WHO-AIMS

WHO-AIMS REPORT ON

MENTAL HEALTH SYSTEM

IN Jamaica

World Health Organization

MINISTRY OF HEALTH
JAMAICA

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A report of the assessment of the mental health system in Jamaica using the World Health Organization - Assessment Instrument for Mental Health Systems (WHO-AIMS).

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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

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The WHO-AIMS project is coordinated by Shekhar Saxena.

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 Jamaica. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This will enable Jamaica 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.

Jamaica's Mental Health Policy was last revised in 1997 and is currently inadequate and requires revision and upgrading to include critical components such as human resources and human rights issues to name a few. The Mental Health Unit has the revision and upgrading of this policy as an activity on its' 2009/10 workplan.

The Strategic Plan for the years 2001 – 2006, which is 65% implemented is in the process of being reviewed and updated for the years 2009-2014. The 2001-2006 strategic plan was not fully implemented because of budgetary constraint.

The Mental Health Law was last revised in 1997 and is also on the Mental Health Unit's 2009/10 work plan to be reviewed and revised to include all human rights policies as a critical component.

The restructuring of the financing of the service is in the Mental Health Plan which has been approved by Cabinet. With the change in Government, however, the Mental Health team will now have to advise the new Minister of Health and make the necessary arrangement for the issue of the redistribution of funding from the costly mental hospital to the community mental health services to support patient care as near as possible to the community in which they live, to be made into policy and implemented. This activity is also on the unit's 2009/10 workplan.

The mental health service is divided into national and regional health authorities. Mental health is integrated into general health care with all regions having most of the essential mental health components and psychotropic medication. A major weakness of the service is the child and adolescent and forensic component of the service. Most patients are treated in the outpatient community facilities at a rate of 1034 per 100,000 population. These facilities exist throughout the island in the various communities, as part of primary health care. In Jamaica epidemiological studies show that the most prevalent disorder is that of Major Depressive Disorder. However, schizophrenia is the most prevalent disorder diagnosed and treated. There is one mental hospital in the country with a bed capacity of 32 beds per 100,000 population. The number of beds in the mental hospital has decreased by 23% in the last 5 years. The patients admitted to the mental hospital are

diagnosed primarily with schizophrenia 79% and most admissions are involuntary. The average days spent in the mental hospital is 280 days. The average length of stay the acute ward is 25 days. Long stay patients account for the majority of the days spent and should be in a residential support living type facility which currently is underserved.

The majority of clinics have mental health assessment and treatment protocols and 78% of the primary health care staff have had refresher training in mental health in the last year.

The majority of clinical services are provided by nurses, which represents 6 per 100,000 under the supervision of the psychiatrists which is 1 per 100,000. There is a dearth of psychologists, social workers and occupational therapists in the island due to the unattractive remuneration in the public sector. Most psychiatrists provide both public and private services. While few psychiatrists emigrate to other countries, a significant number of nurses emigrate on a yearly basis. Consumers, non-government, community based and family associations interact closely with the mental health services.

Mental Health Education and Promotion is a stated priority for both the national and regional authorities. During the last two years there has been an active mental health promotion targeting all sectors, including primary and secondary schools. There is no legislative, financial provision for persons with mental disorders and only 1% of persons with a mental disability receive social welfare benefits.

Introduction

Jamaica is an island nation of the Greater Antilles, 234 kilometres (145 miles) in length and as much as 80 kilometres (50 miles) in width situated in the Caribbean Sea. It is about 145 kilometres (90 miles) south of Cuba. The number of population is 2,660,700 (2005 est.).

English is the official language of Jamaica. Informally Jamaican Patois is more commonly spoken by the majority of the population which is a mixture of English. The mix of accents in the language and the mix of patois in the various area of the country reflect the history of the country.

Christianity makes up the majority of the population with the following break down:

- Protestant 61.3% (including Church of God 21.2%, Seventh-Day Adventist 9%, Baptist 8.8%, Pentecostal 7.6%, Anglican 5.5%, Methodist 2.7%, United Church 2.7%, Jehovah's Witness 1.6%, Brethren 1.1%, and Moravian 1.1%),
- Roman Catholic 4%

Other religious groups:

- Rastafari movement 33.7%,
- Islam 0.5%,
- Judaism 0.5%

Ethnic groups are:

- 76.3% African,
- 15.1% Afro-European,
- 3.4% East Indian, Afro-East Indian,
- 3.2% Caucasian,
- 1.2% Chinese,
- 0.8% Other[2]

Age structure

- *0-14 years:* 33.1% (male 464,297/female 449,181)
- *15-64 years:* 59.6% (male 808,718/female 835,394)
- *65 years and over:* 7.3% (male 90,100/female 110,434) (2006 est.)

- Percentage of the population that is rural is 48% (2005 est.)

Life expectancy at birth

Total Population:

- 71.88 years - *male:*

- 75.38 years - *female:*
- Average: - 73.3 years (2005 est.)

Literacy rate

Defined as individuals: age 15 and more who has ever attended school.

Total population: 87.9% - *male:* 84.1% - *female:* 91.6% (2003 est.)

The current health and mental health structure

- Proportion of health budget to GDP is **10%**
- Per capita expenditure on health – **J$6283.46**
- Per capita government expenditure on mental health **- J$682.21**

Overview of the health system

The Jamaican Health System

The Ministry of Health (MOH) is the pre-eminent Government Organization mandated to care for the nation's health.

Health care in the public sector is free

The Ministry, together with its Regional Health Authorities (RHAs), Agencies and related organizations make up the public health system and they are responsible for health care delivery across the island.

Mental health services

- The Mental Health Unit headed by the Director of Mental Health and Substance Abuse Services functions within the Ministry of Health as part of the Health Services Planning and Integration Division that reports to the Chief Medical Officer.
- There is a sub-division of Child and Adolescent Mental Health within this Unit and the Unit has a collaborative working relationship with the Psychiatry Department of UWI in the areas of services, research and training.
- The Mental Health Unit develops mental health standards, creates mental health policies, reviews, and monitors mental health programs in Jamaica.

Domain 1: Policy and Legislative Framework

Policy, plans, and legislation

Jamaica's Mental Health Policy was last revised in 1997 and needs to be reviewed. It currently includes the following components:

- Organization of services:
    - Developing community mental health services
    - Downsizing the large mental hospital
    - Further development of mental health components in primary health care.
    - Human resources

In addition, there is an essential medicines list called the Vital, Essential and Necessary (VEN) list. This list includes anti-psychotics, anxiolytics, antidepressants, mood stabilizers and antiepileptic.

