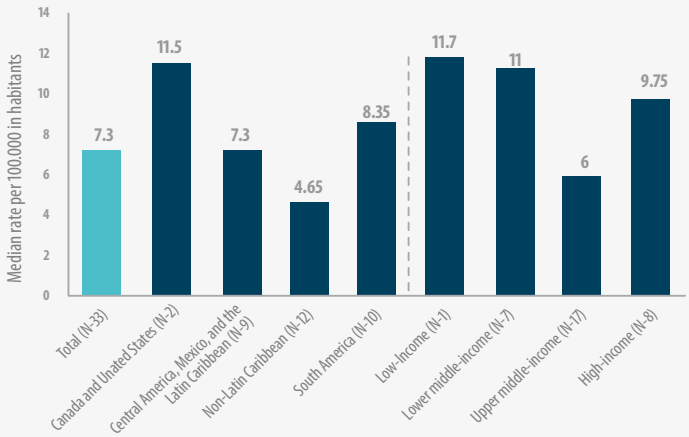
When comparing lower-, middle- and high-income countries, there is also a notable "U" shape curve. The lowest income country in the region (Haiti) has a suicide rate of 11.7 per 100,000 population. The rate is lowest for the 17 middle-income countries in the region, but then goes up again to 9.75 per 100,000 for the highest income countries (Figure 4).

Figure 3. Suicide rates in the Western Hemisphere

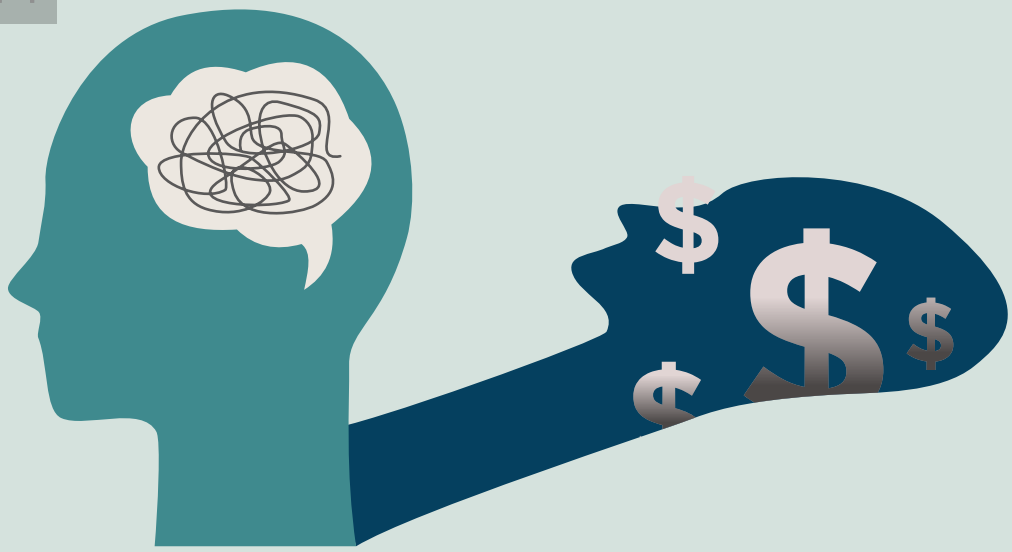


Source: PAHO. Suicide Mortality in the Americas. Regional Report 2010–2014. https://iris.paho.org/handle/10665.2/53348

Figure 4. Suicide per 100,000 population in the Americas, by region and country income levels.



Source: Atlas of Mental Health in the Americas. PAHO, 2018.



