

WHO-AIMS

WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEMS
IN THE CARIBBEAN REGION



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Report of the Assessment of the Mental Health System in the Caribbean Region (16 Countries and Territories) using the WHO-AIMS Instrument for Mental Health Systems (WHO-AIMS)

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Acknowledgements

The number of countries involved in this sub-region is large. The completion of the WHO-AIMS for each one of the countries and territories has seen the active involvement of a number of actors, working for the respective Ministries of Health as well as for PAHO/WHO country offices. In most of the cases, data on mental health is not easily accessible; therefore it has required a long and serious commitment from those actors involved.

Ministries of Health of the sub-region have seen the importance of updating their information on mental health, and have therefore committed to the finalization of the process.

Special acknowledgment goes to the PAHO/WHO Representatives (PWR), who have supported the entire process, offering their technical advice as well as the availability of mental health focal points within the representation to follow up the project. Recognition goes also to the PWR of the Eastern Caribbean Countries, who hired a technical expert to collect data in the ten countries and territories under their Representation.

The following listed names are only key actors involved in the data collection process. Many professionals were consulted at one point or another. For a complete list of each country we recommend to refer to the WHO-AIMS country-reports (1).

PAHO/WHO Representatives: Dr. Merle Lewis, The Bahamas and Turks and Caicos; Dr. Beverley Barnett, Belize; Dr. Gina Watson, Eastern Caribbean Countries; Dr. Kathleen Israel, Guyana; Dr. Ernest Pate, Jamaica; Stephen Simon, Suriname; Dr. Carol Boyd-Scobie, Trinidad and Tobago.

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Introduction

The history of psychiatry and mental health in the Caribbean follows a similar path as found in other regions of the world. Following the British model, psychiatric institutions – more often referred to “mad houses,” – were established in many countries and territories in the region between 1850 and 1900. These asylums were places where the mentally ill could be locked away from society for many years or even forever. (2, 3)

With the gradual introduction of psychotherapeutic treatments and the arrival of the psychiatric pharmacotherapy, several countries and territories started developing services for the mentally ill in the community, as they sought alternative ways to treat people outside the large asylums. Many countries and territories engaged in the process of de-institutionalization and development of community-based mental health services. Developing services at community level initiated 30 years ago but was interrupted or slowed down for different reasons and at different time periods. As a result, there are currently mostly centralized mental health services and less development of community based ones.

It is worth saying that the countries and territories from the Caribbean that have completed the WHO-AIMS – mostly islands and small populations – present common challenges, not always considered in current literature on mental health systems. The classic model of care – moving from large mental hospitals to community care – will be very different in this region due to their unique features (many without a mental hospital and with very limited human resources). The challenge that the Caribbean presents is the need – perhaps – of a different model that will answer to the needs of the peoples from the region.

However, despite the complexities and difficulties of the sub-region, there are still some positive experiences that are not always known by neighboring countries. Examples of good practices should be disseminated in the region. We hope this report contributes to stimulating contacts and visits in this region to learn about each other’s experiences in comparable contexts.

Methodology

A common issue in the Caribbean is lack of epidemiological studies and general information regarding mental health. This has been partially overcome thanks to countries' decision to implement the WHO-AIMS.

The first steps to implement WHO-AIMS took place in the second half of 2006. Since then, gradually, seventeen countries and territories have assessed their mental health systems, which sometimes was difficult. The results of those assessments are summarized in this report, except The Bahamas, whose report wasn't completed by the time of publishing this document.

The whole process has culminated in November 2010. Some countries or territories presented here used data from 2009 and others utilized data from 2006. Countries and territories that began the process earlier, their systems have continued to change and these latest changes are not reflected in this document.

Data collection process was the same in each of the countries and territories. Once the Ministry of Health agreed to initiate the implementation, the Ministry would nominate a focal person to collect the information from all stakeholders. With the support of PAHO/WHO, country level meetings were held with key stakeholders such as mental health professionals, health authorities, and other partners, for presentations and discussions of the tool.

The data collection process followed the workshop. Once the data was collected, PAHO/WHO professionals reviewed the information gathered. The feedbacks were sent to the focal point, whenever there was a need for clarification. This process continued until all indicators were correct. Then, the report was elaborated based on a template, which followed the same procedure of revision. The final version of the report for each country and territory was then uploaded to the PAHO and WHO websites (3).

All country-reports are published on PAHO and WHO websites. (1) For a more comprehensive and general information regarding the WHO-AIMS, please refer to WHO website, where the tool is available for consultation and download. (4)

The countries and Territories

The following document includes sixteen Caribbean countries and territories in the analysis. Although they share several similarities, especially that they belong to the same region, they are also different in terms of size (i.e., range from 90 to 13,000 km²), population (e.g., range from 5000 to 2.5 millions), economic status (e.g., low, middle, and high income), geographical location (e.g., continent, islands), and political situation (e.g., independent, British Overseas Territories). Their common history of colonization binds them as one Caribbean; however, the diversity of cultural influences is apparent and can still be seen today.

Their integration mechanism is their belonging (as members or associate members) to the Caribbean Community and Common Market (CARICOM). (5)

A summary of their basic socio-demographic indicators is presented in table 1.

Table 1 - Basic Socio-Demographic Indicators

	Income Categories of Countries*	Population 2009 (thousands) **	Gross National Income (GNI) per Capita (US\$ per capita) 2007 ***	GDP per Capita 2009 (ppp US\$) ****	Literacy Rate 1999–2007 (% adult) *****	Life Expectancy at Birth (2009)*	Public Expenditures In Health % GDP ***
Anguilla	...	13.6	...	...	...	80.6	4.2
Antigua & Barbuda	High	85.9	17,680	18,691	99	74.8	2.9
Barbados	High	269	...	17,956	...	77.5	5.7
Belize	Lower-middle	301.3	3,760	6,734	75.1	76.6	1.9
British Virgin Islands	...	27.5	...	...	...	79.2	3.5
Dominica	Upper-middle	71.2	4,030	7,893	88	76.0	3.8
Grenada	Upper-middle	107.4	3,920	7,344	96	75.6	3.2
Guyana	Lower-middle	750	1,250	2,782	...	67.4	5.6
Jamaica	Upper-middle	2,660.7	3,330	6,079	86	72.1	2.2
Montserrat	...	4.8	...	...	...	73.0	7.1
St Kitts & Nevis	Upper-middle	44	9,990	14,481	97.8	73.0	2.1
St Lucia	Upper-middle	167	5,520	9,786	94.8	74.0	3.6
St Vincent & the Grenadines	Upper-middle	100.2	4,210	7,691	88.1	71.8	3.7

Suriname	Upper-middle	480	4,730	7,813	90.4	69.2	3.8
Trinidad & Tobago	High	1,328	14,480	23,507	98.7	69.7	2.4
Turks & Caicos	...	33.2	...	...	...	75.0	3.5

* World Bank Data & Statistics (6)

** WHO AIMS (3)

*** PAHO Basic Indicators 2009 (7)

**** Human Development report 2009 (8)

The table shows that, as mentioned above, disparities among countries and territories of the region are several.

Analysis of results

Domain 1 – Policy and legislative framework

The first domain of the WHO-AIMS examines the areas of mental health policies, plans and legislation. It also assesses the presence of mental health plans during emergencies in each country or territory.

It is important to mention that despite the fact that WHO offers a clear definition and distinction between a policy and a plan, there is frequent confusion or overlapping between the two terms, consequently reflected in the documents elaborated by the countries. (1) Indeed, in a WHO publication analyzing the results of WHO-AIMS in low- and middle- income countries, it was decided to consider the two items together. If countries responded positively to one of the indicators, it was considered as if they had a policy/plan. (9) In our case, as shown in details below, only three countries have the two documents, a mental health policy and a plan.

Policy, Plans and Legislation

Table 2 shows a summary of the existence of policies, plans and legislations in the 16 countries and territories assessed. The data shows that 35% of the countries (i.e., six) have a mental health policy, and in five of the six countries, the policy is less than five years old. For mental health plan, 35% of the countries and territories (i.e., six countries) have a plan, and five out of the six countries have produced it during the last five years. Only three countries (i.e., Jamaica, Suriname and Turks and Caicos) have both a policy and a plan. The other countries (i.e., Anguilla, Barbados, Belize, Montserrat, St Lucia and Trinidad and Tobago) either have a policy or a plan.

A disaster/emergency preparedness plan for mental health is present only in 35% of the countries and territories (six countries), in some cases in coincidence with the existence of a mental health policy and plan; in other cases as in British Virgin Islands or Grenada, as a stand-alone document.

Regarding legislation, a mental health act is present in all the countries and territories assessed. However, during last five years, only five countries (i.e., 29%) have approved the laws. In most of the countries and territories, the legislation is prior to 1960s, therefore prior to the promulgation of relevant international conventions and standards (see complete list in WHO Mental Health Legislation and Human Rights). (10)