The Mental Health Unit has on its 2009/10 work plan the activity to review and revise the Mental Health Policy which will include among other things the following components:

- Involvement of users and families
- Advocacy and promotion
- Human rights protection of users
- Equity of access to mental health services across different groups
- Financing
- Quality improvement
- Monitoring system

The last revision of the mental health plan was in 2008. This plan contains the following components:

- Organization of services:
    - Developing community mental health services
    - Downsizing the large mental hospital
    - Further development of mental health components in primary health care.
- Human resources
- Involvement of users and families
- Advocacy and promotion
- Human rights protection of users
- Equity of access to mental health services across different groups
- Financing
- Quality improvement
- Monitoring system

In addition a:

- Budget is mentioned in the last mental health plan
- Timeframe is mentioned in the last mental health plan
- Specific goals are mentioned in the last mental health plan
- Some of the goals from the last mental health plan, have been realized in the last calendar year

There is also a disaster/emergency preparedness plan for mental health which was last revised in 2007.

As it relates to legislation, the last piece of mental health legislation was enacted in 1997 and it focused on a number of issues including:

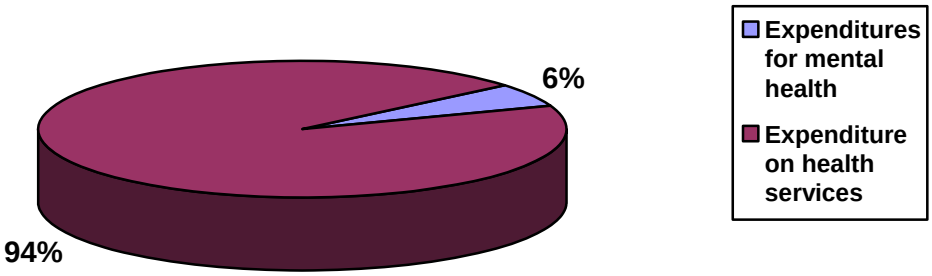
- Access to mental health care including access to treatment in the least restrictive environment.
- Rights of mental health service to consumers, family members and other care givers.
- Competency, capacity and guardianship issues for individuals with mental illness.
- Voluntary and involuntary treatment
- Accreditation of professionals and facilities
- Law enforcement and other judicial system issues for people with mental illness
- Mechanisms to oversee involuntary admissions and treatment practices
- Mechanisms to implement the provisions of mental health legislation.

It is planned that in 2009 the Mental Health Policy will be reviewed and revised. Issues such as human rights, equity, advocacy and consumer involvement will be critical components of the policy. Plans are also in place for the revision of the act to include the human rights component.

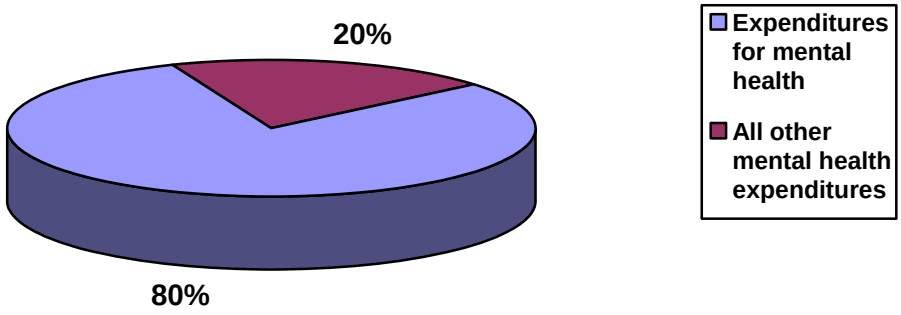
Financing of mental health services

Six percent (6%) of health care expenditures by the government health departments is directed towards mental health. Of all the expenditures spent on mental health, (80%) is directed towards mental hospitals.

GRAPH 1.2 GENERAL HEALTH EXPENDITURE TOWARDS MENTAL HOSPITALS



GRAPH 1.2 MENTAL HEALTH EXPENDITURE TOWARDS MENTAL HOSPITALS



Currently all Jamaicans have access to free health care in the public system, hence all persons in the population who need psychotropic medication have access. or those that pay out of pocket, the cost of antipsychotic medication such as Haloperidol (15mg/day) is J$113 per day (5% of the one daily minimum wage) and antidepressant medication such as Amitriptyline (75mg/day) is J$3.96 per day (1% of the daily minimum wage). In addition all severe and some mild mental disorders are covered in social insurance schemes.

As stated in the introduction, the health service is divided into four regions, the South East Region which covers four parishes, Kingston, St. Andrew, St. Catherine and St. Thomas and has almost half the population of the island hosts the mental hospital. The mental hospital as depicted in the graph receives approximately 6% of the health budget each year. That money is used for the mental hospital operations and also for the mental health community operations in the South East Region. It should also be stated that an anomaly exists in the fact that the mental hospital receives its budget directly from the Ministry of Finance which does not happen in any other hospital across the island.

Human rights policies

There is a national review body, which has human rights functions and has the authority to oversee regular inspections in mental health facilities, review complaints and investigate and review admissions and discharge procedures. Although the review board can use the law to impose sanctions on institutions they do not have direct authority to close facilities or to directly impose sanctions.

As it relates to the monitoring of human rights, in 2007, nineteen percent (19%) of community based inpatient psychiatric units and community based residential facilities have had an external review/inspection of the human rights protection of patients, while the mental hospital has not had such a review. In the same year, one hundred percent (100%) of the mental hospital, seven percent (7%) of inpatient psychiatric units and community residential facilities have had at least one day training meeting or other type of working session on human rights.

Domain 2: Mental Health Services

Organization of mental health services

A national mental health authority exists which provides advice to the government on mental health policies and legislation. The mental health authority is also involved in service planning, service management, coordination, monitoring and quality assessment. The mental health services are organized in terms of geographic areas, where each person in the population can have access to mental health care as near as possible to their place of residence.

