

WHO-AIMS

**WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM**

IN THE

**REPUBLIC OF
TRINIDAD AND TOBAGO**



**World Health
Organization**



**MINISTRY OF HEALTH
REPUBLIC OF TRINIDAD AND TOBAGO**

WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
IN THE REPUBLIC OF TRINIDAD AND TOBAGO

A report of the assessment of the Mental Health System in the Republic of Trinidad and Tobago using the World Health Organization – Assessment Instrument for Mental Health Systems (WHO-AIMS).

Port of Spain
Republic of Trinidad and Tobago

2007



MINISTRY OF HEALTH
REPUBLIC OF TRINIDAD AND TOBAGO

PAHO/WHO Trinidad and Tobago Country Office
PAHO/WHO Regional Office
WHO Department of Mental Health and Substance Abuse (MSD)

This publication has been produced by the WHO, PAHO/WHO Country Office in Trinidad and Tobago in collaboration with PAHO/OCPC and WHO Headquarters. At WHO Headquarters this work has been supported by the Evidence and Research Team of the Department of Mental Health and Substance Abuse, Cluster of Non communicable Diseases and mental Health.

For further information and feedback, please contact.

1. Dr. Rohit Doon, Ministry of Health
rohit.doon@health.govt.tt
2. Dr Guillermo Troya, PAHO/WHO Trinidad and Tobago
troyagui@trt.paho.org
3. Ms. Devora Kestel
kestelde@cpc.paho.org
4. Dr Shekhar Saxena WHO Headquarters
saxenas@who.int

(ISBN)

World Health Organization 2006

Suggested citation: WHO-AIMS Report on Mental Health System in the Republic of Trinidad and Tobago WHO and Ministry of Health, Port of Spain, Republic of Trinidad and Tobago, 2006

(Copyright text as per rules of the Country Office)

Acknowledgement

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system of Republic of Trinidad and Tobago.

The project in Republic of Trinidad and Tobago was implemented by Ministry of Health with technical support from PAHO/WHO Country Office.

The project was also supported by the PAHO/WHO Regional Office team.

The World Health Organization Assessment Instrument for Mental health Systems (WHO-AIMS) has been conceptualized and developed by the Mental Health Evidence and Research team (MER) of the Department of Mental Health and Substance Abuse (MSD), World Health Organization (WHO), Geneva, in collaboration with colleagues inside and outside of WHO.

Please refer to *WHO-AIMS* (WHO, 2005) for full information on the development of WHO-AIMS at the following website.

http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html

The project received financial assistance and/or seconded personnel from: The National Institute of Mental Health (NIMH) (under the National Institutes of Health) and the Center for Mental Health Services (under the Substance Abuse and Mental Health Services Administration [SAMHSA]) of the United States; The Health Authority of Regione Lombardia, Italy; The Ministry of Public Health of Belgium and The Institute of Neurosciences Mental Health and Addiction, Canadian Institutes of Health Research.

The WHO-AIMS team at WHO Headquarters includes: Benedetto Saraceno, Shekhar Saxena, Tom Barrett, Antonio Lora, Mark van Ommeren, Jodi Morris, Anna Maria Berrino and Grazia Motturi.

The WHO-AIMS project is coordinated by Shekhar Saxena.

CONTENTS

WHO-AIMS REPORT ON MENTAL HEALTH SYSTEM	2-3
ACKNOWLEDGEMENTS	4
CONTENTS	5
LIST OF ABBREVIATIONS	6
EXECUTIVE SUMMARY	7-8
INTRODUCTION	9-10
POLICY AND LEGISLATIVE FRAMEWORK	11
Policy, Plans, and Legislation	11
Financing of Mental Healthy Services	11 -13
Human Rights Policies	13
MENTAL HEALTH SERVICES	14
Organization of Mental Health Services	14
Mental Health Outpatient facilities	14
Day Treatment Facilities	14
Community-based Psychiatric Inpatient Units	15
Community Residential Facilities	15
Mental Hospitals	15
Forensic and other Residential Facilities	16
Human Rights and Equity	16 -18
MENTAL HEALTH IN PRIMARY HEALTH CARE	18
Training in mental health care for primary care staff	18
Mental health in primary health care	19
Prescription in primary health care	19
HUMAN RESOURCES	19
Number of human resources in mental health care	19
Consumer and family associations	21
PUBLIC EDUCATION AND LINKS WITH OTHER SECTORS	22
Public education and awareness campaigns on mental health	22
Legislative and financial provisions for persons with mental disorders	22
Links with other sectors	22
MONITORING AND RESEARCH	23
STRENGTHS AND WEAKNESSES OF THE MENTAL HEALTH SYSTEMS IN TRINIDAD AND TOBAGO	24
NEXT STEPS IN STRENGTHENING THE MENTAL HEALTH SYSTEM	25

LIST OF ABBREVIATIONS

AIMS	Assessment Instrument for Mental Health Systems
CDAP	Chronic Disease Assistance Programme
ERHA	Eastern Regional Health Authority
MH	Mental Health
MHS	Mental Health Systems
MoH	Ministry of Health
NCRHA	North Central Regional Health Authority
NGO	Non Governmental Association
NWRHA	North West Regional Health Authority
PH	Public Health
PHC	Primary Health Care
PsH	Psychiatric Hospital
RHA	Regional Health Authority
RMN	Registered Mental Nurse
RN	Registered nurse (General trained nurse)
SW	Social Worker
SMO	Specialist Medical Officer
SWRHA	South West Regional Health Authority
TRHA	Tobago Regional Health Authority
WB	World Bank
WHO	World Health Organization

EXECUTIVE SUMMARY

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in the Republic of Trinidad and Tobago for the year 2007. The goal for collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This will enable Trinidad and Tobago to develop information-based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

There is a mental health policy/plan (Cabinet approved 2000 mental health policy/plan) and an emergency/disaster preparedness plan for mental health. Mental health services are not covered by social insurance. There is a human rights review body in the country and issues related to the human rights protection of mentally ill people are addressed regularly.