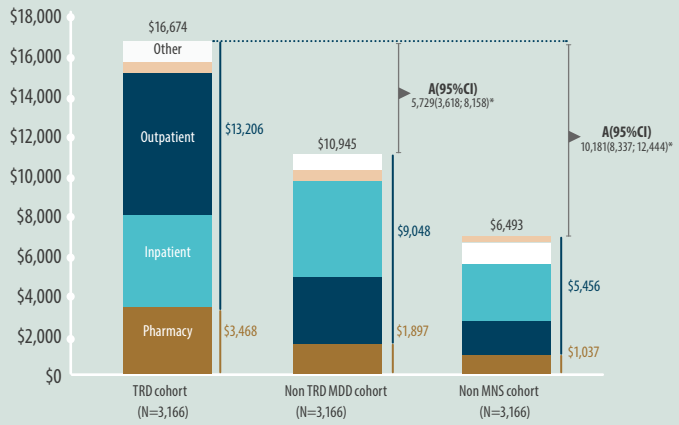
COSTS and ECONOMIC IMPACT

Patients with MNS incur significantly more healthcare costs and miss more days of work than those without MNS. Worldwide, depression and anxiety disorders alone are estimated to cost the global economy over $1 trillion each year in lost productivity.[9]

This is particularly true among patients with mental health disorders that do not respond to medications and are referred to as being "treatment-resistant".

Treatment resistant depression, or TRD, for example, is seen in approximately 30% of patients with a major depressive disorder in Latin America.[10] A study of claims data from commercially insured populations in the U.S. found that **an employee that had treatment-resistant depression (TRD) incurred a total of $16,674 in medical expenses per year.** This compared to $10,945 per year in medical costs for workers that had a major medical disorder that was not treatment resistant (Non-TRD MMD) and $6,493 per year for workers that did not have a major depressive disorder (MDD) (Figure 5).

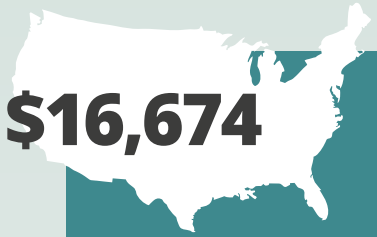
Lost work days mirrored these cost data. Workers with TRD missed an average of 54 days of work per year, compared to 32 days and 17 days, for the Non-TRD MMD and Non-MDD groups, respectively.



Source: Zhdanava M et al. Economic burden of treatment-resistent depression in privately insured US patients with co-occuring anxiety disorder and/or substance us disorder, Current Medical Research and Opinion. 2021.

Figure 5. All-cause health costs (US $2017) per patient per year.

Mental health disorders among youth is also costly. **A recent study by UNICEF found that economies in Latin America and the Caribbean lost over US$30 billion each year due to youth mental health disorders.**[11]



$16,674

(TRD) patient costs per year in E.E.U.U.

Causes of MNS

There is no single cause of mental illness or substance-use disorders. Mental illnesses arise from the interplay of genes, environment and a host of many other factors. **Table 3 summarizes a few of the most common contributors.**

Table 3. Causes of Mental Disorders

- Genes and Family History.
- Life Experiences, including stress or a history of abuse, especially in childhood.
- Biological factors such as chemical imbalances in the brain.
- A mother's exposure to viruses or toxic chemicals while pregnant.
- Use of alcohol or recreational drugs.
- Having a serious medical condition like cancer or other chronic disease.[12]
- Having few friends, and feeling lonely or isolated.

In addition, a range of social determinants affect the risk and outcome of MNS disorders.[13] These social determinants may include: ***socioeconomic factors*** (e.g. unemployment, low education); ***neighborhood factors*** (e.g. overcrowding); and ***environmental events*** (e.g. migration, natural disasters, pandemics). As we explore in a later section of this report, the impact that the COVID-19 pandemic has had on mental health is a prime example of these types of social determinants.

Source: PAHO. Suicide Mortality in the Americas. Regional Report 2010–2014. https://iris.paho.org/handle/10665.2/53348

TREATMENT AND TREATMENT GAPS

There are a range of effective interventions and medical treatments for MNS, including medications, psychological treatments, and social interventions. A detailed discussion of medical and psychological treatments is outside the scope of this report, but can be found elsewhere (see for example, Patel et al, 2016)[14]. In this report, we offer a summary overview, with a focus on ways in which employers can support workers with MNS.