Table 2 - Mental Health Policies, Plans and Legislation

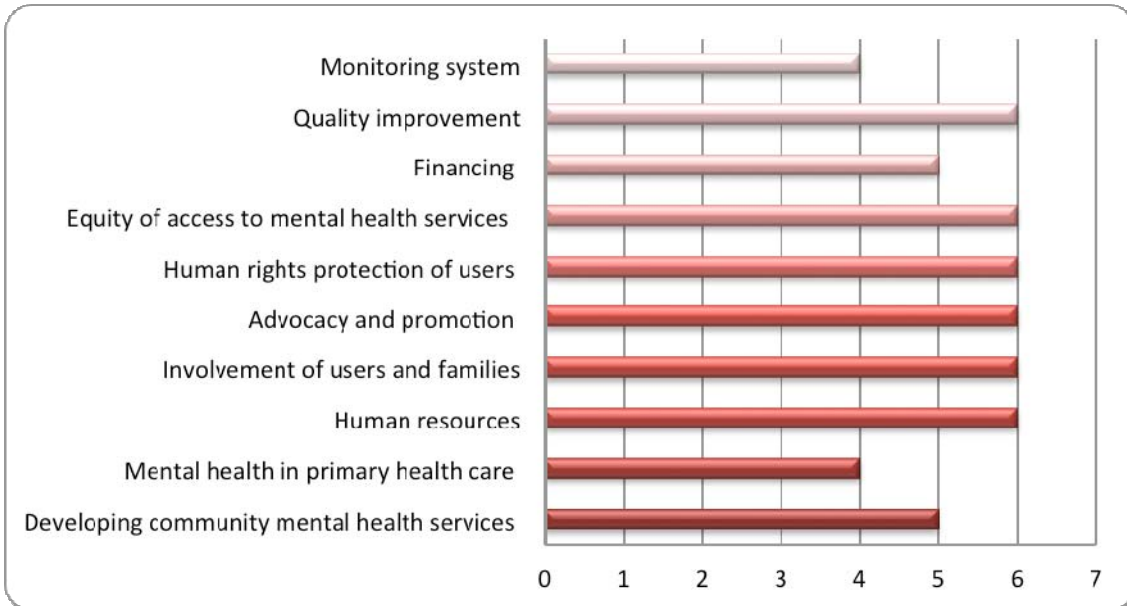
	Year of Last Mental Health Policy	Year of Last Mental Health Plan	Year of Last Disaster Plan for Mental Health	Year Mental Health Legislation
Anguilla	2005	NA	NA	2006
Antigua & Barbuda	NA	NA	NA	1957
Barbados	2004	NA	NA	1985
Belize	NA	2006	2004	1957
British Virgin Islands	NA	NA	2000	1986
Dominica	NA	NA	NA	1986
Grenada	NA	NA	2005	2008
Guyana	NA	NA	NA	1930
Jamaica	1997	2008	2007	1997
Montserrat	NA	2002	NA	2006
St Kitts & Nevis	NA	NA	NA	1956
St Lucia	2007	NA	2000	1957
St Vincent & the Grenadines	NA	NA	NA	1989
Suriname	2007	2007	2006	2002
Trinidad & Tobago	NA	2000	NA	1975
Turks & Caicos	2005	2005	NA	1904

In summary, a mental health policy has been formally approved in: Anguilla, Barbados, Jamaica, St. Lucia, Suriname, and Turks and Caicos. A mental health plan has been formally approved in: Belize, Jamaica, Montserrat, Suriname, Trinidad and Tobago, and Turks and Caicos.

To note that during the last years (in some cases it means after the completion of the WHO-AIMS) many countries and territories have developed their policies and plans. As previously mentioned, this document considers exclusively information provided by the WHO-AIMS reports.

Figure 1, shows that the content of mental health plans in the sub-region is similar. This means that in general they have followed WHO guidelines and recommendations. (11)

Figure 1 - Content of Mental Health Plan (Number of Countries and territories)



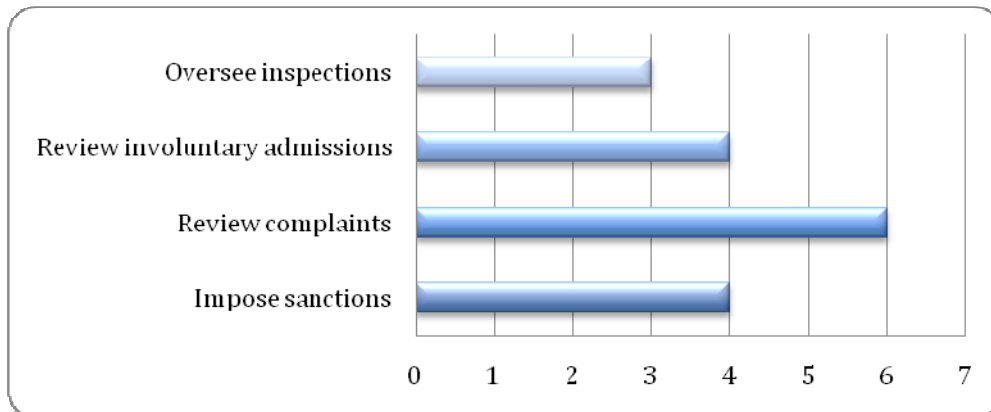
Downsizing large mental hospitals is another component of many mental health plans. However, considering that many of the countries and territories in the sub-region do not have mental hospitals, only three countries (Belize, Guyana and Jamaica) have included this component in their plans.

Human Rights Protection

The WHO-AIMS also assesses the protection of human rights through monitoring a country’s main mental health institutions. Although six out of the sixteen countries and territories do not have mental health hospitals, they have certain mental health facilities with day services. Figure 2 shows that only three countries have bodies in charge of overseeing regular inspections of mental health facilities. Four countries reviewed involuntary admissions and discharge procedures; six countries reviewed complaints investigation processes and four countries have a review body that can impose sanctions.

None of the countries assessed has at least one yearly external review or inspection of human rights protection of patients in its mental institutions. Only one country (Jamaica) has a yearly external review to one out of four community-based inpatient psychiatric units.

Figure 2 - Human Rights Protection



Three countries (Belize, Jamaica and Suriname) had at least one working session at their mental hospitals on patients' human rights protection. Belize and Jamaica had a session for the personnel working at their outpatient facilities (50% in Jamaica and 100% in Belize).

Mental Health Financing

Information about mental health financing is hard to obtain. In most cases, the final figure was obtained after making ad hoc calculations and therefore it may not be as accurate as with other indicators. However, the information is still accurate enough to do a comparison. Table 3 shows that the mental health services' financial situation in this region is not homogeneous.

The average percentage of the health budget dedicated to mental health from fourteen countries assessed is 4.33% (i.e., Anguilla and Grenada do not provide the information). Four countries receive more than 5% of the health budget and seven countries receive less than 3% (see table 3). On average, the Caribbean dedicates 3,8% of the government health budget to mental health. Although there are considerable differences among countries, this average is higher than the one emerging from a cross-national analysis of WHO-AIMS, where the average of health expenditure to mental health is 2%. (9)

For countries and territories that have a mental institution and are able to provide information regarding their expenditures, it appears that Barbados, St Vincent and the Grenadines spend 100% of their mental health budget on their mental institution. The situation is somewhat different in Jamaica, St Lucia, Suriname, Trinidad and Tobago), where mental hospitals consume above 80% of the total budget available for mental health issues. Guyana spends 61% and Belize only 26% (i.e., the costs of medicaments and other running costs are not included in the total cost for Belize). The remaining countries and territories do not have a mental institution.

Table 3 – Mental Health Expenditure

	% of Mental health Expenditures from Total Health Budget	% of Mental health Expenditures Spent in Mental Hospitals
Anguilla	UN	NA
Antigua & Barbuda	4	UN
Barbados	7	100%
Belize	2	26%
British Virgin Islands	3	NA
Dominica	3	NA
Grenada	UN	UN
Guyana	1	61%
Jamaica	6	80%
Montserrat	2	NA
St Kitts & Nevis	1	0%
St Lucia	4	97%
St Vincent & the Grenadines	6	100%
Suriname	9	83%
Trinidad & Tobago	4	94%
Turks & Caicos	2	NA

All sixteen countries and territories have declared that 100% of their population has free access to essential psychotropic medicines, which means that “essential psychotropic medicines - once prescribed - are provided to people with mental disorders free of cost or with reimbursement equal or more than 80% of the retail price”. (4) Seven out of the seventeen countries and territories have social insurance covering all mental health disorders. However, in four countries (Belize, St Lucia, St Vincent and the Grenadines, and Trinidad, and Tobago) no mental disorder cost is covered by the social insurance.

Although all countries and territories have free access to essential psychotropic medicines for the population, some have added information regarding the cost of an anti-psychotic and an anti-depressant for those that pay out of pocket. The information is offered in table 4, below.

Table 4 – Affordability of Psychotropic Medication

	Proportion of the daily minimum wage needed to pay for one day of antipsychotic medication	Proportion of the daily minimum wage needed to pay for one day of antidepressant medication
Jamaica	5%	1%
Suriname	1%	1%
Turks & Caicos	4%	2%

The cost of one day of antipsychotic medication, using the cheapest available drug in Jamaica represents 5% of the daily minimum wage; 1% in Suriname and 4% in Turks and

Caicos. Similarly, for an antidepressant medication, the cost of one day represents 1% of the daily minimum wage in Jamaica and Suriname; and 2% in Turks and Caicos.

Domain 2 – Mental health services

The second domain introduces mental health services' situation in general: characteristics, distribution, quantity, etc.

The WHO-AIMS defines a 'mental health authority' as "an organizational entity responsible for mental health care within a region or country". (4) This entity is expected to provide advice to governments on mental health policies and legislation, services' planning and management, program monitoring, etc. Only five countries had a mental health authority in the Ministry of Health at the time when the mental health systems were assessed (i.e., British Virgin Islands, Guyana, Jamaica, St. Lucia and Turks and Caicos).

All countries and territories have their services organized in catchment areas and all those with mental hospitals assured that the hospital is organizationally integrated with mental health outpatient facilities.

Mental Health Facilities

According to the WHO-AIMS, community-based mental health facilities are those ones located outside of mental hospitals. According to this definition, all Caribbean countries and territories have outpatient facilities.

Other mental health facilities assessed are community-based psychiatric units (psychiatric units located in general hospitals), mental hospitals, day treatment facilities and community-based residential facilities.

There are considerable differences among countries and the way they have organized their mental health services. Although mental hospitals are still the most common facility in the region, many small island-states don't have these institutions. This is the case of Anguilla, British Virgin Island, Dominica, Montserrat, St Kitts and Nevis, and Turks and Caicos. Some countries and territories offer an alternative with a higher number of psychiatric beds located in general hospitals. Such countries are Anguilla, Dominica or St Kitts and Nevis. Others have instead more outpatient facilities, which is the case in Montserrat or Turks and Caicos.

Day treatment facilities are not very common in the sub-region. They are available only in Antigua and Barbuda, Jamaica, Suriname, and Trinidad and Tobago. Residential facilities are also limited, and available only in Barbados, Jamaica, and Trinidad and Tobago.

Mental health outpatient facilities in the Caribbean consist of regular visits from mental health professionals to primary health care facilities to hold their weekly or monthly clinics. However, this kind of service is not very common; in 10 countries and territories there are 5 or less facilities per 100,000 people. Table 5 gives a summary of mental health facilities available in each country and territory.