The Ministry of Health of Trinidad and Tobago is the mental health authority body in the country. Thirty-one outpatient mental health facilities treat 27.8 users per 100,000 general population. Day treatment facilities treat 1.8 users per 100,000 general population. There are 2 community-based psychiatric inpatient units in the country for a total 0.001 beds per 100,000 population. None of these beds in community-based inpatients units are reserved for children and adolescents. There is one mental hospital (MHs) in the country for a total of 68 beds per 100,000 population. The patients admitted to the mental hospital belong primarily to schizophrenia, schizophreniform and delusional disorders (45 %).

Violations of human rights are not practiced in this mental hospital. Less females access health care in this institution. 100% of mental health facilities had at least one free psychotropic medicine of each therapeutic class available in the facility.

Primary health care staff receives little training in mental health and interaction with mental health services is rare.

There are 45 human resources working in mental health for 100,000 population. Rates are particularly low for social workers and clinical psychologists. There are 4 occupational therapists working in mental health. Most psychiatrists work for the government in the facilities. There is an uneven distribution of human resources in favor of the mental hospital and the capital city. Decentralization of the services are slowly been taken up by the Regional Health Authorities. Consumer and family associations in mental health are in their initial stages.

There is no coordinating body to oversee publication and awareness campaigns in the field of mental health. Legislation provisions for employment and housing exist, but are not enforced. There is formal interaction between mental health service and

departments/agencies responsible for HIV/AIDS, reproductive health, substance abuse, military and criminal justice.

Data are collected and compiled by facilities to a variable extent. Facilities produce internal reports based on the information, but no official report has been published and distributed by the government based on these data or internal reports. Limited number of the research carried out in the country focused on non-epidemiological clinical/questionnaires assessments of mental disorders, services research, psychosocial interventions/psychotherapeutic interventions, and pharmacological interventions.

INTRODUCTION

The Republic of Trinidad and Tobago is the most southerly island of the Caribbean. It has an area of 5,128 sq. km. (1,980 sq. mi.). Trinidad 4,828 sq. km. (1,864 sq. mi.) and Tobago 300 sq. km. (116 sq. mi.). The capital city, Port of Spain, has a metropolitan population of 310,000 inhabitants. The population of Trinidad and Tobago is 1,303,188 (2007 est.). The proportion of population under the age of 15 years is 25,347 per 100,000 population and the proportion above the age of 60 years is 10,020 per 100,000 population. Twenty percent (20%) of the population is considered rural. Annual growth rate is 0.4%.

The main language used in the country is English. The ethnic grouping distribution is as follows: East Indians 40%; Africans 37.5%; Mixed 20.5%; European 0.6%; Chinese 0.3%; Others 1.1%.

Religious tolerance is high with Roman Catholic 26%; Hindu 22.5%; Anglican 7.8%; Pentecostal 6.8%; Baptist 7.2%; other Christians 5.8%; Muslims 5.8%; Seventh Day Adventist 4%; Other 10.8%; and Unspecified 1.4%; and None 1.9%.

Education is compulsory at the primary level (5-13 years). The literacy level is 98.6%. Infant mortality rate (2005 est.) was 25.81/1,000. The healthy life expectancy for males is 66 years and for females 68 years (2006 est.)

Trinidad and Tobago is a middle income group country, based on World Bank 2004 criteria. The proportion of the government's health budget to GDP is 1.96%. Per capital government expenditure on mental health is Total amount spent for health services by the government health department is two billion seven hundred and ninety four million one hundred and fifty thousand nine hundred and thirty eight dollars and seven cents, (\$2,794,150,938.07) a year.

The structure of the health system in Trinidad and Tobago was formerly based on a county distribution, where in Trinidad, the larger island was divided into eight counties, and Tobago classified as one county, being run by a central government. At present the structure is reflected by five (5) Regional Health Authorities (RHAs); four in Trinidad and one in Tobago.

A positive mental health is conceived as an inner balance, ability to manage the everyday deals and to choose a correct solution of personal problems, as well as to adhere to the conventional behavioral standards. Some psychiatric disorders such as mild or moderate depression or anxiety are not perceived as serious emotional problems, whilst the concept of "mental illness" is attributed to severe psychiatric disorders. Because of stigma accompanying psychiatric disorders patients and their families try to hide mental problems and avoid applying to the official mental health system. Little change has been realized by the mental health system over the last twenty years in terms of perception of mental illness as just another disease or illness. The physical structure has been renovated and the creation of a more positive ambience now greets the client and their family.

There are eight hundred and ninety three (893) hospital beds at the major hospital, 22 hospital beds at the San Fernando Hospital, and thirty four (34) beds at the two (2) community based psychiatric inpatient facilities. In terms of primary care, there are a

hundred and five (105) primary health care clinics, and seven (7) public hospitals. There is also a large private health care sector in Trinidad and Tobago.

The WHO-AIMS Instrument

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) is a new WHO tool for collecting essential information on the mental health system of a country or region (WHO, 2005; Saxena et al. 2005). The goal of collecting this information is to improve mental health systems and to provide a baseline for monitoring the change. WHO-AIMS is primarily intended for assessing mental health systems in low and middle income countries, but is also a valuable assessment tool for high resource countries. For the purpose of WHO-AIMS, a mental health system is defined as all the activities whose primary purpose is to promote, restore or maintain mental health. The mental health system includes all organizations and resources focused on improving mental health. WHO-AIMS 2.1 consists of 6 domains, 28 facets and 155 items to cover the key aspects of mental health systems. In addition, it includes other resources, such as a data entry programme and a template for writing a country report, which allows countries to efficiently collect data and then quickly translate that information into knowledge that can assist planning.

The implementation of WHO-AIMS can generate information on strengths and weaknesses to facilitate improvement in mental health services. WHO-AIMS will enable countries to develop information-based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention care and rehabilitation.

The mental health system in Trinidad and Tobago is hospital based. For the last 10 years efforts have been made to shift attention to community, with little success. Overall, mental health system resources are scarce and centralized.

This study was carried out by Mr. Gerald Peters, Public Health Consultant – Trinidad and Tobago. Technical support was provided by PAHO Sub-regional Mental Health Advisor, Ms. Devora Kestel and the PAHO Country Office, represented by Dr Boyd Scobie.