Mental health outpatient facilities

There are 139 outpatient mental health facilities in the country, of which 9% are for children and adolescents. These facilities treat 1035 users per 100,000. Of all the users treated in the outpatient facilities forty-five percent (45%) are females and nineteen percent (19%) are children and adolescents. The users treated in outpatient facilities are primarily diagnosed with Schizophrenia (51%) and Mood Affective Disorder (36%). The average number of contacts per user is approximately 3 times per year and all the mental health outpatient facilities have at least one psychotropic medicine of each therapeutic class. In terms of available treatment, some (21-50%) of patients in outpatient facilities

last year received one or more psychosocial interventions. All outpatient facilities provide follow-up care in the community, while forty-two percent (42%) have mental health mobile teams.

Day treatment facilities

There are nine (9) day treatment facilities available in the country, of which none are accessible for children and adolescents. These facilities treat seventeen (17) users per 100,000 population. Of all users treated in day treatment facilities twenty-four (24%) are females and there are no children or adolescents. On average users spend 241 days in day treatment facilities.

Facilities for children and adolescents exists but are residential such as children's homes for ward of the state, homes of safety and other residential homes for children and adolescents at risk, those with mental disorders retardation and/or psychosis operated by private citizens/NGO.

Community-based psychiatric inpatient units

There are two (2) community-based psychiatric inpatient units available in the country for a total of three (3) beds per 100,000 population. None of these beds are reserved for children and adolescents only. Forty-one percent (41%) of admissions to community-based psychiatric inpatient units are females and as stated before children and adolescents are not usually admitted to these wards. The diagnoses of admissions to community-based psychiatric inpatient units for 2007 were primary from the diagnostic groups, neurotic, stress-related and somatoform disorders (32%) and schizophrenia (46%)

On average patients spend 22 days per discharge. The majority (51-80%) of patients in community-based psychiatric inpatient units received one or more psychosocial intervention in 2007.
Both community-based psychiatric units have at least one psychotropic medicine of each therapeutic class.

Community residential facilities

There are 13 community residential facilities available in the country for a total of 16.53 beds/places per 100,000 population. These facilities treat 17.66 patients per 100,000 population. There are zero beds in community residential facilities which are reserved for children and adolescents only. Thirty-one percent (31%) of users treated in residential facilities are females and eighteen percent (18%) are children. On average patients spend 365 days in community residential facilities.
Community residential facilities mentioned above include infirmaries. These infirmaries generally house mentally ill patients, who after entering that institution never leave.

Mental hospitals

There is one mental hospital available in the country providing 31.8 beds per 100,000 population. This facility is organizationally integrated with mental health outpatient facilities. None of these beds are reserved specifically for children and adolescents, however, if the need arise they will be accommodated, which was not the case. The number of beds in the mental hospital has decreased by twenty-three percent in the last five (5) years. Thirty-seven percent of the patients treated are female. The patients admitted to the mental hospital are diagnosed primarily with schizophrenia (79%) and mood affective disorder (10%). In 2007 the number of patients admitted to the mental hospital was 972. The average number of days spent in the mental hospital is 280 days and is outlined as follows:

- 14% of patients spend less than one year in hospital
- 12% spend 1-4 years
- 25% spend 5-10 years and
- 49% of patients spend more than 10 years in the mental hospital.

The occupancy rate in the mental hospital is 88%.

All or almost all (81-100%) patients in the mental hospital receive one or more psychosocial interventions in the past year (2007). The mental hospital had at least one psychotropic medicine of each therapeutic class available in the facility.

The average length of stay in the mental hospital on the acute ward is usually 21 days for females and approximately 30 days for males. The long stay patients on the chronic wards and those who are there because of social conditions increased the length of stay. Currently there are approximately 300 patients at the mental hospital who should be in a nursing home or infirmary or home with family. However, due to the shortage of social services they have been at the mental hospital, some for most or all of their adult lives. Plans for deinstitutionalization of the mental hospital, it is hoped will address this issue as outlined in the plan for mental health services and recent workshop on the same issue.

Forensic and other residential facilities

In addition to beds in the mental health facilities, there are also 13 beds per 100,000 population for persons with mental disorders in forensic inpatient units and 87 beds or 3.6 beds per 100,000 population for persons with mental retardation, detoxification inpatient facilities and homes for the destitute to name a few.

Forensic facilities treat 12.5 users per 100,000. Information regarding time spent by patients in forensic units was unavailable.

Human rights and equity

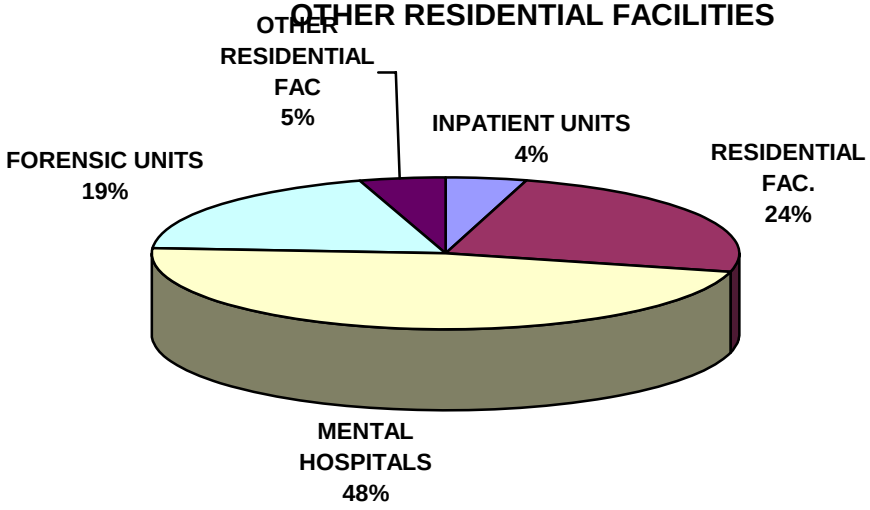
Ninety – one percent (91%) of all admissions to community-based inpatient psychiatric units and ninety-five (95%) of all admissions to the mental hospital are involuntary. Between two to five percent (2-5%) of patients were restrained or secluded at least once within the last year in community-based psychiatric inpatient units, in comparison to 11-

20% of patient in the mental hospitals. The density of psychiatric beds in or around the largest city is 3.78 greater than the density of beds in the entire country. Such distribution increases the difficulty of access to rural patients and family members. The fact that 2.11.5 illustrates a smaller percentage of minority groups are admitted to the mental hospital the reason has nothing to do with inequity of service but more with personal believes, religious believes, accessing service in the private sector and the high level of stigma in the society.