Table 5 - Mental Health Facilities in Countries and Territories

	Mental Hospitals	MH Outpatient Facilities	Day Treatment Facilities	Community-based Psychiatric Inpatient Units	Community Residential Facilities
Anguilla	0	3	0	1	0
Antigua & Barbuda	1	9	1	0	0
Barbados	1	14	0	1	2
Belize	1	8	0	1	0
British Virgin Islands	0	4	0	1	0
Dominica	0	13	0	1	0
Grenada	1	5	0	1	0
Guyana	1	2	0	1	0
Jamaica	1	139	9	2	25
Montserrat	0	5	0	1	0
St Kitts & Nevis	0	7	0	1	0
St Lucia	1	9	0	3	0
St Vincent & the Grenadines	1	5	0	1	0
Suriname	1	5	1	0	0
Trinidad & Tobago	1	31	3	2	8
Turks & Caicos	0	11	0	0	0
Sub-regional total	11	278	15	18	39

Facilities distribution in each country and territory doesn't necessarily represent the needs of the population. In most of the cases, a high concentration of beds in one institution implies equal concentration of human and financial resources, limiting consequently the establishment of other services in the community. Table 6 below offers the same information, only this time as rates of facilities per 100 000 population.

Table 6 - Mental Health Facilities in Countries and Territories per 100 000 population

	Mental Hospitals	MH Outpatient Facilities	Day Treatment Facilities	Community-Based Psychiatric Inpatient Units	Community Residential Facilities
Anguilla	0	22.1	0	226.7	0
Antigua & Barbuda	128	10.5	1.2	0	0
Bahamas	105.1	2.4	0.3	3.6	10.5
Barbados	200	5.2	0	3	11.2
Belize	16.6	2.7	0	1.3	0
British Virgin Islands	0	14.5	0	7.3	0
Dominica	0	18.3	0	56.1	0
Grenada	74.5	4.7	0	18.6	0
Guyana	32	0.3	0	0.5	0
Jamaica	31.8	5.2	0.3	3	16.5
Montserrat	0	104.2	0	0	0
St Kitts & Nevis	0	15.9	0	27.6	0
St Lucia	71.9	5.4	0	1.8	0
St Vincent & the Grenadines	159.6	5.0	0	190	0
Suriname	62.5	1.0	0.2	0	0
Trinidad & Tobago	67.2	2.3	0.2	2.6	14.7
Turks & Caicos	0	33.1	0	0	0

Beds in Mental Hospitals and in General Hospitals

The development of community-based psychiatric inpatient units in the sub-region is generally limited. There is a clear imbalance between the number of beds in general hospitals and the number in mental hospitals. According to beds' distribution it appears that centralization of services in a unique institution has been the choice so far made in many countries and territories.

Table 6 shows the number of beds and beds per 100,000 population, distributed between mental hospitals and general hospitals in each country or territory.

Table 7 – Distribution of Beds in Mental Hospitals, General Hospitals and in Residential facilities

	Psychiatric Inpatient Units in General Hospitals (# of beds)	Psychiatric Inpatient Units in General Hospitals (beds per 100,000)	Mental Hospitals (# of beds)	Mental Hospitals (beds per 100,000)	Community Residential Facilities (# of beds)	Community Residential Facilities (beds per 100,000)
Anguilla	31	226.7	0	0	0	0
Antigua & Barbuda	0	0	110	128	0	0
Barbados	8	3	537	200	30	11.2
Belize	4	1.3	50	16.6	0	0
British Virgin Islands	2	7.3	0	0	0	0
Dominica	40	56.1	0	0	0	0
Grenada	20	18.6	80	74.5	0	0
Guyana	4	0.5	240	32	0	0
Jamaica	80	3	846	31.8	440	16.5
Montserrat	0	0	0	0	0	0
St Kitts & Nevis	14	27.6	0	0	0	0
St Lucia	3	1.8	120	71.9	0	0
St Vincent & the Grenadines	0	0	160	159.6	0	0
Suriname	0	0	300	62.5	0	0
Trinidad & Tobago	34	2.6	893	67.2	195	14.7
Turks & Caicos	0	0	0	0	0	0
Sub-regional total	252	3.7	3688	54.4	700	10.3

As mentioned, the high concentration of financial and human resources in one institution could be a barrier for the development of community-based mental health services. Table 7 shows great variability among the countries. This difference may be determined by the existence of a mental hospital or its absence: a country with a mental hospital will have fewer inpatient units in general hospitals.

Gender, Children and Adolescents and Community Follow-Up

At sub-regional level, the results shows that 56.7% of users treated in the outpatient facilities are female, while 9.3% are children or adolescents. Antigua and Barbuda, Barbados, Jamaica, Suriname, and Trinidad and Tobago offer services that are only for children and adolescents, which means 20 out of 278 facilities are only for these users.

Except Barbados, Guyana, St Lucia and St Vincent and the Grenadines, all other countries and territories offer follow-ups in the community from their outpatient facilities.

In community-based inpatient facilities, 41.5% of the users treated were female, while 1.6% were children or adolescents. None of these services are for children and

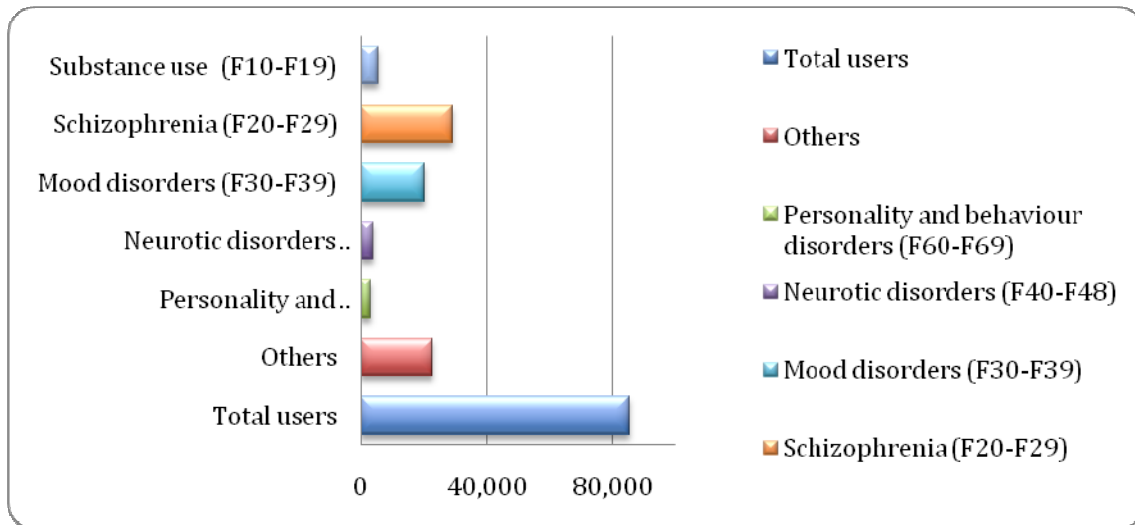
adolescents exclusively. Eleven countries reported patients' length of stay in these facilities, resulting in a 10.6 days average of a discharged patient spent in community-based inpatient units in the year previous to the assessment.

There are 3,688 beds in mental hospitals, equivalent to 14 beds per 100,000 people. The percentage of female users treated was 24%; while 2.7% were children or adolescents (this information was not provided by Barbados and Trinidad and Tobago, both with important number of patients treated per year). The only country that has beds in mental hospitals that are exclusively for children and adolescents is Trinidad and Tobago. From all admissions, 51.3% of all admissions were involuntary.

Diagnosis of Users Treated

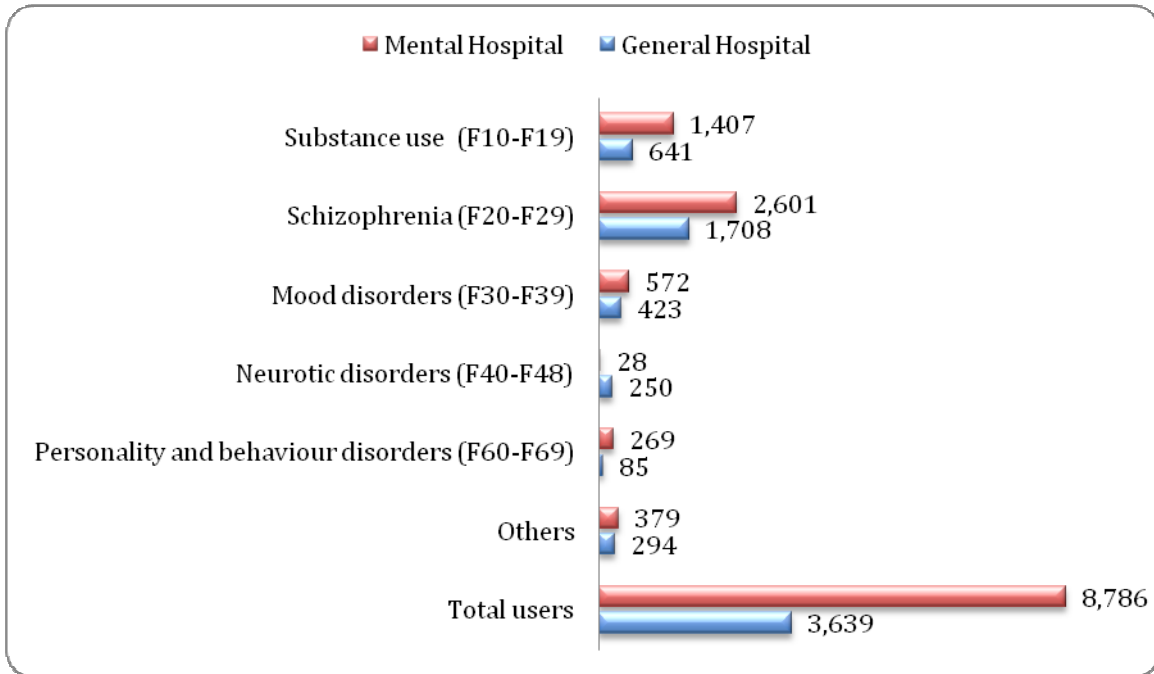
Figure 3 shows a summary of patients' diagnosis seen in outpatient facilities in the sub-region (to note that information was not available for Barbados, Dominica, Grenada, St Lucia). Figure 4 shows the typical diagnoses encountered in general and mental hospitals.