The preparation of this study would not have been possible without the collaboration of the Ministry of Health and the five (5) Regional Health Authorities. We are grateful for the support to Dr. Rohit Doon, Ms Carla Ruiz, Prof. Gerard Hutchinson, Mr. Errol Blackman, Dr. Indar Ramtahal, Mr. Joseph Blugh, Dr. Krishna Maharaj, Carlton Jackman, Mr. Carlton Jackman, Mr. Pooran Sankar, Mr. Abraham Abdool, Mr. Darryl Sealey, Mrs. Dorn George-Cyrus, Mrs. Peggy Sue Griffith-Phillip Dr. Helen Marceau-Crooks, Ms. Gloria Andrews, Ms. Rhoda A. Patiram, Ms. Sakesha Julien.

Data for the report were collected in 2008-9 and based on the year 2007.

POLICY AND LEGISLATIVE FRAMEWORK

Policy, Plans and Legislation

There is a mental health plan and an emergency/disaster preparedness plan for mental health in Trinidad and Tobago (2000).

The first piece of mental health legislation was revised in 1975. At present it is the only available legal act regulating mental health care provision. This legislation focuses on the following components:

1. Access to mental health care including access to the least restrictive care
2. Organization of services: developing community mental health services
3. Organization of services: downsizing the large mental hospital
4. Organization of services: reforming mental hospitals to provide more Comprehensive care
5. Human resources
6. Involvement of users and families
7. Advocacy and promotion
8. Human rights protection of users
9. Equity of access to mental health services across different groups
10. Financing
11. Quality improvement and
12. Monitoring system

Mental health issues are also covered in both criminal and civil legislation. Standardized documentation and procedures for implementing mental health legislation do not exist for the most of components of mental health legislation. Attorneys and consumers are not sufficiently informed about the existent norms of mental health legislation.

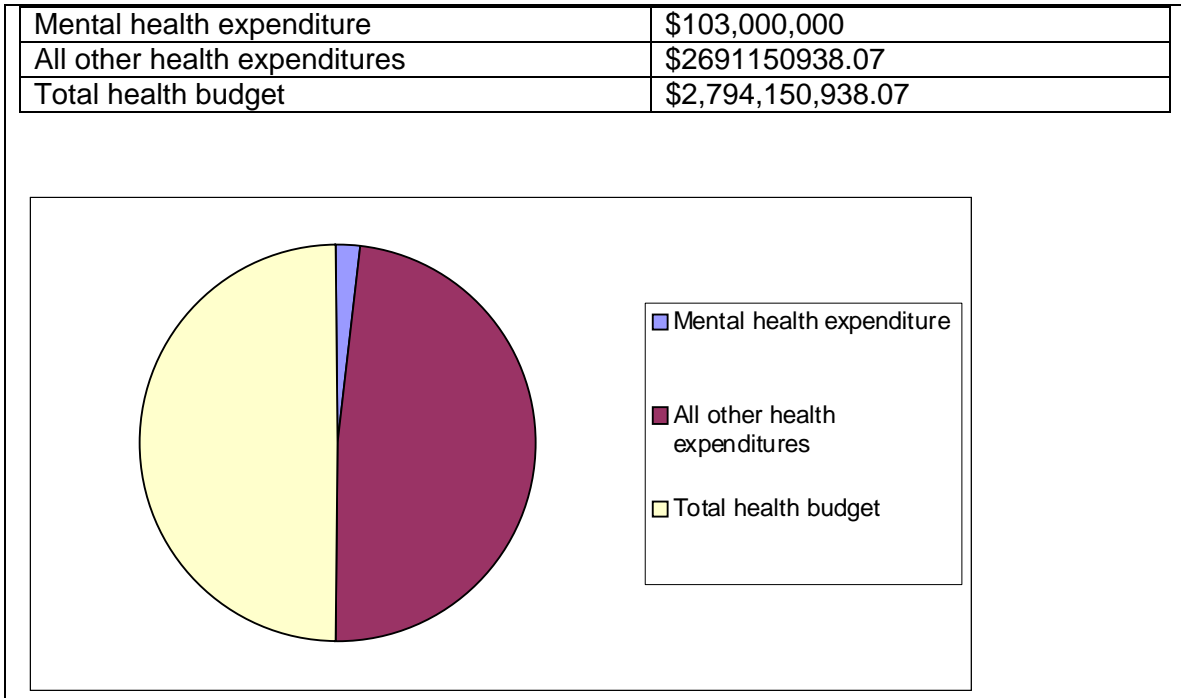
Financing of Mental Health Services

Four percent (4%) of health care expenditures by the Ministry of Health are devoted to mental health. Of all the expenditure spent on mental health, eighty five (85%) are allocated to the mental hospital. One hundred (100%) of the population has free access to essential psychotropic medicines. There are no social insurance schemes but all mental disorders are covered by social welfare. The biggest share of mental health expenditures lay in the payment of salaries and wages of human resources within the sector.

All clients/patients have free access to all essential psychotropic medicines. At least one psychotropic medicine from each category is available for all patients. Mental health patients fall within the category of chronic diseases programme, funded by the government, Chronic Disease Assistance Program (CDAP).

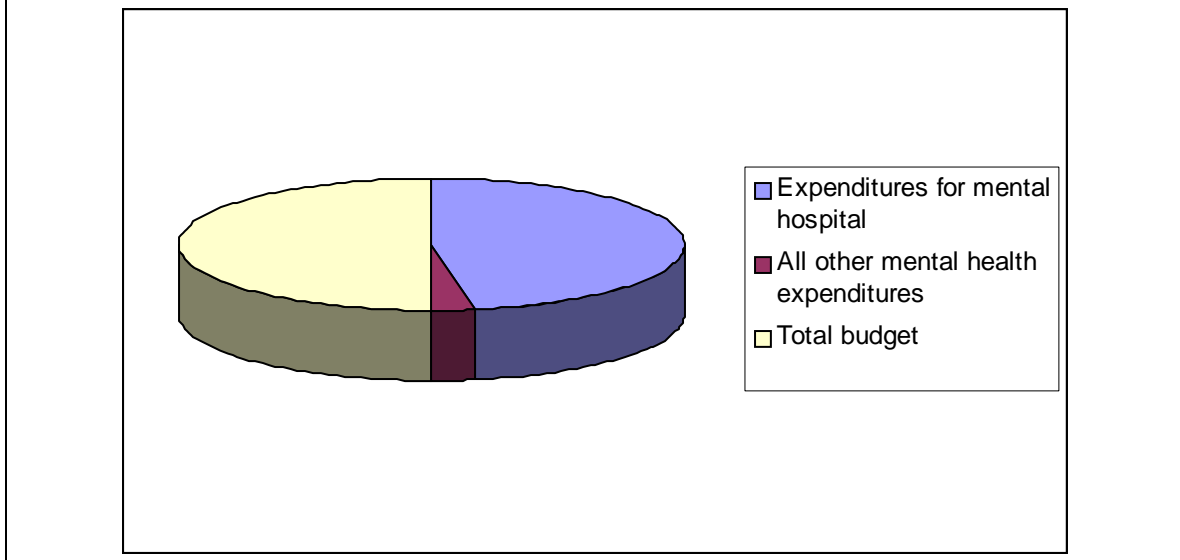
Mental health services are covered by the social welfare scheme. The government covers expenses for treatment and care in the mental hospital, outpatient clinic and in-patient psychiatric clinics.