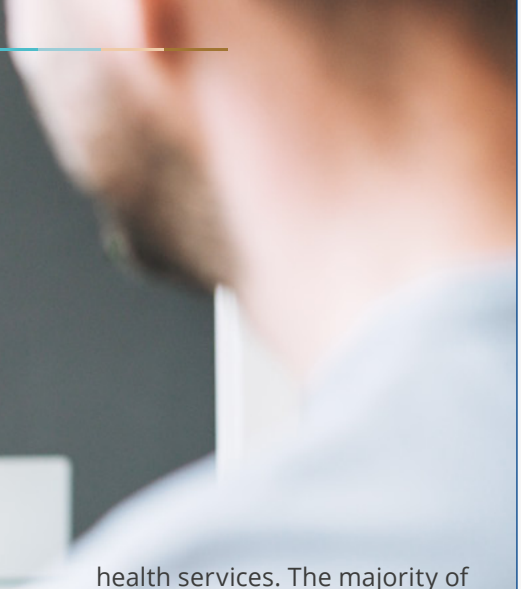
At the employer-level, supporting employees with MNS includes creating an open and supportive environment to raise awareness of these conditions, and ensuring assistance and access to coaching and counseling programs. Additional, detailed guidance and some key resources for employers is presented in a later section of this report.

Companies can contribute to the creation of open environments and spaces for training and support for awareness of MNS.

At the population-level, best practices for treating and preventing MNS include legislative measures that make educational and treatment resources available. At the community-level, best practices include life-skills training in schools and workplaces to build social and emotional competencies. At the health-care-level, self-management (e.g., web-based psychological therapy for depression and anxiety disorders) and primary care and community outreach (e.g., non-specialist health worker delivering psychological and pharmacological management of selected disorders). Specialized services for MNS disorders at first-level hospitals play an important part for the most severely ill.

The "treatment gap" between the widespread occurrence of mental-health and substance-use disorders and the resources that are dedicated to addressing these conditions is a global challenge, including in Latin America and the Caribbean[15]. In Latin America, for example, the treatment gap for substance use disorders was 83.7% compared to 69.1% for North America. The treatment gap for anxiety disorders ranged from 56.2% in North America to 81.8% in Mesoamerica. For affective disorders, the treatment gap was 58.4% in North America and 77.4% in Mesoamerica.

That said, spending on mental health varies widely among countries in the Americas. The United States and Canada each spend approximately 8% of their total government health budget on mental health. Some Caribbean island nations (i.e. Barbados, Jamaica) also spend approximately 8% of their total health budget on mental health services. At the other extreme, Bolivia, Guatemala and the Dominican Republic spend only about 0.2% of their healthcare budget on mental



health services. The majority of Latin American and Caribbean countries spend between 1-2% of their health budgets on mental health, a figure that contrasts sharply with the figure of nearly 20% burden of disease associated these conditions, cited earlier in this report.

Looking at the disparities in investment in mental health another way, the U.S. and Canada spend an average of $193.50 per capita on mental health programs and medical care. Non-Latin Caribbean countries spend an average of about $24 per capita while most countries in the Central American and South American regions invest just $1.00 and $2.30 per capita.

Mental Health Worker Shortage

The treatment and spending gap is also reflected in the shortage of mental health workers in many Latin American and Caribbean countries. In the U.S. and Canada, for example, there are 235.5 mental health workers, i.e. psychiatrists, mental health nurses, social workers, etc. per 100,000, compared to 10.9 per 100,000 for Central America/Mexico/Latin Caribbean region, and 9.7 and 8.8 per 100,000 population for Non-Latin Caribbean, and South America, respectively (Table 4).

Table 4. Median number of mental health workers in the 39 countries of the Americas, by region (rate per 100,000 population)

	Psychiatrists	Child psychiatrists	Other medical specialists	Mental health nurses	Psychologists	Social workers	Occupational therapists	Speech pathologists	Other salaried workers	Total
Total (N=39)	1.4	0.0*	0.0*	3.9	5.4	0.4	0.0*	0.0	0.2	10.3
Subregion										
Canada and United States (N=2)	12.6	2.0	-	36.5	39.3	92.5	3.7	25.50	78.1	235.5
Central America, Mexico, and the Latin Caribbean (N=18)	0.9	0.0*	0.1	0.2	7.3	0.3	0.0*	0.0	0.0	10.9
Non-Latin Caribbean (N=18)	1.2	0.0	0.0	7.9	0.6	0.5	0.0	0.0	5.0	9.7
South America (N=18)	2.4	0.2	0.6	0.1	8.6	0.2	0.1	0.1	0.5	8.8

* = <0.04

Source: Atlas of Mental Health in the Americas. PAHO, 2018.