Figure 3 - Diagnosis of Users Treated in Mental Health Outpatient Facilities in the Sub-Region



According to the information available, schizophrenia is the most common disorder reported in outpatient facilities. The second most frequent diagnosis is mood disorders.

Figure 4 - Diagnosis of Users Treated in Inpatient Facilities (General Hospital and Mental Hospital)



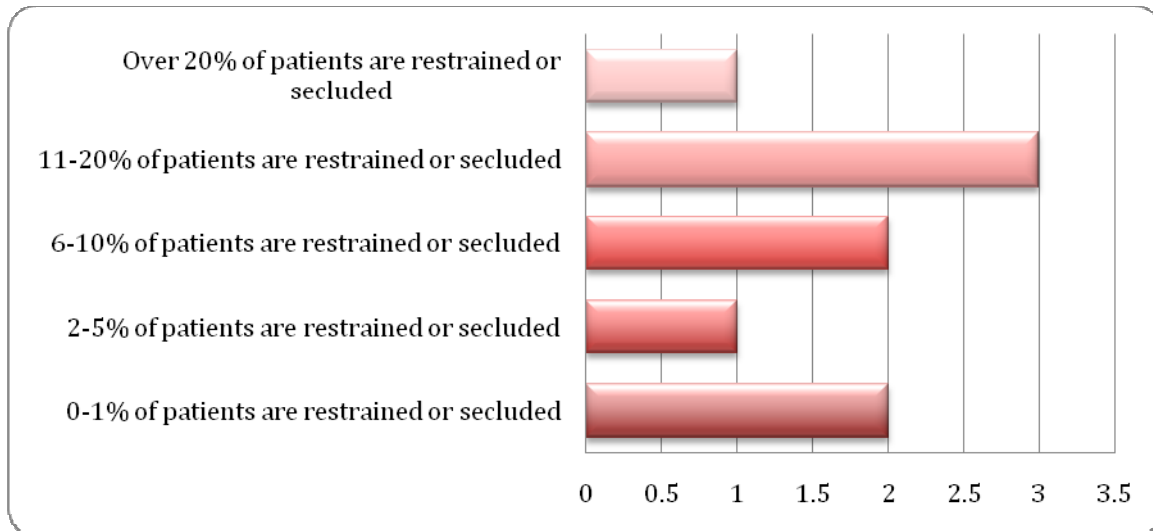
For countries and territories with available data, the most common disorder is schizophrenia, followed by substance use disorders for general and mental hospitals.

The data was not available from the mental hospital in Trinidad and Tobago, where there were almost 3,000 patients treated during the year assessment. Similarly, the information was not available for community-based inpatient units for Barbados and partially for Guyana.

Restrain and Seclusion of Patients

Unfortunately, it is still a common practice in many institutions to restrain and seclude mentally ill during their hospitalization. This practice is not always recorded. Figure 5 shows the number of countries and territories that physically restrain or seclude patients and the respective percentage.

Figure 5 - Percentage of Patients Who Were Physically Restrained or Secluded Patients at Least Once in the Last Year in Mental Hospitals



Although with different percentages, all countries and territories with mental hospital have declared they practice the physical restrain or seclusion of patients. Secluded or restrained patients represent more than 20% in St Lucia; between 11% and 20% in Grenada, Guyana and Jamaica; between 6% and 10% in Belize and Trinidad and Tobago; between 2% and 5% in Antigua and Barbuda; and less than 1% in Suriname and Barbados.

Psychotropic Medicine

The availability of at least one psychotropic medicine of each therapeutic category was reported in all mental hospitals, in all community-based psychiatric inpatient units and in 98% of all outpatient facilities.

Domain 3 – Mental health in Primary Health Care

The third domain introduces the role that primary health care professionals play in the provision of mental health care to the population, and the interaction between primary care and mental health professionals.

Undergraduate and Postgraduate Training

Training of Primary Health Care personnel in mental health in the Caribbean region is poorly developed. Only seven countries and territories provided information about the number of hours in the undergraduate training devoted to psychiatry and mental health related subjects for medical doctors. One possible explanation for the limited information available is that many of these countries do not have medical schools;

therefore training is conducted elsewhere. However, table 5 summarizes the findings. Based on the available data, Suriname have 6% of training dedicated to these subjects; 3% in Jamaica, Trinidad and Tobago; 1% in British Virgin Islands, St. Vincent and the Grenadines; and 0% in Belize and Guyana.

The situation for nurses is different. All countries and territories but two have reported a known percentage of training hours dedicated to psychiatry or mental health as part of the undergraduate training programs for nurses. Table 7 shows the proportion varies between 1 % and 6 % of the total training hours.

The training for other professionals working in PHC (e.g., non-physicians and non-nurses) is less known. Only three countries have provided information: Guyana, with 4% of training hours devoted to psychiatry or mental health; Jamaica, with 37% and St. Lucia with 11%.

Table 8 - Proportion of Undergraduate (first degree) Training Hours Devoted to Different Mental Health Professionals

	Medical Doctors Faculties	Nursing Schools	Non-Doctor/Non- Nurse Primary Health Care Workers in Colleges/ Vocational Schools
Anguilla	UN	3%	NA
Antigua & Barbuda	UN	3%	UN
Barbados	UN	6%	UN
Belize	0%	4%	NA
British Virgin Islands	1%	5%	UN
Dominica	UN	1%	UN
Grenada	UN	4%	UN
Guyana	0%	2%	4%
Jamaica	3%	1%	37%
Montserrat	UN	6%	NA
St Kitts & Nevis	UN	3%	UN
St Lucia	UN	UN	11%
St Vincent & the Grenadines	1%	3%	NA
Suriname	6%	4%	NA
Trinidad & Tobago	3%	4%	UN
Turks & Caicos	UN	UN	UN

Table 8 illustrates refresher training situation in primary health care for main professional categories. The table shows that in thirteen countries and territories none of their doctors received at least two days refresher training on psychiatry/mental health in the last year. Guyana has offered at least two days refresher training to 43% of its medical doctors; and Jamaica to 8%. There is no information for Trinidad and Tobago.

For nurses' refresher training, half of the countries and territories have organized at least two days refresher training during the last year to a proportion of nurses, which varies from 3% to 86%.

Regarding refresher training for other professionals working in primary health care (i.e., non-physicians and non-nurses), Guyana has trained 3% of their other professionals, and Jamaica has trained 20% of them.

Table 9 - Proportion of Mental Health Professionals with at Least Two Days of Refresher Training in Psychiatry/Mental Health in the Year Previous to the Assessment

	Primary Health Care Doctors	Primary Health Care Nurses	Non- Doctor /Non-Nurse Primary Health care Workers
Anguilla	0%	15%	NA
Antigua & Barbuda	0%	0%	0%
Barbados	0%	46%	UN
Belize	0%	6%	0%
British Virgin Islands	0%	0%	0%
Dominica	0%	0%	NA
Grenada	0%	0%	0%
Guyana	43%	57%	3%
Jamaica	8%	50%	20%
Montserrat	0%	86%	NA
St Kitts & Nevis	0%	39%	0%
St Lucia	0%	0%	0%
St Vincent & the Grenadines	0%	0%	0%
Suriname	0%	0%	0%
Trinidad & Tobago	UN	0%	0%
Turks & Caicos	0%	NA	NA

Assessment and Treatment Protocols

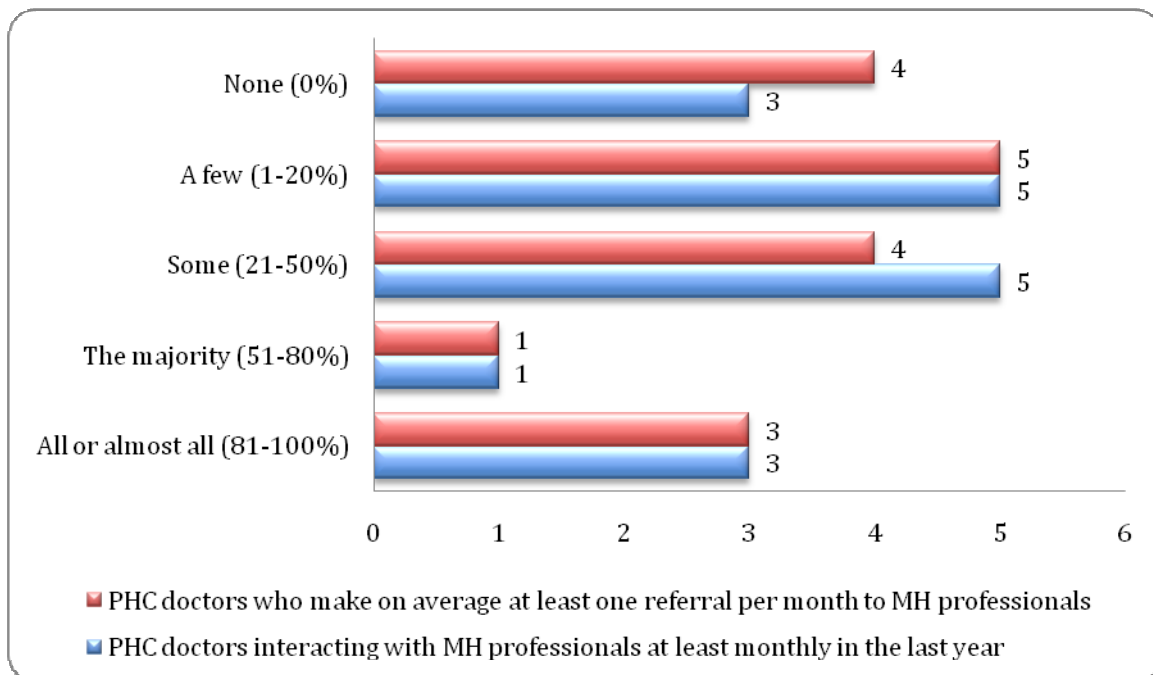
Thirteen of the countries and territories don't have assessment and treatment protocols for key mental health conditions in physician based primary care clinics. In Belize and Trinidad and Tobago, protocols were available in some of the clinics (i.e., between 21% and 50%). In Jamaica the protocols were available in the majority of the clinics (i.e., between 50% and 80%), while in Turks and Caicos the protocols were present in all or almost all the clinics (i.e., between 81 and 100%).