GRAPH 1.1 STATE HEALTH EXPENDITURE TOWARDS MENTAL HEALTH



GRAPH 1.2 STATE MENTAL HEALTH EXPENDITURE TOWARDS MENTAL HOSPITAL

Expenditures for mental hospital	\$97,500,000.00
All other mental health expenditures	\$6,000,000.00
Total budget	\$103,000,000.00



Human Rights Policies

There is no human rights body which has the authority to oversee regular inspections or to impose sanctions in mental health facilities.

Thus, neither the mental hospital nor the community-based inpatient psychiatric units have had at least one yearly external review/inspection of human rights protection of patients. Some of the staff of the mental hospital and community-based inpatient psychiatric units has had at least one-day training, meeting or other type of working session on human rights protection of patients. The Patients Charter of Rights is incorporated in the nurses' curriculum of studies. However, in the last two years, non-governmental and professional organizations have provided training on patients' human rights to approximately forty percent (40%) hospital staff.

MENTAL HEALTH SERVICES

Organization of Mental Health Services

There is no mental health authority in the country. There is a Specialist Medical Officer (SMO) Psychiatry, or Chief of Staff, position, for the Ministry of Health, at the lone mental hospital in the country. The formal scope of work is defined by the job description according to the Public Service Regulations.

Mental health services are governed by the Ministry of Health and organized in terms of catchments/service areas. The majority of the psychiatrists and psychiatric nurses are based at the one major mental hospital in the capital city. From this major hospital teams comprising of psychiatrists, psychiatric nurses, mental health officers and psychiatric social workers pay scheduled visits to specific catchment areas and deliver care. The community-based psychiatric inpatient facilities are also serviced by this team from the major hospital.

Mental Health Outpatient Facilities

There are thirty-one (31) outpatient mental health facilities available in the country, of which one (1) facility is for children and adolescents only. Thirteen (13) out of the thirty-one (31) mental health facilities have beds for inpatient care. These facilities treat two thousand seven hundred and eighty eight (2788) users per 100,000 general population. Of all users treated in mental health outpatient facilities sixty percent (60%) are females. One point two eight percent (1.28%) of all contacts are with patients seventeen (17) years or younger.

The users treated in outpatient facilities are primarily diagnosed with schizophrenia and related disorders (30%) and mood disorders (18%). Information on diagnosis is based on contacts not users. The average number of contacts per user is 3431 per 100,000 pop. One hundred percent (100%) of outpatient facilities provide follow up care in the community, while twelve percent (12 %) have mental health mobile teams. In terms of available treatments, one hundred (100%) of the outpatient facilities offer psychosocial treatments. All one hundred percent (100%) mental health outpatient facilities have at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility or a nearby pharmacy all year round.

Day Treatment Facilities

There are three (3) day treatment facilities available in the country (NWRHA, SWRHA and TRHA). These facilities treat 0.92 users per 100,000 general population. Of all users in day treatment facilities, forty two percent (42%) of them are females and eight percent (8%) are children or adolescents. There are no day treatment facilities for children and adolescents only. No data was available for the time average users spend in year 2007 in the mental health day treatment facilities.

Community-Based Psychiatric Inpatients Units

There are two community-based psychiatric inpatients units (SWRHA and TRHA) available in the country for a total of 0.2 beds per 100,000 population. None of the beds in community-based inpatient units are reserved for children or adolescents only. Thirty eight percent (38%) of admissions to community-based psychiatric inpatients units are females, and eleven point seven percent (11.7%) are children/adolescents. The diagnoses of admissions to community-based psychiatric inpatients units are primarily from the following two diagnostic groups: mood disorders (20%) and schizophrenia and related disorders (49%). On average patients spend 6.3 days per discharge.

One hundred percent (100%) of patients in community-based psychiatric inpatient units receive one or more psychosocial interventions in the last year. All of community-based psychiatric inpatient units have at least one psychotropic medicine of each therapeutic class (anti-depressant, anti-psychotic, mood stabilizer, anxiolytic, and anti-epileptic medicines) available in the facility.

Community Residential Facilities

There are eight (8) community residential facilities available in the country for a total of fourteen point nine (14.9) beds/places per 100,000 population. Thirty (30) of the beds in community residential facilities are reserved for children or adolescents only. Four percent (4%) of users treated in community residential facilities are children. The number of users in community residential facilities is one hundred and sixty one (161).

The community residential facilities are part of an NGO initiative. Data on gender and days spent in facilities are not readily available. No other private or public residential facilities are available in the country for the year of assessment.

Mental Hospitals

There is one (1) mental hospital available in the country for a total population of 69 beds per 100,000 population. The operations of mental health in the country, is coordinated from this hospital. Zero point nine, 0.9% of these beds in the mental hospital are reserved for children and adolescents only. The patients admitted to this mental hospital belong primarily to the following two (2) groups: schizophrenia and related disorders and mood disorders. The information concerning these two (2) groups is not readily available. The number of patients in this hospital is 13.03 per 100,000 population.

The average length of stay for acute in-patient cases is between 8 and 10; there is no date on chronic patients. All patients (100%) in this mental hospital received one or more psychosocial interventions in the last year. The mental hospital has at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

The number of beds in this facility has not increased in the last five years. The number of patients in hospital has increased however, to an occupancy rate of 100%.