International and local governmental agencies in the Americas recognize that there are gaps in mental health services. The "Brasilia Concensus of 2013"[16] and resulting regional "Plan of Action on Mental Health 2015-2020"[17] are often cited as evidence that there is a recognition of the problem.

Today, however, there remains a dramatic shortage of mental health services and providers in the majority of the Americas relative to the large and growing needs of these populations. This shortfall is especially acute among Central America and Latin-Caribbean nations. The lack of funding and attention to MNSS is likely due, in part, to the stigma and a range of cultural issues associated with these conditions, an area we explored in an earlier section of this report.

20% to **40%**
increase in mental health disorders during the pandemic in Latin American and Caribbean countries

COVID-19 AND MENTAL HEALTH

The COVID-19 Pandemic has had significant, negative impact on mental health, among both healthcare providers as well as the population as a whole.[18]

A global study of the prevalence and burden of depressive and anxiety disorders due to the COVID-19 pandemic found that rates of mental health disorders increased by 20% to 40% in Latin American and Caribbean countries – some of the highest increases in the world.

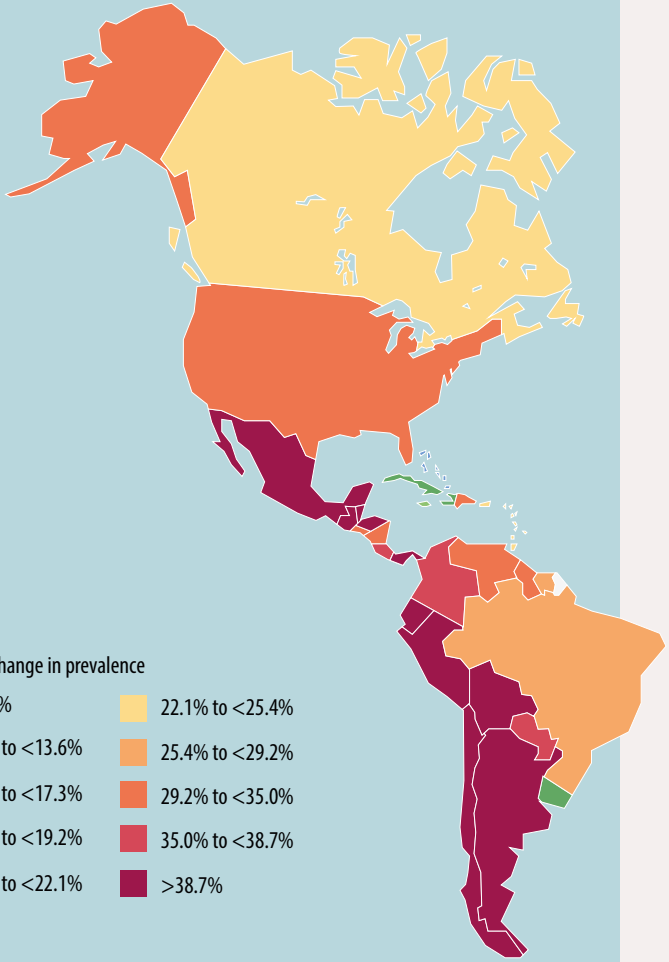
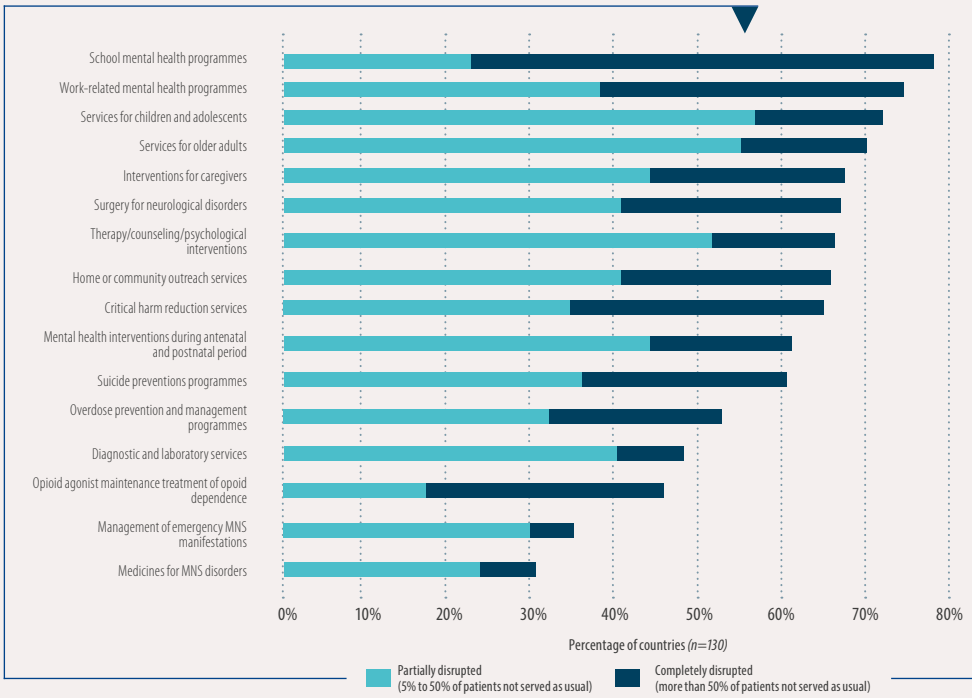