As per the non-physician based primary care clinics, only Jamaica (i.e., between 21% and 50%), and Turks and Caicos (i.e., between 81% and 100%) have assessment and treatment protocols.

Referral System

The referral system between primary care and mental health professionals varies according to whether it is a primary care doctor or a non-doctor in charge of the service. Figure 6 offers a summary of the findings.

Figure 6 - Referrals and Interaction between Primary Care Doctors and Mental Health Professionals



Full-time primary health care doctors who give on average at least one referral per month to a mental health professional is another indicator assessed. Four countries, Anguilla, Antigua and Barbuda, Montserrat, St Kitts and Nevis have zero referrals. Five countries, Grenada, Guyana, Jamaica, Suriname and Trinidad and Tobago, have between 1% and 20% doctors who have made referrals. Three countries, British Virgin Islands, St Lucia and St Vincent and the Grenadines, have between 21% and 50% doctors making referrals. Only one country (Belize) has the highest percentage between 51% and 80% of doctors who made at least one referral per month to a mental health professional.

Prescription of Psychotropic Medicines

In all countries and territories of the region, health regulations authorize primary care doctors to prescribe psychotropic medicines. Except in St. Lucia and Antigua and Barbuda, all the other countries and territories affirm that psychotropic medicines are available in all or almost all physician-based primary care facilities.

The same authorization offers more diversity in the case of non physician-based primary care facility, where only in five countries and territories (Guyana, Jamaica, Suriname, Trinidad and Tobago and Turks and Caicos) psychotropic medicines are available in all or almost all clinics. In eight countries and territories (Anguilla, Antigua and Barbuda, Barbados, Belize, British Virgin Islands, Dominica, Grenada, St Kitts and Nevis and St. Lucia) non physician-based clinics do not have psychotropic medicines. This is not the case in Montserrat and St Vincent and the Grenadines.

Primary care nurses are not allowed to prescribe psychotropic medicines in eleven countries and territories. Instead, in Dominica, Jamaica, Montserrat, Suriname and Turks and Caicos, nurses are allowed to prescribe it but with restrictions.

All countries and territories but three have declared none interaction with complementary/traditional/alternative practitioners. In Jamaica there is a few interaction, while in St Kitts and Nevis and Turks and Caicos, all or almost all practitioners interact with primary care or mental health professionals.

Domain 4 – Human resources

Domain 4 describes the situation of human resources working in mental health at a country/territory level. It assesses the number, characteristics and distribution across the different services.

Number of Human Resources Working in Mental Health Facilities

Table 9 shows the distribution of human resources, specifically psychiatrists, psychologists and nurses, working in mental health in each country and territory. It is important to consider that many of these countries assessed have a population that is considerably below 100,000 inhabitants and therefore the figures offered should be considered accordingly. For instance, the high rate of psychologists in the British Virgin Islands is due to the fact that they count with 5 psychologists for a population of 27,518. A similar situation can be found in Montserrat with psychiatrists' and nurses' rates.

However, this is an uncommon situation in the sub-region, where the scarcity of human resources in the mental health field is evident. Ten countries have 2 or fewer psychiatrists per 100,000 people; ten countries and territories have 1 or fewer psychologists per 100,000 people. The number of nurses seems higher than other professions, with just 5 countries having less than 10 nurses per 100,000 people.

Table 10 - Human Resources: Number of Professionals per 100,000 People

	Psychiatrists	Psychologists	Nurses
Anguilla	7.3	0	14.6
Antigua & Barbuda	1.1	1.2	9.3
Barbados	4	8.9	39.8
Belize	0.6	0.3	8
British Virgin Islands	3.6	18.2	14.5
Dominica	2.8	0	11.2
Grenada	1.8	0	15
Guyana	0.5	0	0.4
Jamaica	1.1	0.3	7.6
Montserrat	20.8	0	145.3
St Kitts & Nevis	2	4	19.8
St Lucia	1.8	3.6	18
St Vincent & the Grenadines	2	0	11
Suriname	1.5	0.63	14
Trinidad & Tobago	1.7	0.3	32.7
Turks & Caicos	3	3	3

Mental Health Professionals Working in Different Sectors

Figures 7 and 8 show the percentage of psychiatrists and psychologists, social workers, nurses, and occupational therapists working in various mental health sectors. In the first one, the majority of psychiatrists of the Caribbean (63%) work in both, government and NGOs or for profit or private practice; 26% work only for the government; 7% work only for NGOs/for profit/private sector.

Figure 7 - Psychiatrists Working in Different Sectors

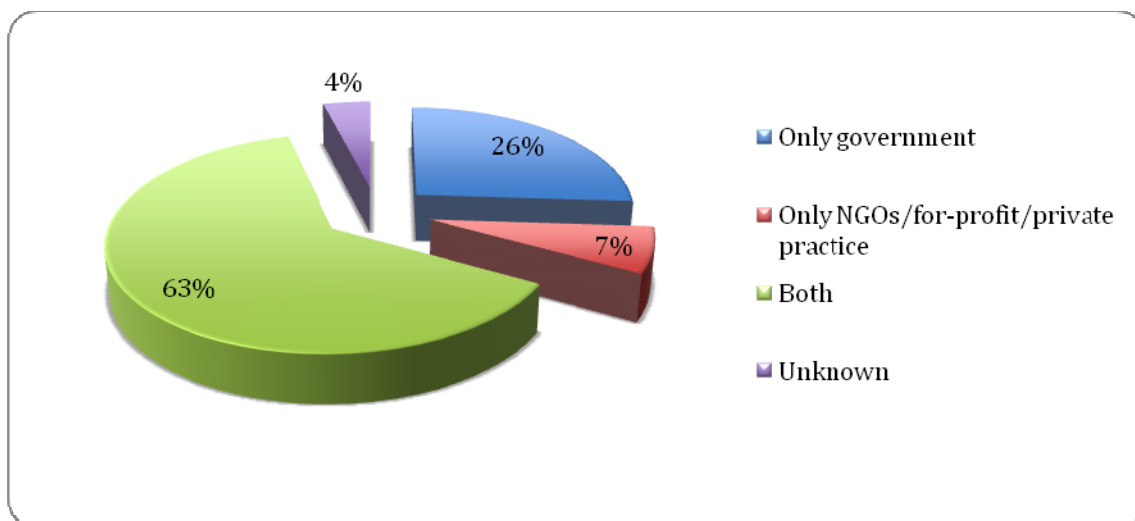
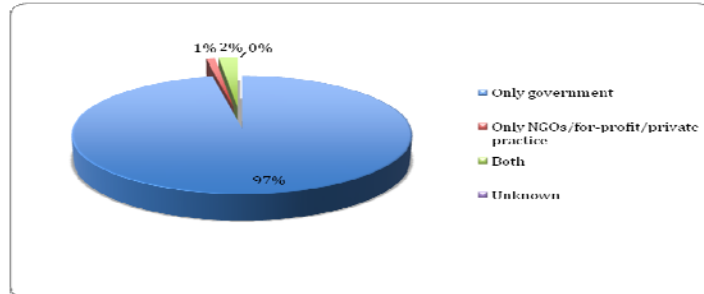


Figure 8 illustrates a similar description to the above, only this time referring to other professionals working in mental health facilities. In this case, however, the majority of

professionals (i.e., 97%) work exclusively for the government. Only 1% of these professionals work for NGOs/for-profit/private, while 2% of them work for both sectors.

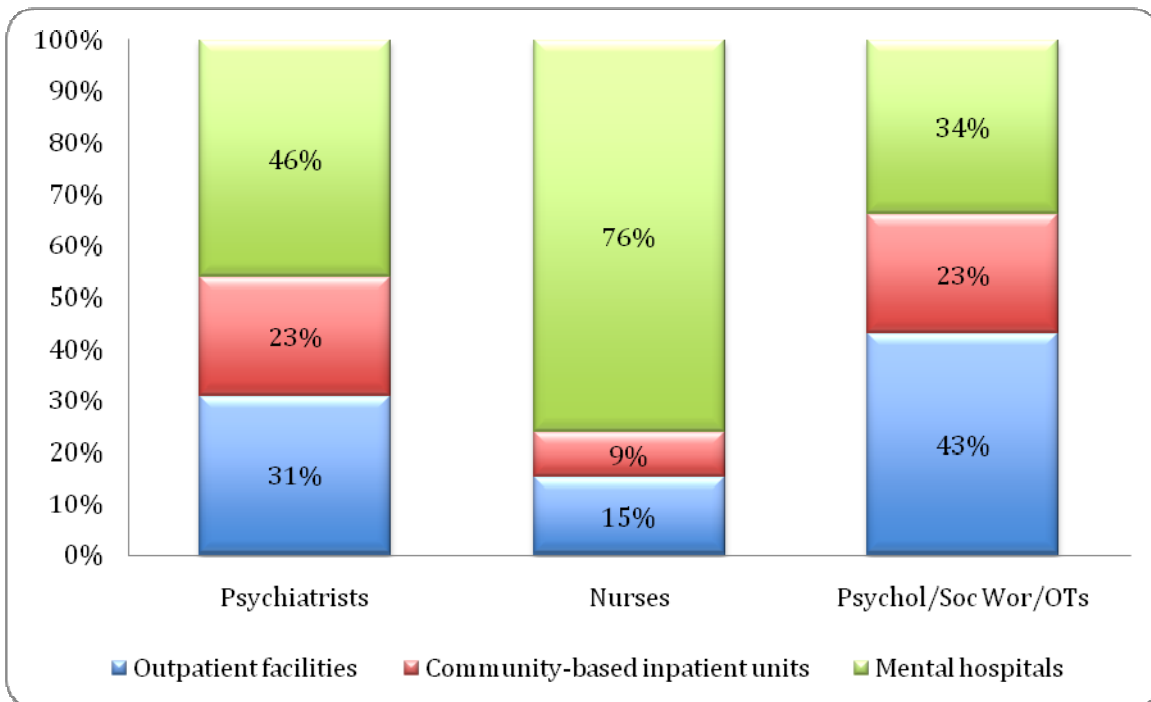
Figure 8 - Psychologists, Social Workers, Nurses, and Occupational Therapists Working in Different Sectors



Human Resources in Different Mental Health Facilities

The next figure (Figure 9) shows the percentages of psychiatrists, nurses and psychologists, social workers and occupational therapists, working in outpatient facilities, community based inpatient psychiatric units and mental hospitals.