Forensic and other Residential Facilities

In addition to beds in mental health facilities, there are also 58 beds for people with mental disorders in forensic inpatient units. There are other residential facilities in the country but the numbers are unknown. E.g. homes for people with mental retardation, detoxification inpatient facilities, homes for the destitute, etc. Forensic facility offers four (4) beds per 100,000 population. All forensic beds are in the main mental hospital. In this facility twenty two (22.2%) of patients spend less than one year, thirty three (33.3%) of patients spend 1-4 years, twenty six percent (26.6%) of patients spend 5-10 years, and seventeen point seven percent (17.7%) spend more than 10 years.

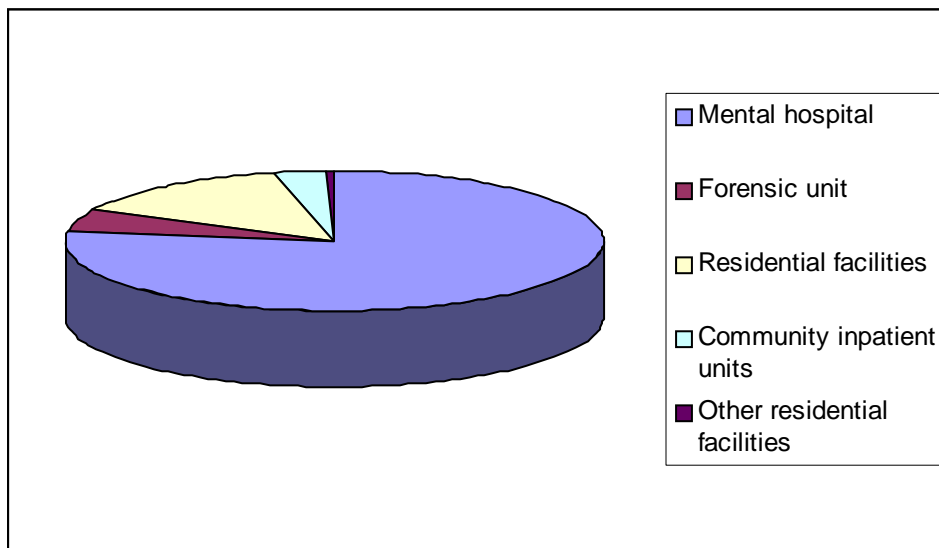
Human rights and equity

Six percent (6%) of all admissions to community-based inpatient psychiatric units are voluntary. The proportion of involuntary admissions to the mental hospital is ninety four (94%). The status of voluntary/involuntary admissions to hospital is of great importance to administration. One percent (1%) or less of patients were restrained or secluded at least once within the last year in community-based psychiatric inpatient units, in comparison to an estimated 11-20% of patients in mental hospital.

Seventy seven point four percent (77.4%) of psychiatry beds in the country are located in or near the largest city. However, this distribution of beds does not deter easy access to mental health services to the rest of the population. Inequity of access to mental health services to linguistic, ethnic or religious minorities is non-existent in the country.

GRAPH 2.1 BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES

Mental hospital	77.4%
Forensic unit	5%
Residential facilities	14%
Community inpatient units	3%
Other residential facilities	0.6%

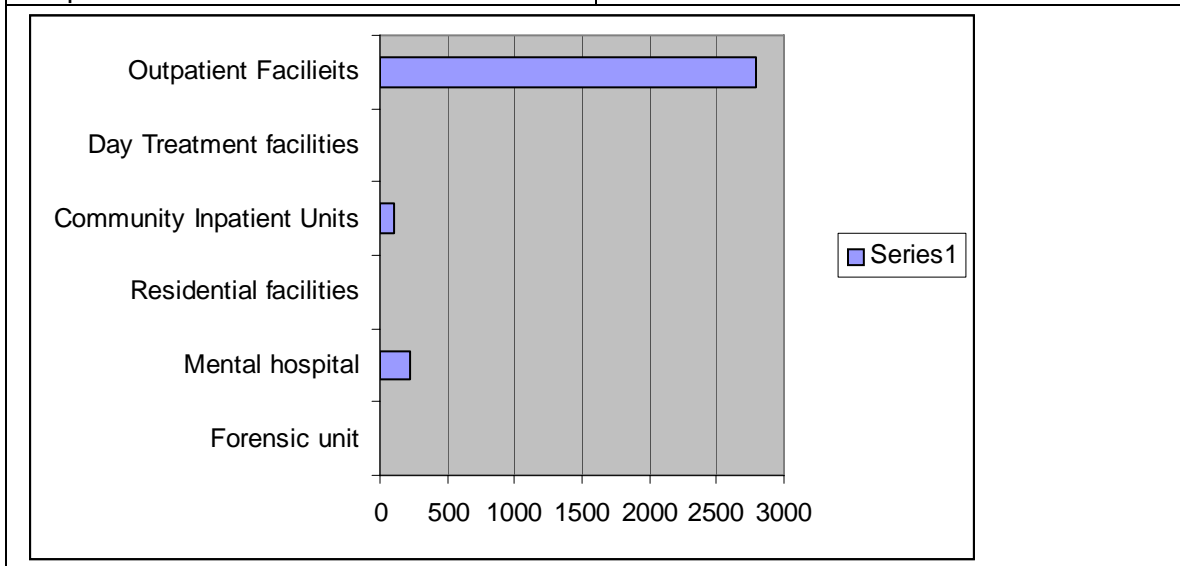


Summary of Graph 2.1

The majority of beds in the country are provided by the mental hospital, followed by the residential facilities.