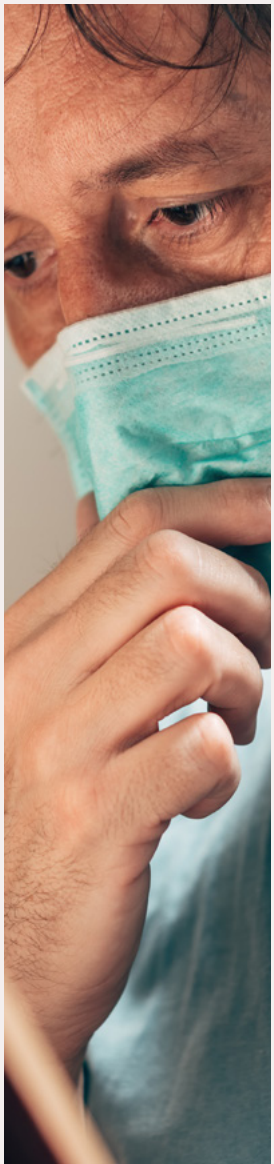
Figure 6. Change in the prevalence of major depressive disorder as a result of the COVID–19 pandemic, 2020

In an earlier, 2020 global survey that included 130 member countries, the WHO found that in the majority of countries worldwide, MNS-related interventions and services were disrupted due to COVID-19.

As shown in Figure 7, work-related mental health programs were second only to school-related programs in terms of the degree and scope of disruption due to the COVID-19 pandemic.

Figure 7. Disruptions of MNS-related intervention/services in 130 countries due to COVID-19





The causes of the disruptions reflected are many, with decreases in outpatient volume due to patients not presenting and travel restrictions hindering access to the health facilities for patients topping the list.[19].

At the individual patient level, the COVID-19 outbreak **has increased the prevalence of depression and other mental health disorders** among people that were already suffering from chronic disease.

A study conducted in Mexico, for example, found that patients with rheumatic diseases were much more likely to be anxious and depressed during the COVID-19 outbreak than they were before the pandemic. The specific drivers of these concerns related to: drug shortages and difficulty finding medication and the fear of not being able to access medical care when they needed it.[20] Another recent study of five Spanish-speaking countries (Honduras, Chile, Costa Rica, Mexico and Spain) found that "confinement stress" related to family and financial concerns were the most important drivers of anxiety and depression during the COVID-19 pandemic.[21]

CARING
FOR YOUR MENTAL HEALTH

There are specific activities and actions that individuals can take to boost their mood, reduce stress and lower the risk for depression. According to the CDC, PAHO and other experts, the best ways to cope with stress and depression include:

Taking care of your body

- Get plenty of sleep.
- Avoid excessive alcohol, tobacco, and substance use.
- Take deep breaths, stretch, meditate.
- Try to eat healthy, well-balanced meals.
- Exercise regularly.