Figure 9 - Percentage of Professionals Working in Mental Health Services

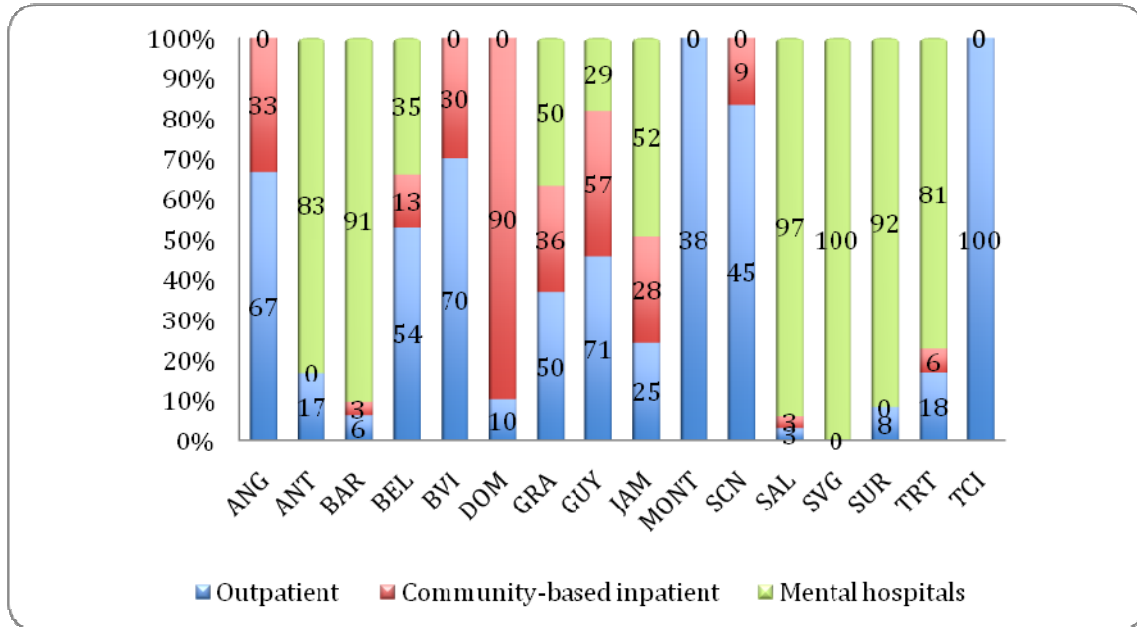


At sub-regional level, there is an imbalance in the distribution of mental health professionals that varies according to the profession being considered. Nurses are mainly concentrated in mental hospitals; psychologists, social workers and occupational

therapists are located mostly in outpatient facilities. Psychiatrists on the other hand are also more concentrated in mental hospitals, with a smaller presence in other facilities.

Figure 10 shows the distribution of psychiatrists and nurses in mental health facilities (e.g., mental hospitals, community-based inpatient facilities and outpatient facilities) in each country, in terms of a proportion of resources available in each facility.

Figure 10 - Proportion of Psychiatrists and Nurses in MH Facilities



The figure above shows that in countries where there is a mental hospital, psychiatrists and nurses are concentrated in those institutions, while only limited personnel works in outpatient or community-based inpatient units. According to the available information, professionals working in outpatient or community-based inpatient units are the same as those working in mental hospitals, attending on part time basis the clinics in primary care facilities or elsewhere.

Professionals (Psychiatrists and Nurses) Working in or Near the Largest City

This section provides information on the location of psychiatrists and nurses in countries' capitals or main cities. In general, there is a tendency to concentrate human resources in these main cities. An exception would be for those countries that have small geographical dimension, where the ratio of professionals in main cities is 1.00, meaning that there is equity between rural and urban areas in terms of the distribution of human resources. Values over 1.0 indicate that human resources are concentrated in urban areas, and values of less than 1.0 indicate that resources are concentrated in the rural areas.

Figure 11 - Psychiatrists and Nurses working In or Near the Largest City

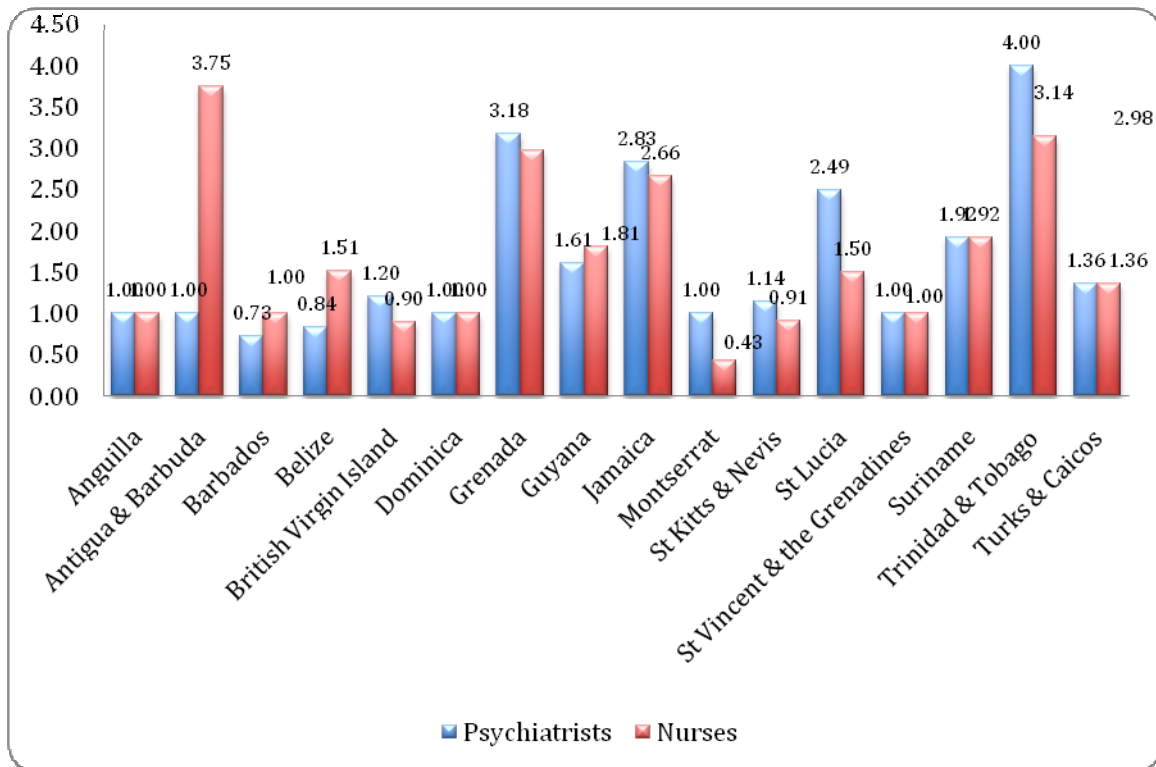


Figure 12 shows ratios of psychiatrists and nurses working in or near the largest city in each country. Trinidad and Tobago, Grenada, Antigua and Barbuda (in the case of nurses) and Jamaica have higher ratios, which indicates an unbalanced in the geographic distribution of professionals.

Training of Health and Mental Health Professionals

There is a limited number of health professionals recently graduated in the sub-region. In most cases, the number of professionals (medical doctors, nurses and psychiatrists) graduated during the year previous to the assessment is zero. Table 11 shows that Jamaica is the only country with psychiatrists newly graduated.

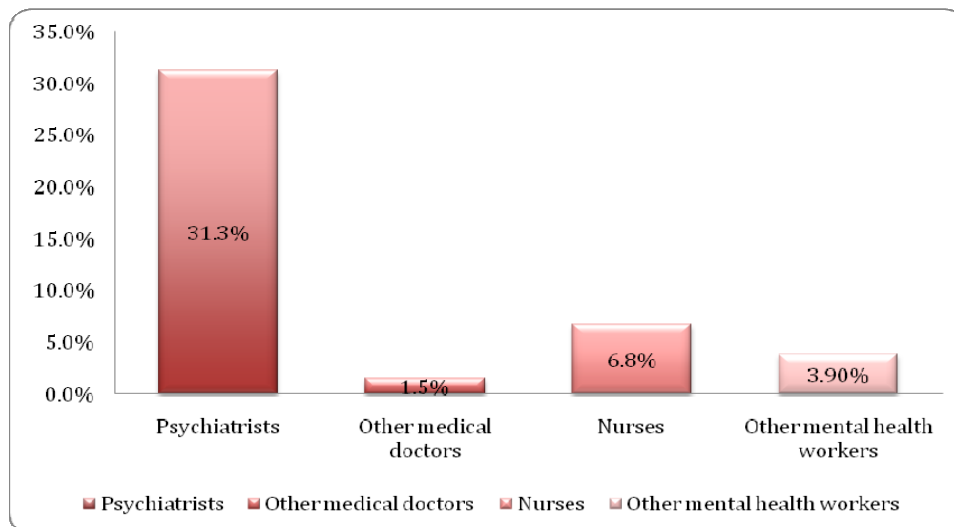
Table 11 - Rate of Professionals Graduated in the Year Previous to the Assessment for 100,000 Population

	Medical Doctors	Nurses	Psychiatrists
Anguilla	0	0	0
Antigua & Barbuda	0	1.2	0
Barbados	UN	UN	UN
Belize	0	7.6	0
British Virgin Islands	0	0	0
Dominica	2.8	0	0
Grenada	0	1.9	0
Guyana	0.3	1.1	0
Jamaica	6.7	97.8	0.1
Montserrat	0	0	0
St Kitts & Nevis	0	0	0
St Lucia	0	0.6	0
St Vincent & the Grenadines	0	1	0
Suriname	1.9	14	0
Trinidad & Tobago	UN	1.6	0
Turks & Caicos	0	0	0

The number of psychologists, nurses and social workers with at least one year of specialization in mental health is zero in all countries and territories with the exception of Belize and Jamaica where there has been a rate of 6, 3.3 and 0.4 nurses trained respectively. In addition, a 0.3 rate for 100,000 people were psychologists trained during the same period.