GRAPH 2.2 PATIENTS TREATED IN MENTAL HEALTH FACILITIES (RATE PER 100,000POPULATION)

Forensic unit	4.4
Mental hospital	221
Residential facilities	12.3
Community Inpatient units	99
Day Treatment facilities	1.8
Outpatient Facilities	2788

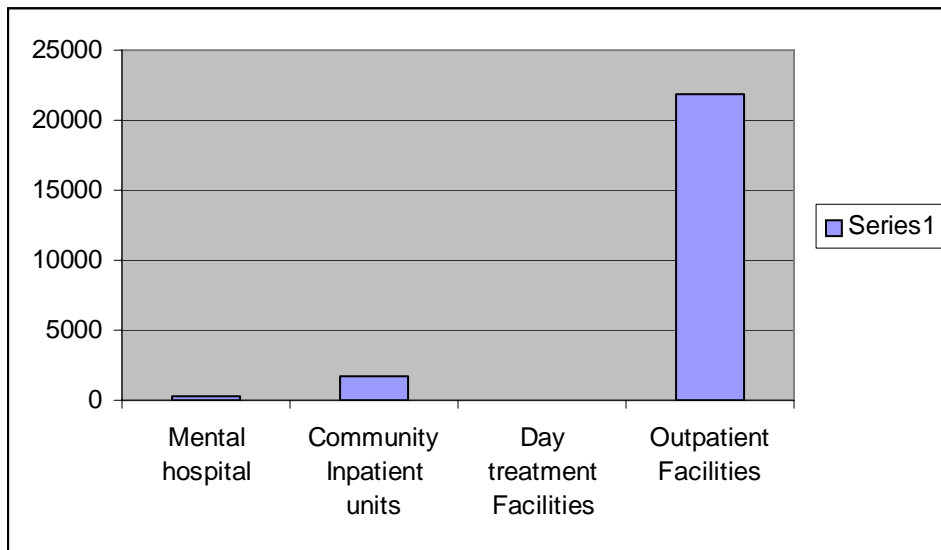


Summary of Graph 2.2

The majority of the users are treated in outpatient facilities and the mental hospital, while the rate of users treated in community inpatient units, day treatment facilities and residential facilities is lower.

GRAPH 2.3 PERCENTAGE OF FEMALE USERS TREATED IN MENTAL HEALTH FACILITIES

Mental hospital	1.34%
Community Inpatient units	7.3%
Day treatment Facilities	0.06%
Outpatient Facilities	91.3%



Summary for Graph 2.3

Female users make up over 50% in outpatient facilities and inpatient units. The proportion of female users is the lowest in mental hospital. There is no data available on gender distribution in residential facilities.

The longest length of stay for users is in the mental hospital. There is no data available on the length of stay in residential facilities.

MENTAL HEALTH IN PRIMARY HEALTH CARE

Training in Mental Health Care for Primary Care Staff

Two point six percent (2.6%) of the training for medical doctors is devoted to mental health, (320hrs out of 12,000 hrs over the five years) in comparison to 3.3% for nurses RN; 240 hrs out of 7,200 hrs; RMN, (3 yrs). In terms of refresher training, 0.3% of primary health care doctors have received at least two days of refresher training in mental health, while none of the nurses and non-doctor/non-nurse primary health care workers have received such training.

Mental Health in Primary Health Care

Physician based primary health care (PHC) clinics are in the country. Assessment and treatment protocols for key mental health conditions are available in twenty one percent (21%) to fifty percent (50%) physician based primary health care clinics. Most of these clinics have assessment and treatment protocols for key mental health conditions. Most of the physician based primary health care clinics make at least one monthly referral to a mental health professional. As for professional interaction between primary health care staff and other care providers, there has been an increase in the interaction between primary care doctors and mental health professionals during the last year. None of the physician based PHC facilities or mental health facilities, has had interaction with a complementary/alternative/traditional practitioner.

Prescription in Primary Health Care

Nurses and non-doctor/non-nurse primary health care workers are not allowed to prescribe psychotropic medications in any circumstance. Primary health care doctors are allowed to prescribe psychotropic medicines without restrictions. As for availability of psychotropic medicines, all physician based PHC clinics have at least one psychotropic medicine of each category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and anti-epileptic).

HUMAN RESOURCES

Number of Human Resources in Mental Health Care

The total number of human resources working in mental health facilities or private practice is forty five (45) per 100,000 population. The breakdown is as follows: Twenty three (23) psychiatrists, nineteen (19) other medical doctors (not specialized in psychiatry), four hundred and thirty three (433) nurses, four (4) psychologists, twenty seven (27) social workers, four (4) occupational therapists, seventy six (76) other health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counselors). All psychiatrists work for the government, but some also has their own private practice. Psychologists, social workers, nurses and occupational therapists work for government administered mental health facilities, either exclusively or along side with work in other sectors. Private practice is largely unregulated, especially in the case of psychologists.

Figures provided are best estimates based on official registration and data from professional associations.

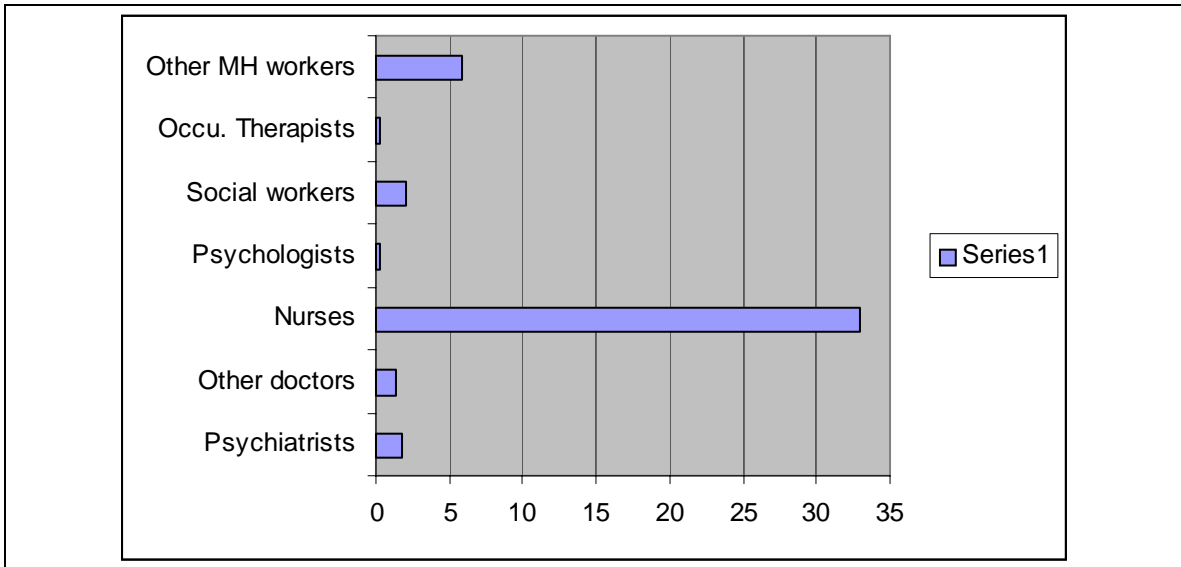
Regarding the workplace, nineteen (19) psychiatrists from the main hospital work in outpatient facilities. The six (6) psychiatrists who work in community-based psychiatric inpatient units two are from the main hospital. There are twenty three (23) psychiatrists in total who work for the government. in mental hospital. As for other medical doctors