Making time to unwind

Try to do some other activities you enjoy.

Letting go

Learn to let things go that you cannot control.

Limiting the time you spend on social media

Avoid too much sad, disturbing or political news.

Connecting with others

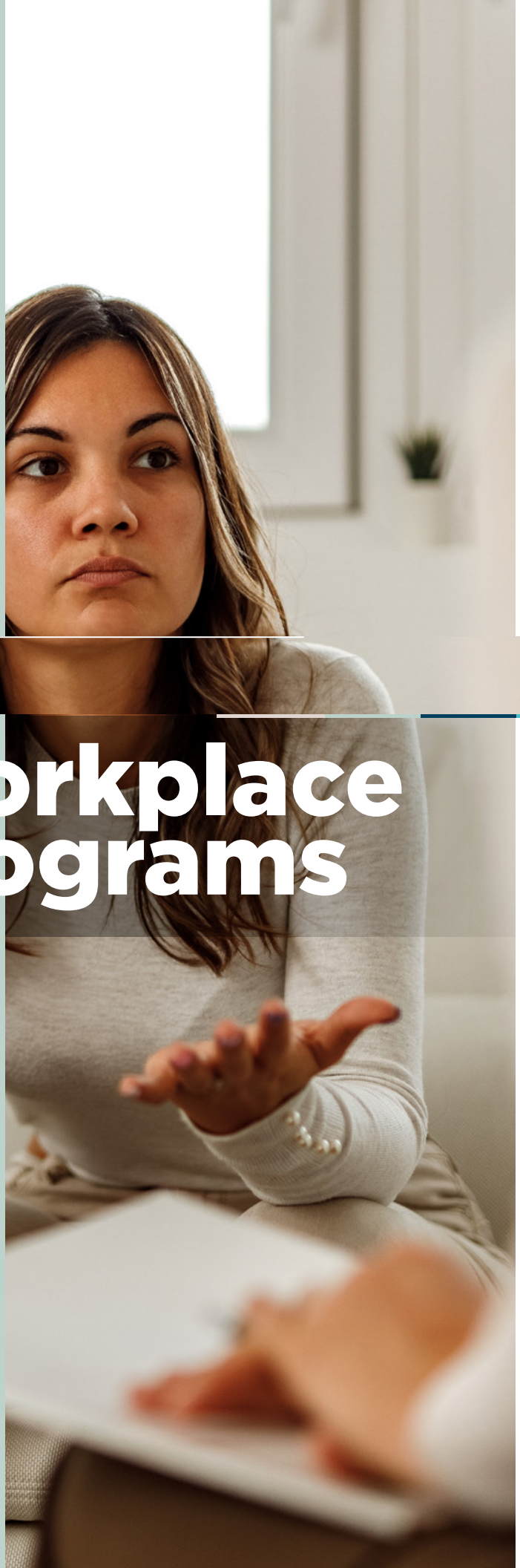
Talk with people you trust about your concerns and how you are feeling.

Connecting with your community- or faith-based organizations

While social distancing measures are in place, try connecting online, through social media, or by phone or mail.

Ask for Help

If your stress or depression persists, seek medical attention.



Workplace Programs

The workplace can be an ideal site for delivering mental health prevention programs[22] as well as increasing access to appropriate treatment.[23] Such proactive actions can be of benefit to both employees and their employers.[24] Use of these resources, and health seeking by employees with mental health or substance use disorders in general, is often low[25], with one study reporting that only 15% of workers with a mental health problem had sought help in the preceding month.[26] Against the widespread stigma described earlier, as well as the more limited behavioral health resources currently available, health seeking among employees is likely to be even lower among Latin American and Caribbean workers.

The 4 A's of a Mental Health-Friendly Workplace

Source: Zhdanava M et al. Economic burden of treatment-resistent depression in privately insured US patients with co-occuring anxiety disorder and/or substance use disorder, Current Medical Research and Opinion. 2021.