The situation is slightly different when analyzing the percentage of professionals working in mental health facilities who have received at least two days of refresher training on the rational use of psychotropic drugs in the previous year to the assessment. As shown in figure 12, 31.3 % of the psychiatrists did receive this kind of training. The percentages diminish for the other professional profiles listed.

Figure 12 - Percentage of Staff Working in Mental Health Facilities with at Least Two Days of Refresher Training on the Rational use of Psychotropic Dugs in the Last Year



Migration of Psychiatrists

With the exception of Barbados and Jamaica, none of the psychiatrists have migrated to other countries. There were between 1% and 20% psychiatrists in Jamaica that have migrated; and between 21% and 50% in Barbados.

User/Consumer Associations and Family Associations

The role of civil society in general, and in particular the role of users of mental health services and their families, is still incipient in the region. The presence of users and families' associations is limited in the Caribbean. Belize alone has information about the number of users or consumers of mental health services that are part of an association (i.e., 15 members); while Jamaica and Trinidad and Tobago do not know the number, and zero is the answer for all remaining countries and territories.

The situation is similar for family associations. Antigua and Barbuda and Suriname have the number of members of family associations (i.e., 4 and 35 respectively). The information was unknown for Jamaica, Trinidad and Tobago, while zero was the answer for all other countries and territories.

Domain 5 – Public education and links with other sectors

This domain introduces elements of public education, awareness campaigns and similar initiatives, as well as the relation between mental health sector and other sectors.

Public Education and Awareness Campaigns on Mental Health

Seven countries have reported the existence public education and awareness campaigns' coordinating bodies on mental health. In any case, governmental institutions and international agencies are among organizations promoting public education and awareness campaigns in almost every country and territory. NGOs are involved in these initiatives in seven countries (Antigua and Barbuda, Belize, Jamaica, St. Kitts and Nevis, St. Lucia, Trinidad and Tobago and Turks and Caicos); while professional associations and private foundations are present in four (Antigua and Barbuda, Jamaica, Trinidad and Tobago and Turks and Caicos) and two countries (Anguilla, Antigua and Barbuda) respectively. Most of the campaigns addressed the general population, with a number of countries and territories addressing specific target groups, particularly children and adolescents. Twelve countries have confirmed the production of campaigns for these last target groups.

Legislative Provisions for the Protections of Persons with Mental Disabilities

None of the countries and territories have legislative provisions to compel employers to hire a percentage of employees with disabilities, except Turks and Caicos, where these provisions exist but they are not enforced.

Also, few countries and territories protect against discrimination (e.g., dismissal, lower wages) based on mental disorder alone. Two exceptions are Montserrat, where the provision exists but it is not enforced, and Turks and Caicos, where the provision exists and it is enforced.

Trinidad and Tobago; and Turks and Caicos are the only countries that have legislative provisions offering priority to people with severe mental disorders in state and subsidized housing schemes; however, the provision is not enforced by the first country. Turks and Caicos have protection from discrimination in housing allocation for people with severe mental disorders, although it is not enforced.

Formal Collaborative Programs with Other Health and Non-Health Agencies

Mental health organizations from all countries and territories have formal collaboration with different agencies within and outside the health sector. Primary health care, the welfare and the judicial systems are those institutions with which there is more collaboration from the mental health perspective. Table 12 shows that between 12 and 13 countries have collaborations with the mentioned sectors. This collaboration is less frequent in areas such as employment, housing or reproductive health. While around half the countries and territories have collaborated with organizations that work on HIV/AIDS, child and adolescent health, substance abuse, child protection, education and the elderly.

Table 12 - Formal Collaborative Programs with Health and Non-health Agencies

Areas/Sectors of Formal Collaboration		# of Countries	%
1.	Primary health care/ community health	12	75%
2.	HIV/AIDS	7	44%
3.	Reproductive health	3	19%
4.	Child and adolescent health	6	38%
5.	Substance abuse	7	44%
6.	Child protection	5	31%
7.	Education	6	38%
8.	Employment	2	13%
9.	Housing	3	19%
10.	Welfare	11	69%
11.	Criminal justice	12	75%
12.	The elderly	5	31%

Specifically in the area of education, it has been reported that there are 523 out of 3376 primary or secondary schools in the Caribbean region that have a full time or part time mental health professional working at the school. It means that, at sub-regional level, only 15.5% of the schools have trained mental health professionals. Table 13 shows that Jamaica is the only country that contribute to the percentage (i.e., 52%). Most of the countries and territories in the region do not count with such resource.

Table 13 - Number of Schools with Mental Health Professionals by Country/territory

	Total Number of Schools	Number of Schools with Mental Health Professionals	%
Anguilla	9	0	0%
Antigua & Barbuda	74	0	0%
Barbados	UN	UN	UN
Belize	308	27	9%
British Virgin Islands	23	1	4%
Dominica	79	0	0%
Grenada	98	0	0%
Guyana	546	0	0%
Jamaica	957	495	52%
Montserrat	4	0	0%
St Kitts & Nevis	32	0	0%
St Lucia	99	0	0%
St Vincent & the Grenadines	89	0	0%
Suriname	337	0	0%
Trinidad & Tobago	550	0	0%
Turks & Caicos	13	0	0%

However, efforts are being made in order to have mental health promotion and prevention initiatives at schools, where more than half of the countries and territories assessed (i.e., eleven countries and territories) have promotion and prevention initiatives taking place at certain schools (see figure 13).

Training police officers of mental health related issues is also limited. Six countries and territories have had no police officers participating in educational activities on mental health in the last 5 years; seven countries and territories have had a few police officers trained; while three countries have had some police officers participating in training activities. Table 14 summarizes the results.

Figure 13 - Number of Countries with Promotion and Prevention Activities in Primary and Secondary Schools

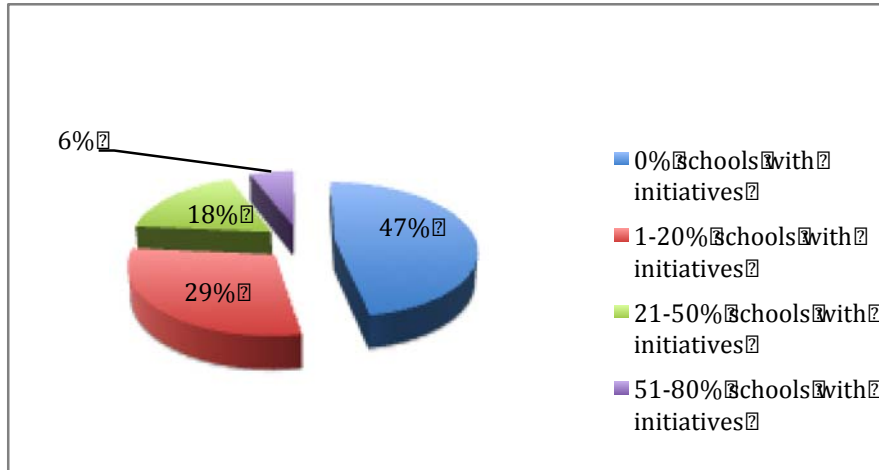


Table 14 - Educational Activities with Police Officers

	0%	1-20%	21-50%
Countries	Antigua and Barbuda British Virgin Islands Dominica Montserrat Trinidad and Tobago Turks and Caicos	Anguilla Granada Guyana Jamaica St Kitts and Nevis St Vincent and the Grenadines Suriname	Barbados Belize St Lucia

Educational activities on mental health issues with judges and lawyers were less frequent in the sub-region. Only three countries (i.e., Belize, Jamaica and St Kitts and Nevis) have had educational activities to train judges and lawyers (1%-20%) on mental health. All others countries and territories had no such activities.

Only Guyana reported to have a few prisons (1%-20%) with at least one prisoner per month in treatment contact with a mental health professional. Trinidad and Tobago has the service offered in the majority of the prisons (51%-80%). All other countries and territories have the service offered in all the prisons of the country.

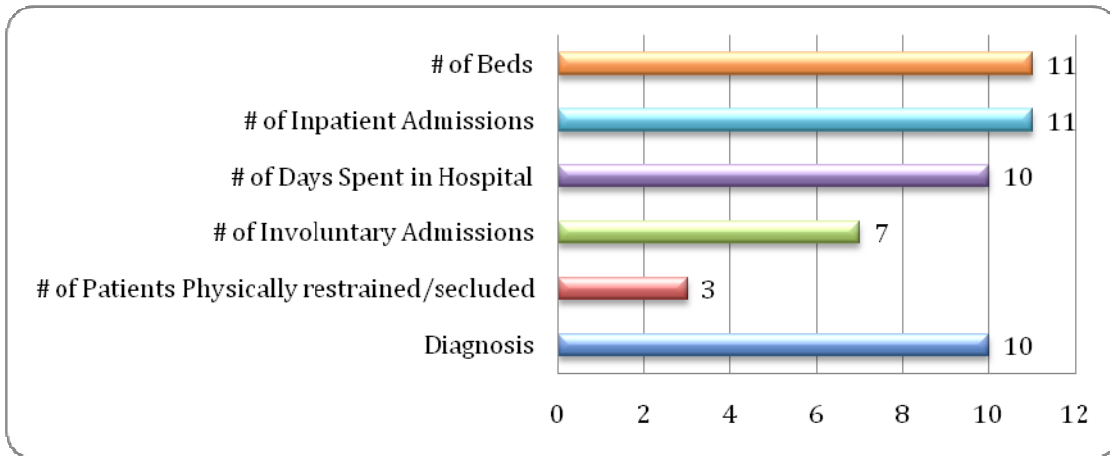
Domain 6 – Monitoring and research

Domain 6 assesses the existence of data collection and reporting mechanisms in the country, as well as the level of participation of mental health in the production of research papers at national level.