(i.e., those not specialized in mental health), thirty five (35) work in outpatient facilities, six (6) in community-based psychiatric working in the inpatient units, and thirty five (35) in mental hospital. There are four hundred and thirty three (433) nurses working in an outpatient facility, twenty two (22) in community-based psychiatric inpatient units and thirty five (35) in mental hospital. As for other mental health professionals, there are thirty five (35) psychologists, social workers and occupational therapists working in outpatient facilities, One (1) of these professionals works in a community-based psychiatric inpatient unit, and twenty (20) of these professionals work in mental hospital. Finally, regarding other health or mental health workers, twenty three (23) works in outpatient facilities, there are none working in community-based psychiatric inpatient units, and there are twenty five (25) working in mental hospital. These figures do not include private practice.

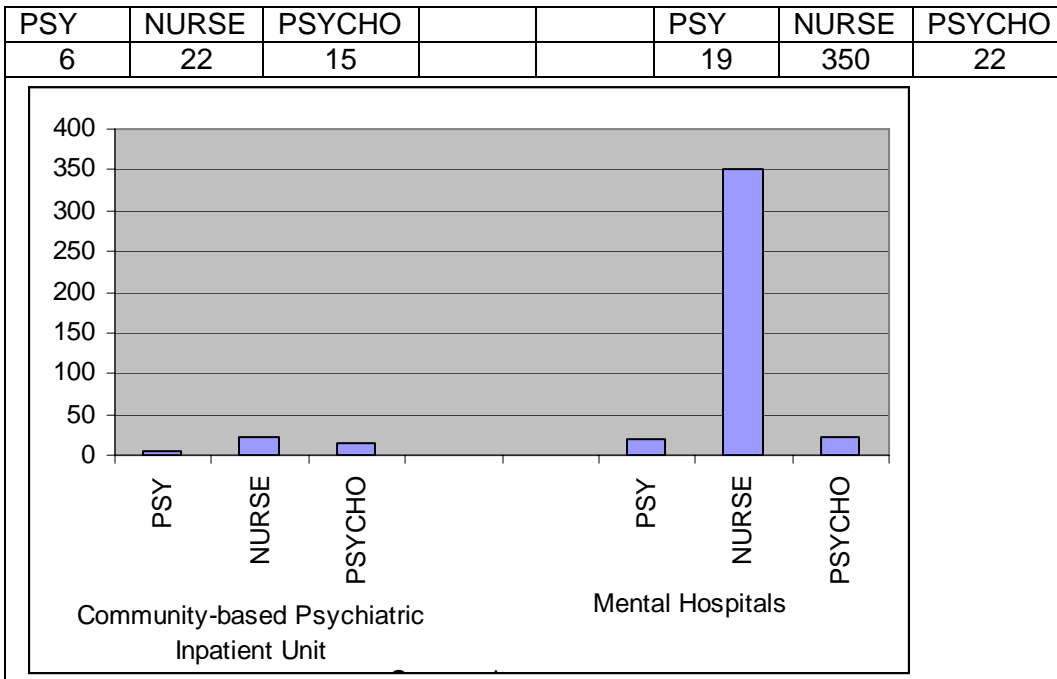
In terms of staffing in mental health facilities, there are 0.08 psychiatrists per bed in community-based psychiatric inpatient units, in comparison to 0.02 psychiatrists per bed in mental hospital. As for nurses, there are 0.79 nurses per bed in community-based psychiatric inpatient units, in comparison to 0.18 per bed in mental hospital. Finally, for other mental health care staff (e.g. psychologists, social workers, occupational therapists, other health or mental health workers), there are 0.07 per bed for community-based psychiatric inpatient units, and 0.36 per bed in mental hospital. The distribution of human resources between urban and rural may appear to be unfair, but one needs to consider that the island is small and transportation (communication) is excellent. It should be taken into consideration that psychiatrists, psychologists and social workers work only 12-15 hours per week in government administered facilities. Thus the number of professional and professional per bed ratios may overestimate effective staffing of these facilities.

GRAPH 4.4 HUMAN RESOURCES IN MENTAL HEALTH (RATE PER 100,000POPULATION)

Psychiatrists	1.8
Other doctors	1.4
Nurses	33
Psychologists	0.3
Social workers	2
Occu. Therapists	0.3
Other MH workers	5.8



GRAPH 4.3 AVERAGE NUMBER OF STAFF PER BED



Training professionals in Mental Health

The number of nurses graduated last year in academic and educational institutions per 100,000 population is as follows: 1.6 per 100,000 population. No information is available for the other professionals e.g. psychiatrists, medical doctors, psychologists and occupational therapists.

Consumer and Family Associations

There are no consumer associations. The number of persons who are members of family associations is unknown. Most family associations include family and friends of users. The government does not provide economic support for either consumer or family associations. Family associations have not been involved in the formulation or implementation of mental health policies, plans or legislations. Few mental health facilities interact with these associations. In addition to family associations, which are in their initial stages, there are NGOs in the country involved in individual assistance activities such as counseling, housing or support groups.

PUBLIC EDUCATION AND LINKS WITH OTHER SECTORS

Public education and awareness campaigns on mental health

There are coordinating bodies that oversee public education and awareness campaigns on mental health and mental disorders. Government agencies, NGOs, professional associations, private trusts and foundations, and international agencies all have promoted public education and awareness campaigns in the last five years. These campaigns have targeted the following groups: the general population, children, adolescents, women, and trauma survivors. In addition, there have been public education and awareness campaigns targeting professional groups including health care providers and teachers.

Legislative and financial provisions for people with mental disorders

At the present time, there is no legislative or financial support for employment, provision against discrimination at work, provision for housing, and provision against discrimination in housing for people with mental disorders.