As it relates to access and the distribution of beds, the problem mostly lies with the inability of family members to visit their relatives who have been referred to the mental hospital which is located in the largest city – the capital city. This is a violation of the WHO regulation that the patient should be treated as near to his/her community as possible. The implementation of the mental health plan should amend this violation. The revision of the Mental Health Policy will also address this issue.

Summary Charts

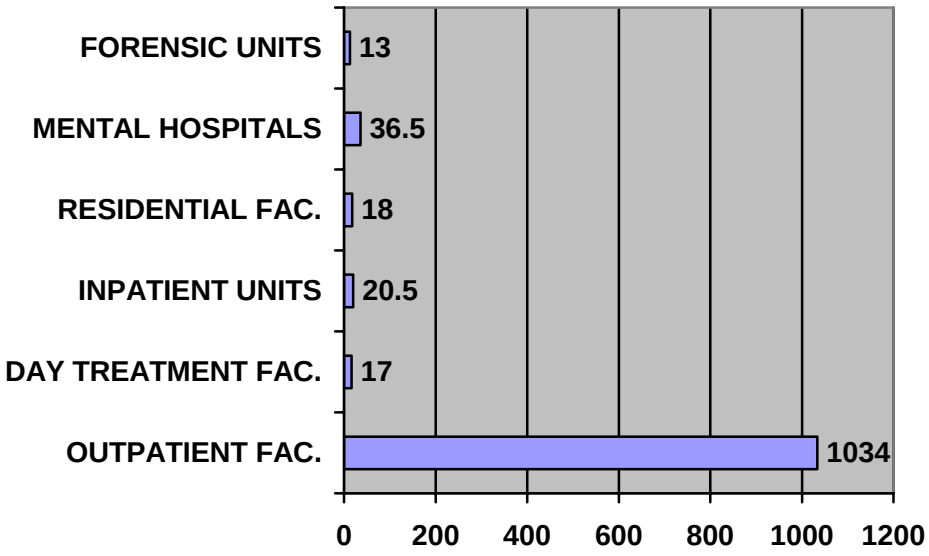
GRAPH 2.1 - BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES



The mental hospital which is located in the capital city has the largest number of beds per 100,000 population. In fact it accounts for almost 50% of the mental health beds in the island. It should be highlighted, however, that over 326 of these beds are occupied by persons who should be at home with family or in the infirmaries or homes for persons with mental retardation. Due to the scarcity of social services in terms of personnel and physical places these persons are currently residence at the mental hospital.

There are 350 beds in the prisons across the island. There are no forensic beds in the mental hospital and as it relates to length of stay in the forensic facilities efforts to obtain that information was fruitless.

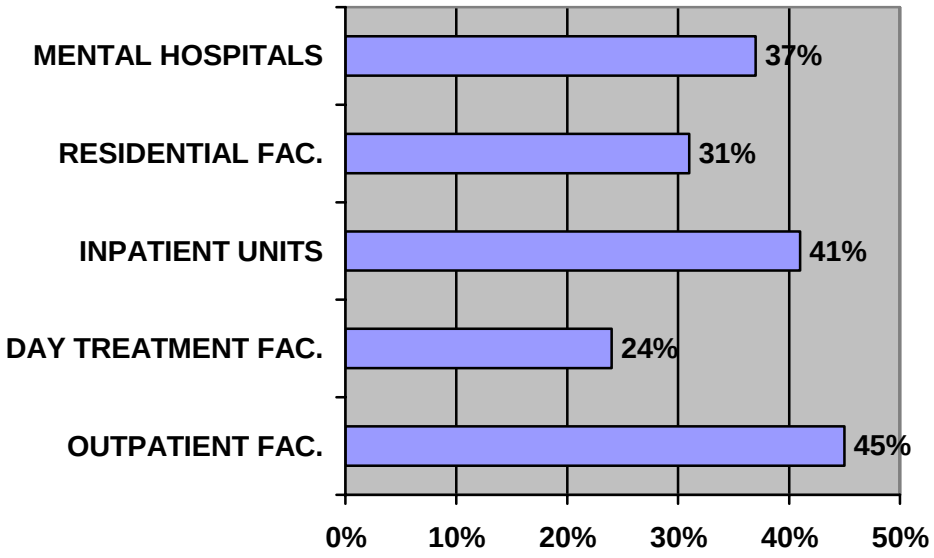
GRAPH 2.2 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES (rate per 100.000 population)



Summary for graph 2.2

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

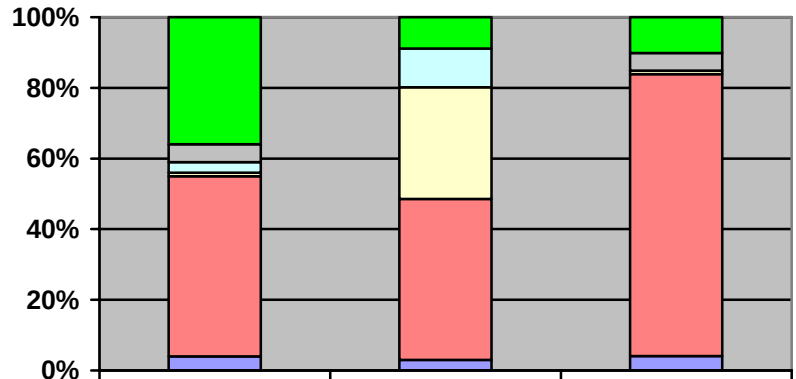
GRAPH 2.3 - PERCENTAGES OF FEMALE USERS TREATED IN MENTAL HEALTH FACILITIES



Summary for graph 2.3

The proportion of female users is higher in outpatient and inpatient facilities and the mental hospital and lower in the day treatment and residential facilities. This result is not surprising.