Mental Health Information

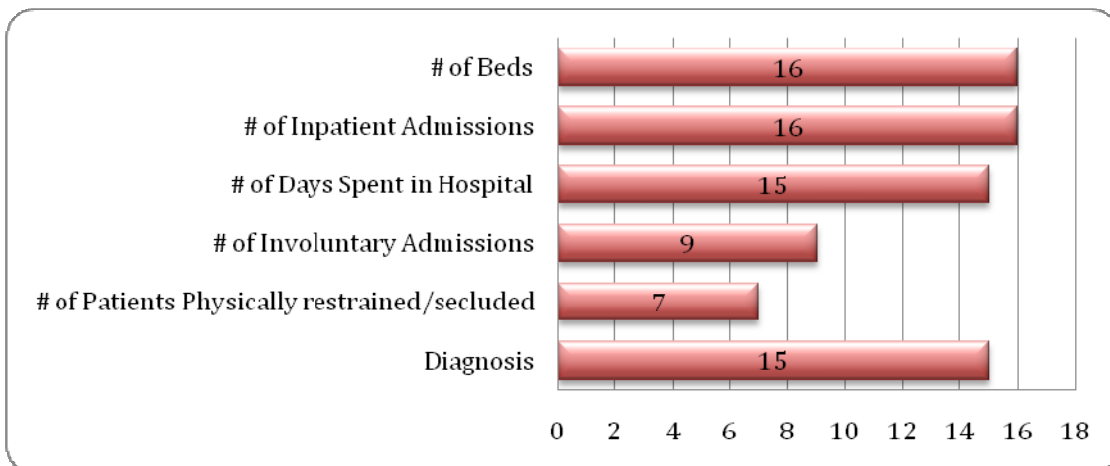
The figures below show the status of data collection and the use of information in the sub-regional countries and territories. Figure 14 shows the number of mental hospitals that collect data on routine basis. All or almost all hospitals collect data about number of beds, number of admissions, days spent in hospitals, and diagnosis. The number of involuntary admissions is collected in few countries, while only three countries collected data about the number of patients that are physically restrained or secluded.

Figure 14 - Number of Mental Hospitals Routinely Collecting and Compiling Data by Type of Information



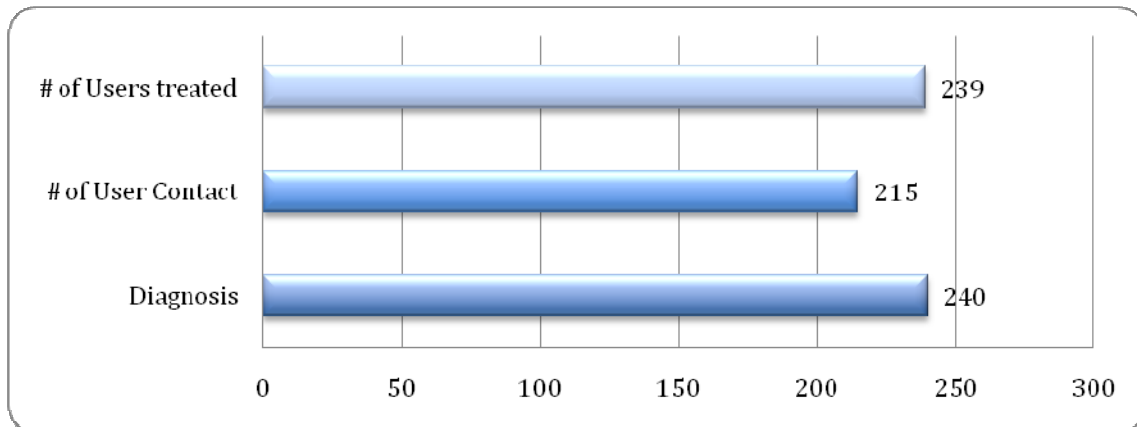
The trend is very similar in the mental health inpatient units, where the data collected on the number of involuntary admissions and patients physically restrained or secluded is less common than for other categories, as shown in figure 15.

Figure 15 - Number of Mental Health Inpatient Units Collecting and Compiling Data by Type of Information



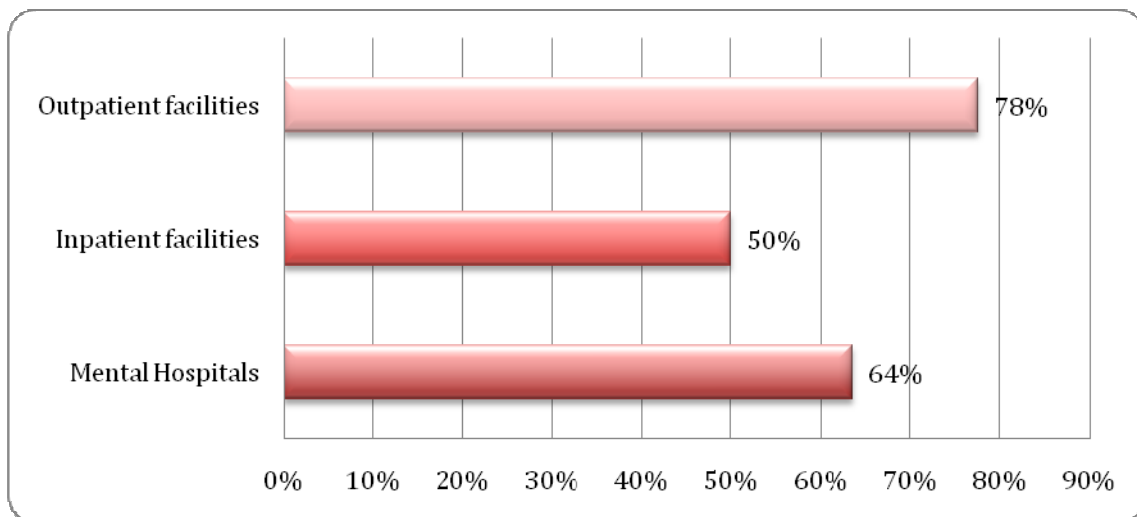
The majority of the 278 mental health outpatient facilities collects and compiles data about the number of users treated, the number of contacts that each user had with the service and the diagnosis of patients, as shown in figure 16.

Figure 16 - Number of Mental Health Outpatient Facilities Collecting and Compiling Data by Type of Information



Given the available information, almost 80% of the outpatient facilities forward the data collected to health authorities at central level in all countries and territories of the sub-region. Only 50% of inpatient facilities and 64% of mental hospitals transmit their data to the central level. See figure 17.

Figure 17 - Data Transmission from Facilities to Central Level



Publications

According to countries' reports, in the last five years, there have been 95 health publications in the sub-region as identified on PubMed. Eleven among these reports are on mental health issues.

Limitations

The mental health information systems in most countries and territories of the sub-region are limited and incomplete. As a consequence it has been very difficult in many cases to gather the information required by WHO-AIMS. For instance some indicators could be completed only after approaching different sources and persons who are directly involved in certain service. In other cases, the best data estimates available were chosen.

The report did not include indicators for which the majority of countries and territories assessed could not provide the required information. Several of the countries and territories studied have initiated processes to address this weakness – partially thanks to the process to collect data for this report .

This document is not the official viewpoint of member countries and territories. It is, however, a description of the current status of Mental Health in these countries and territories given the information available to PAHO/WHO.

Conclusions

The analysis of mental health systems in sixteen Caribbean countries and territories has given a good opportunity to assess the current situation, to see their strengths as well as their weaknesses.

The sub-region has many rich experiences not always known by neighboring countries. There are examples of good practices in different areas, such as the integration of mental health into primary care, the role of psychiatric nurses, the development of psychosocial rehabilitation programs and social re-integration of patients with mental health problems. Basic information about some of these good practices can be deduced from the data introduced with this document.

Despite the many good examples, there is still a tendency to offer centralized services. In many countries and territories the only or the main service is the mental hospital, which absorbs most available human and financial resources. In the meantime, the mental hospital doesn't provide an answer to the needs of the population. On one hand high percentage of patients hospitalized (60% to 70% in some cases) in those hospitals have been there for many years and don't require any specific psychiatric answer. On the other hand there are not enough resources available to develop community-based psychiatric service. Therefore, patients with less severe disorders would try to avoid going to the mental hospital because of the stigma attached to it and by doing so they may prevent their only possibility to receive care.

In summary, based on the information gathered through the compilation of the WHO-AIMS and presented in this report, the following are priorities for action, in order to strengthen the mental health systems in the sub-region:

- Issuing and updating mental health policies and plans. Ensuring the nomination of focal points at Ministry of Health level, with the capacity to monitor and follow up policies and plans implementation;
- Updating and ensuring implementation of mental health legislations that promote and protect the human rights of mentally ill;
- Increase – in most of the cases – the budget allocated to mental health, allowing for a flexible utilization of existing resources within the mental health system, avoiding for instance the link between funds and number of beds in mental hospitals;
- Re-organizing existing services. Downsizing mental hospitals should be the priority in those countries with a relative big number of beds concentrated in one facility. Exploring alternative solutions for the high number of persons living in those facilities;
- Adding psychiatric beds in general hospitals, and/or promoting the hospitalization of psychiatric patients in emergency rooms in general hospitals;

- Strengthening the development of outpatient facilities, by moving resources from the mental hospitals when possible or by allocating resources from outside the system, when needed;
- Continuing the effort of decentralization of services by implementing as well other community-based facilities such as day treatment centers and residential facilities, as alternatives to offer treatment and care for mentally ill, and in the mean time offer some respite to families and relatives;
- Increasing the number of personnel working in mental health, mainly by promoting the possibility to work in outpatient facilities, as a more interesting and challenging alternative than the traditional mental hospital;
- Ensuring adequate training to primary health care workers would promote the provision of care of persons with mental disorders by services other than the traditional mental hospital;
- Supporting existing users' and families' associations as well as the establishment of these groups whenever they are not constituted; promote their participation to discussions concerning national mental health policies and plans;
- Improving mental health information systems.

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The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was developed to collect data on a mental health system of a country or region.

The implementation of the WHO-AIMS in sixteen Caribbean countries and territories is the result of the collaboration between the respective Ministries of Health, PAHO/WHO representations and Regional Office, as well as the WHO Department for Mental Health and Substance Abuse.

This report offers a comparative study of a peculiar region, where countries with small territories and population may have limited human resources in the health sector in general and particularly dedicated to mental health. The challenges are many, as are many the answers that most of the members of this region have encountered to overcome the difficulties by introducing innovative services and modalities of care. Comparing results among countries and territories could contribute to identify weaknesses and strengths for the improvement of mental health systems in the region.