Links with other sectors

In addition to legislative and financial support, there are formal collaborations with the departments/agencies responsible for primary health care/community health, HIV/AIDS, child and adolescent health, substance abuse, child protection, education, and criminal justice. There is no primary or secondary school that has either a part-time or full-time mental health professional. Few (1-20%) primary or secondary schools have school-based activities to promote mental health and prevent mental disorders. However, within the last year (2008-2009) "School psychologists" (these officers do not possess PhD. Qualifications) have been assigned to a few schools as a trial basis. One (1) school psychologist attached to the north of the country and one (1) attached to the south of the country. The proportion of prisoners with psychosis and mental retardation is estimated to be less than 2% for each diagnosis. Regarding mental health activities in the criminal justice system, less than 20% of prisons have at least one prisoner per month in treatment contact with a mental health professional. As for training, few (1-20%) police officers and no (0%) judges and lawyers have participated in educational activities on mental health in the last five years. In terms of financial support for users, none of the mental

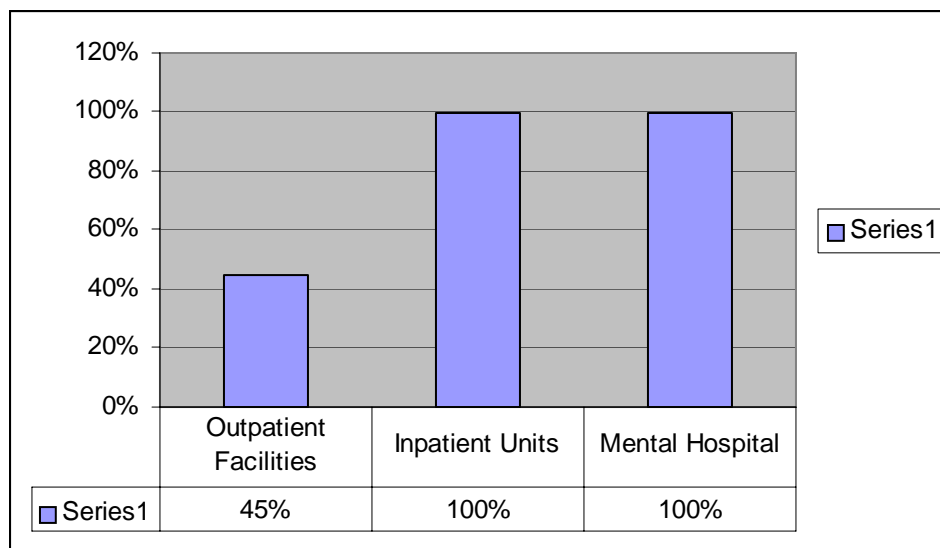
health facilities have access to programs outside the mental health facility that provide outside employment for users with severe mental disorders. Finally, there are some social welfare benefits for disability.

MONITORING AND RESEARCH

A formally defined list of individual data items that ought to be collected by all mental health facilities exists and includes the number of psychiatric beds, number of admissions, number of days spent in hospital, and diagnoses. As shown in table 6.1, the extent of data collection is variable among mental health facilities. The government health department receives data from (100%) mental hospital, (100%) community-based psychiatric inpatient units, and (45%) mental health outpatient facilities. However no report was produced using the data transmitted to the government health department.

Research in Trinidad and Tobago is focused on the following areas: epidemiological studies in clinical samples, non-epidemiological clinical/questionnaires assessments of mental disorders, service research, psychosocial interventions/psychotherapeutic interventions and policy, programmes, financing/economics. These researches have not been published.

GRAPH 6.1 PERCENTAGE OF MENTAL HEALTH FACILITIES TRANSMITTING DATA TO HEALTH DEPARTMENT



One hundred (100%) of Mental Hospital and Psychiatric Inpatient Units submit data to Health Department, whereas 45% of outpatient facilities do.

APPENDIX 1

STRENGTHS AND WEAKNESS IN THE MENTAL HEALTH SYSTEMS OF TRINIDAD AND TOBAGO

Strengths

- Dedicated and committed health care providers – psychiatrists, psychologists, nurses, social workers, occupational therapist and others
- History of a strong public health/community health system that acts as a backbone for all other health care systems.
- Easy communications; access to the major mental hospital.
- Availability of medicines for all conditions in the treatment of mental disorders/diseases
- Proactive out-patient department

Weaknesses

- Lack of vigorous awareness campaigns to facilitate “Buy in” for the general public.
- The need for closer collaboration between other actors in the health sector and the mental health team.
- Lack of resources –human, financial and material resources for the efficient and effective running of the mental health system.
- There is need for technological improvements in data entry - medical record keeping – at all mental health facilities in the country.
- Absence of a research culture that would encourage other health professionals and professionals in general to gravitate towards mental health.

APPENDIX 2

NEXT STEPS IN STRENGTHENING THE MENTAL HEALTH SYSTEM

Considering the WHO-AIMS data and the context given by the situations mentioned above, possible areas for action are:

Domain 1

- Enactment of a Mental Health Policy for the country, Trinidad and Tobago at the earliest opportunity.
- Updating of the 1975 legislation.

Domain 2

- Accelerate the decentralization of care from the main hospital (MHs) to more community/residential facilities.

Domain 3

- A vigorous Primary Health Care Training Programme for Health Care Professionals and supporting staff in Mental Health. This could be short term, medium term and long term.

Domain 4

- Increase the number of “school psychologists” in our primary and secondary schools.

Domain 5

- Facilitate family associations.

Domain 6

- Encourage external monitoring of facilities by experts in mental health.

- Further training to be encouraged in Data entry – Medical Records – to the pervade entire system.
- Networking with the Community Care Department, which facilitates Community residences for chronic patients. Placement of these patients/clients would then become more smoothly.

The network of Mental Health Facilities pervade the entire length and breath of the twin island Republic of Trinidad and Tobago.

The lone mental hospital, located in the capital city, Port of Spain is easily accessible to the rest of the country. The eight (8) community mental health facilities are located in strategic catchment/service areas of the country.

Greater proportion of clients is seen via the out patient route, rather than the inpatient route.

The patient Charter of Rights is visible in all Health Institution and is gradually becoming a part of total quality care in Mental Health Care and Health Care generally.

Equity of access is not a challenging concern for the mental patient.

Most of the money allocated to mental health is spent on the mental hospital.

Training in mental health has been few and far between. As a result most of the mental health and primary care staff have not been exposed to continuous training.

All facilities are well stocked with essential psychotropic medicines.