GRAPH 2.5 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS

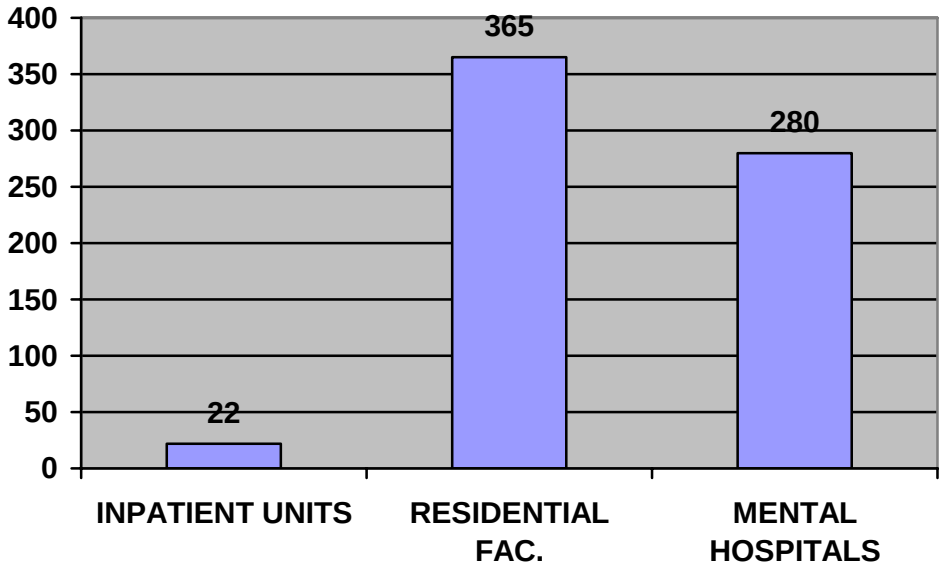


	OUTPATIENT FAC.	INPATIENT UNITS	MENTAL HOSPITALS
MOOD (Affective) DI	36%	9%	10%
OTHERS	5%	0%	5%
PERSONALITY DIS.	3%	11%	0%
NEUROTIC DIS.	1%	32%	1%
SCHIZOPHRENIA	51%	46%	79%
SUBSTANCE ABUSE	4%	3%	4%

Summary for graph 2.5

The distribution of diagnoses does not vary much particularly as it relates to the most common diagnosis, for example for the outpatient, inpatient facilities and the mental hospital, schizophrenia is the most common diagnosis. While the second most common diagnosis is mood affective disorder for the outpatient facilities and the mental hospital. Neurotic disorder, on the other hand is the second most commonly diagnosed disorder in the inpatient units.

GRAPH 2.6 - LENGTH OF STAY IN INPATIENT FACILITIES
(days per year)



Summary graph 2.6

The longest length of stay for users is in community residential facilities, followed by mental hospitals. The length of stay in the mental hospital is high because there are over 600 resident patients who are social cases in the hospital. Persons spent all their lives in the community residential facilities and they are rarely reunited to family members, particularly males.

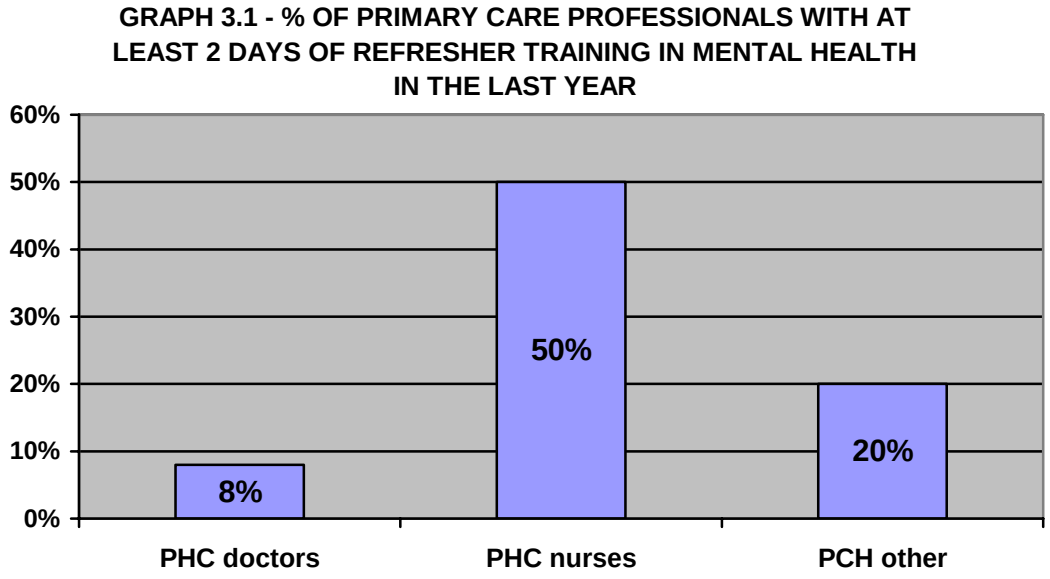
It is reasonable to expect that the shortest length of stay will be the psychiatric inpatient unit, where the length of stay is 22 days and is in keeping with the goal of successfully treating acute mental disorders within at least 21 days.

Domain 3: Mental Health in Primary Health Care

Training in mental health care for primary care staff

Three percent (3%) of the training for doctors is devoted to mental health, in comparison to one percent (1%) for nurses and thirty-seven percent (37%) for non-doctor/non-nurse primary health care workers. In terms of refresher training, eight percent (8%) of primary health care doctors have received at least two days of refresher training in mental health, while fifty percent (50%) of nurses and 20% of non-doctor/non-nurse primary health care workers have received such training.

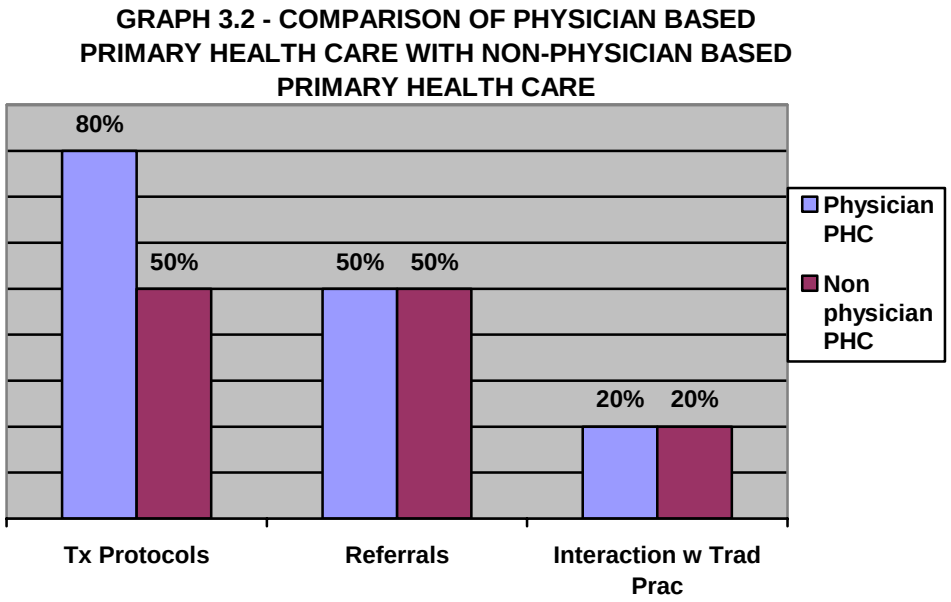
Graph 3.1: Percent of primary health care professionals with at least two days of refresher training in mental health in the last year