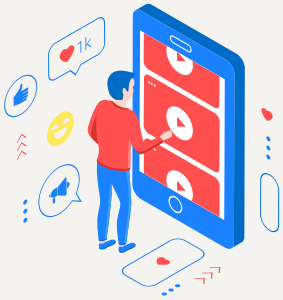
Figure 8. The 4 A's of a Mental Health-Friendly Workplace

The four immediate steps that employers can take to support their employees with MNS are to: (1) Build awareness of the mental-health and substance-use disorders; (2) provide accommodations, e.g. flex time, to employees that may be struggling with these conditions; (3) offer assistance through employee-benefits programs and; and (4) ensure access to treatment through selection of quality insurance products and services. In-depth resources for employers on establishing a healthy work environment are available through the CDC's website[27].

Resources on Mental Health for Latin America and the Caribbean

PAHO has produced a number of excellent educational videos on mental health that are available in English and Spanish. These are available at no cost on the PAHO website[28]. A selection of the types of videos available at the website shown in Figure 9.

Figure 9. Mental Health Educational Videos available through PAHO/OPS



PAHO Pan American Health Organization

World Health Organization Americas

WATCH ON:
https://www.paho.org/en/topics/mental-health

Source: https://www.paho.org/en/topics/mental-health.

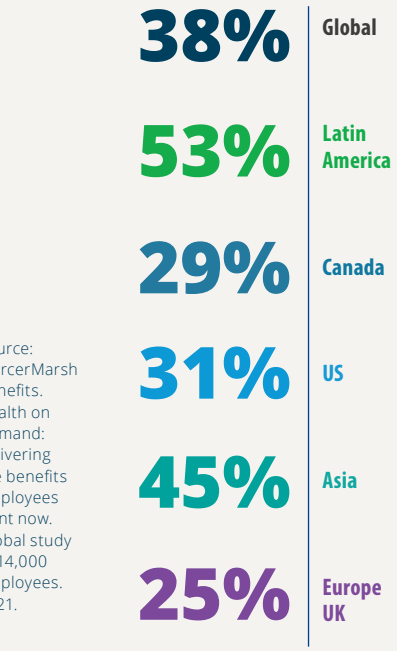
Pan-American Life Insurance Group also offers useful Spanish-language articles, tips and guidance on mental health at https://www.paligmed.com/es/salud-mental.

Web-based psychological interventions delivered in the workplace are a growing and promising area of improving employee well-being. In a systematic review of 21 studies that examined the effectiveness of digital mental health interventions, researchers found that these programs had statistically significant benefits for both psychological well-being as well as worker productivity.[29] As we look towards designing and implementing these programs in Latin America and the Caribbean, it is crucial that internet- and mobile-based interventions for mental disorders are culturally adapted to the local populations for maximal effectiveness.[30]

In a recent global study of employers by MercerMarsh Benefits, 53% of Latin American employees were open to the use of Artificial Intelligence (AI)-driven (i.e. no human involved) virtual mental health advice to address anxiety, sadness or personal relationship issues, a figure higher than any other region (Figure 9).

Figure 10. Receptivity to virtual mental health advice, by region

AI-driven counseling by the numbers: Employees by region who said virtual mental health advice via chat, powered by artificial intelligence (no human involved), to address anxiety, sadness or personal relationship issues, was highly or extremely valuable (%)



Source: MercerMarsh Benefits. Health on Demand: delivering the benefits employees want now. Global study of 14,000 employees. 2021.

CONCLUSION

People you can *trust for life*

Mental, neurological and substance-use disorders are second only to chronic diseases in their negative impact on worker productivity and costs. The COVID-19 pandemic has opened further dialogue about the urgency of providing support for employees and patients with MNS disorders. We encourage all PALIG members to take full advantage of the mental health benefits that are available to them, according to their policy contract. We also invite our employer, broker and provider partners to engage with us on the topic of mental health and welcome dialogue on collaborative solutions - together we can make a difference.

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A PALIG White Paper

MENTAL HEALTH

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