Mental health in primary health care

Both physician based primary health care (PHC) and non-physician based PHC clinics are present in the country. The majority of clinics (51-80%) have assessment and treatment protocols for key mental health conditions available, in comparison to some non-physician based primary health care clinic 21-50%. 21-50% of doctors in physician based primary health care clinics make an average of at least one referral to a mental health professional. 21-50% of non-physician based primary health care clinic make a referral to a higher level of care. As it relates to professional interaction between primary care staff and other care providers, 21-50% of primary care doctors have had interaction with a mental health professional at least once in the last year. The physician-based, non-physician based PHC and the mental health facilities have all had a few interactions with a complimentary/alternative/traditional practitioner.

Graph 3.2: Comparison of physician-based primary health care with non-physician based primary health care



Note: Tx protocols = % of PHC clinics with treatment protocols available for key mental health conditions; Referrals = % of PHC who make at least one mental health referral per month; Interaction w Trad Prac = % of PHC interacting with complimentary/alternative/traditional practitioners per month.

Prescription in primary health care

Health regulations do not allow non-doctor/non-nurse primary health care workers to prescribe and/or to continue prescription of psychotropic medications. Primary health care doctors are allowed to prescribe without restrictions. Primary health care nurses are allowed to prescribe but with restriction. As for availability of psychotropic medication all or almost all (81-100%) of physician and non-physician based PHC clinics have at least one psychotropic medicine of each category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic and antiepileptic).

Domain 4 Human Resources

Number of human resources in mental health care

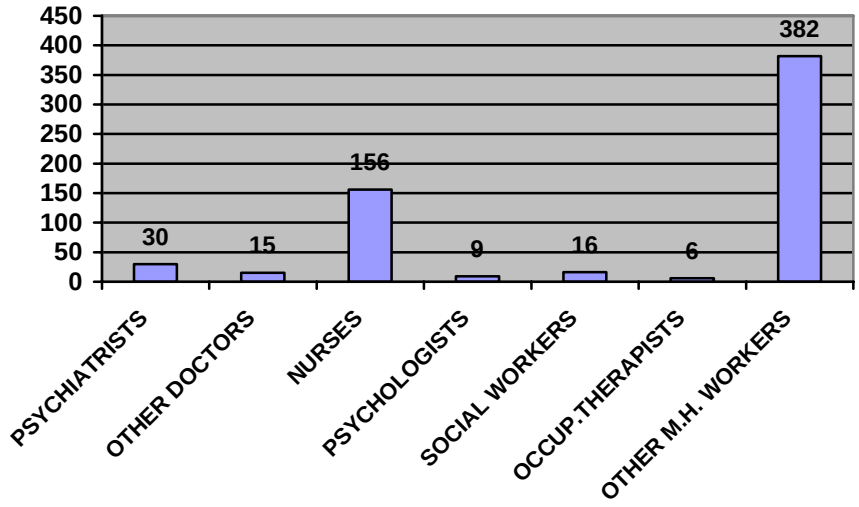
The total number of human resources working in mental health or private practice is 23.357 per 100,000 population. The breakdown according to profession is as follows:

- Psychiatrist – 1.127 per 100,000
- Other medical doctor, not specialized in psychiatry – 0.564
- Nurses – 5.863

- Psychologists – 0.338
- Social Workers – 0.601
- Occupational Therapists – 0.225
- Other Health Workers – 14.357

All psychiatrists who work in the public sector, also work either for NGOs, for profit mental health facilities and/or in private practice. Most psychologists, social workers, nurses and occupational therapists work only for the government administered mental health facilities. Some psychologists, nurses and occupational therapists offer their services in the private sector on an ad hoc basis. At this time we are unable to give more details, because these sessions are not planned or regular. We are also unable to pro rate these sessions. These same psychologists, social workers and occupational therapists work both in the community and hospitals and this is a part of their job description. For example, if there is a mentally ill patient on the community-based inpatient ward the psychologist and occupational therapist is engaged if needed as apart of their daily duty, the same is applied if their skills are needed in the community.

GRAPH 4.1 - HUMAN RESOURCES IN MENTAL HEALTH



Summary for graph 4.1

It should be noted that although it is reported that there are sixteen social workers in some regions such as the Southern Region do not have a social worker specifically assigned to the mental health programme, but they have access to those in the general health system and there are four (4).

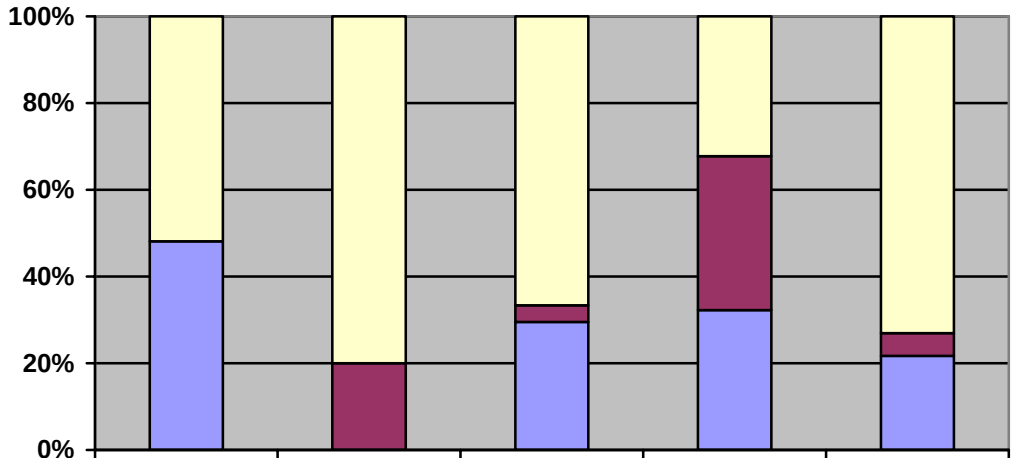
Regarding the workplace thirteen (13) psychiatrists work in both outpatient facilities and community-based psychiatric inpatient units, while three (3) work specifically for the private sector and fourteen (14) work in the mental hospital. It should be noted that the psychiatrists do not work part time in either facility. They are consultants; therefore those who work in community are on call if a mentally ill is admitted on a general ward. For example, if a mentally ill patient is admitted on a general ward and the generalist is having a difficulty treating that patient the psychiatrist is called. Hence it is a part of his/her duty to work in both facilities in the community, when the need arises.

There are nine (9) psychologists, sixteen (16) social workers and six (6) occupational therapists. There are few doctors (if any) who do not specialize in mental health working in outpatient facilities. There are three (3) such non-specialist doctors in community-based psychiatric in-patient units and twelve (12) in the mental hospital. As far as mental health specialist nurses, fifty-two (52) work in outpatient facilities, if a patient is admitted on a community based inpatient ward a mental health specialist nurse is on call to oversee that patient, hence 6 nurses are assigned island wide, out of the 52 nurses for such duties. They are not assigned part time, they are simply on call if any difficulty arises, it is a part of their job duty. (Kindly bear in mind that mental health is integrated into general health care and as such the general health staff oversees the patient unless a difficulty arises with the patient which the general staff cannot handle). There are one hundred and four (104) nurses working in the mental hospital.

A total of thirty-one (31) psychologists, social workers and occupational therapists work in mental health facilities, island wide, ten (10) in outpatient, eleven (11) in community-based psychiatric inpatient units and ten (10) work in mental hospitals. As regards other health or mental health workers eighty-three (83) work in outpatient facilities, twenty (20) in community-based psychiatric inpatient units and two hundred & seventy-nine (279) in mental hospitals. 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 hospitals. As for nurses, there are 0.08 nurses per bed in community-based psychiatric inpatient units, in comparison to 0.12 per bed in mental hospitals. Finally, for other mental health care staff (e.g., psychologists, social workers, occupational therapists), there are 0.14 per bed for community-based psychiatric inpatient units, and 0.01 per bed in mental hospitals.

The distribution of human resources between urban and rural areas is indeed iniquitous, one psychiatrist in 2.83 per 100,000 population and one nurse in 2.66 works in or near the largest city.

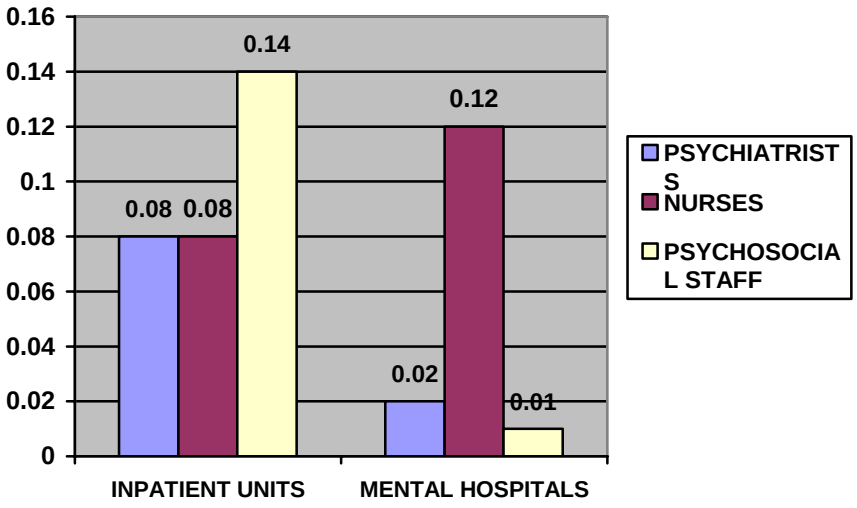
GRAPH 4.2 - STAFF WORKING IN MENTAL HEALTH FACILITIES
(percentage in the graph, number in the table)



	PSYCHIATRISTS	OTHER DOCTORS	NURSES	PSYCHOSOCIAL STAFF	OTHER M.H. WORKERS
MENTAL HOSPITALS	14	12	104	10	279
INPATIENT UNITS	0	3	6	11	20
OUTPATIENT FAC.	13	0	46	10	83

NB: **A zero is placed at the areas where the same people cover that area, except for "other doctors in outpatient", where there are actually no "non-mental health physicians" working in outpatient department.**

GRAPH 4.3 - RATIO HUMAN RESOURCES/BEDS



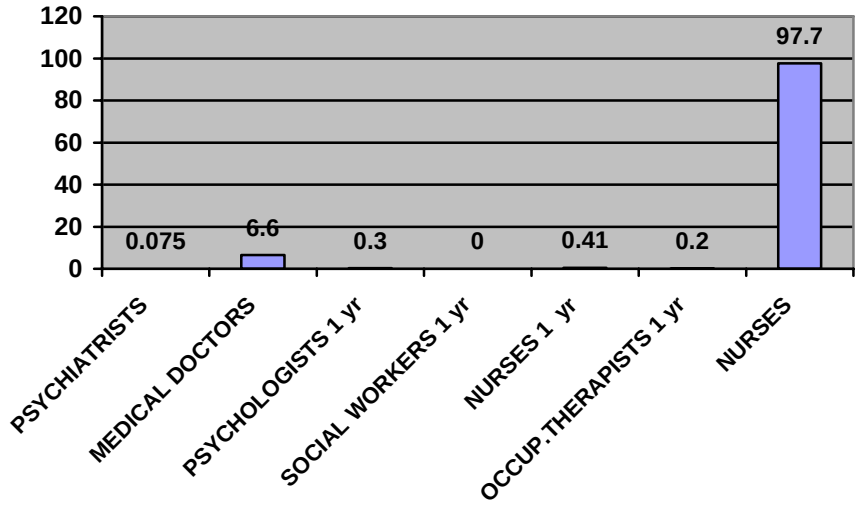
Training professionals in mental health

The number of professionals graduated last year in academic and educational institutions per 100,000 is as follows:

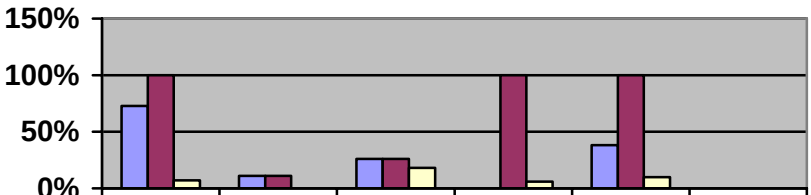
- 6.6 medical doctors,
- 0.075 psychiatrists,
- 97.7 nurses
- 0.3 psychologists with at least 1 year training in mental health care,
- 0.41 nurses with at least 1 year training in mental health care
- 0 social workers with at least 1 year training in mental health care, and
- 0.2 occupational therapists with at least 1 year training in mental health care

Few psychiatrists (1-20%) emigrated to other countries within five of the completion of their training. The following graph shows the percentage of mental health care staff with at least two days of refresher training in the rational use of drugs, psychosocial interventions, and child/adolescent mental health issues.

GRAPH 4.4 - PROFESSIONALS GRADUATED IN MENTAL HEALTH (rate per 100.000 population)



GRAPH 4.5 - PERCENTAGE OF MENTAL HEALTH STAFF WITH TWO DAYS OF REFRESHER TRAINING IN THE PAST YEAR



	Psych.	MD	Nurses	Psycho social	Other	
Rational use of drugs	73%	11%	26%	N/A	38%	
Psychosocial interventions	100%	11%	26%	100%	100%	

Psych = psychiatrists; MD =other medical doctors not specialized in psychiatry; psychosocial staff = psychologists, social workers, and occupational therapists. Others = other health and mental health workers

Consumer and family associations

Information on members and users of consumer and family associations were not available. The government provides economic support for both consumer and family associations. User/consumer associations as well as family associations have been involved in the formulation or implementation of mental health policies, plans, or legislation within the past two years. Approximately 51-80% mental health facilities have had interactions with user/consumer associations in the past year, while 1-20% has had interactions with family associations. In addition to family and consumer associations there are twelve (12) NGOs involved in community and individual assistance activity.

Domain 5: Public education and links with other sectors

Public education and awareness campaigns on mental health

There is a coordinating body to oversee public education and awareness campaigns on mental health and mental disorders. The Ministry of Health, Regional Health Authorities, NGOs and Professional Associations have promoted public education and awareness in the last five (5) years. The mental health public education and awareness campaigns over the years targeted:

- General public
- Children and adolescents
- Women
- Trauma survivors
- Ethnic groups
- Other vulnerable or minority groups.

The campaigns also targeted professional groups such as:

- Health care providers
- Complimentary/alternative/traditional sector
- Teacher
- Social service staff
- Leader and politicians
- Other professional groups linked to the health sector.

Legislative and financial provisions for persons with mental disorders

Currently no legislative or financial support exists for the following:

- Employers hiring a certain percentage of employees who are disabled.
- Discrimination at the workplace.
- Priority in subsidizing housing schemes for persons with severe mental disorders
- Protection from discrimination in allocation of housing for people with severe mental disorder.

Links with other sectors

There are formal collaborations with the departments/agencies responsible for:

- Primary Health Care/ Community Health
- HIV/AIDS
- Reproductive Health
- Child & Adolescent Health
- Substance Abuse
- Child Protection
- Education
- Employment
- Housing
- Welfare
- Criminal Justice
- Elderly
- Other departments/agencies such as Social Services

In terms of support for child and adolescent health fifty-two percent (52%) of primary and secondary schools have either a full or part time mental health professional (guidance counsellor). Approximately 21-50% of primary and secondary schools have school-based activities to promote mental health and prevent mental disorders.
As for training, 1-20% police officers and 1-20% judges and lawyers have participated in educational activities on mental health in the last five years.
The percentage of prisoners with psychosis is 11-15%, while 2% are mentally retarded.
81-100% of prisons have at least one prisoner per month in treatment contact with a mental health professional.
Finally, one percent (1%) of people who receive social welfare benefits do so for a mental disability.

Domain 6: Monitoring and Research

There is a formally defined list of individual data items that is collected by all mental health facilities and the extent of the data collection is consistent. The government health departments receive data from all its programmatic areas and mental health is no different. For example it receives data from, the one (1) mental hospital, two (2) community-based in-patient psychiatric units and the one hundred and thirty-nine (139) outpatient facilities.

Mental health data have been published in a report with comments on the data.
In terms of research, few mental health professionals (less than 20% of psychiatrists, nurses, psychologists and social workers) are involved in mental health research as investigator or co-investigator (including dissertations and theses).

Table 6.1 - Percentage of mental health facilities collecting and compiling data by type of information

TYPE OF INFORMATION COMPILED	MENTAL HOSPITALS	INPATIENT UNITS	OUTPATIENT FAC.
N° of beds	100%	100%	NA
N° inpatient admissions/users treated in outpatient facilities	100%	100%	100%
N° of days spent/user contacts in outpatient facilities.	100%	100%	100%
N° of involuntary admissions	100%	100%	NA
N° of users restrained	100%	100%	NA
Diagnoses	100%	100%	100%

Strengths and Weaknesses of the Mental Health System in Jamaica

Strengths

- Mental Health Officers implement similar work as that of the Mental Health Nurse Practitioners treating patients in the least restrictive environments as close to their communities as possible.
- Availability of psychotropic medication and mental health care free of cost in the government health care system
- Integration of mental health with Primary Health Care
- Official and unofficial linkages with related ministries, agencies and association such as Child Development Agency, Children Advocates, Ministry of Local Government, Ministry of National Security, Ministry of Justice, Ministry of Education, Early Childhood Commission, Ministry of Social Security, MENSANA, CITISPIRIT, WASP, a variety of Golden Age Homes and Infirmaries, advocacy groups, NGOs, CBOs, consumer groups, minority groups such as Rastafarians, community leaders etc.

Weaknesses

- Limited number of supportive and supervised living arrangements
- Most of the funding is currently being channelled to the mental hospital
- There is a dearth of local quantitative and qualitative researches on mental health issues
- Shortages of staff such as psychologists, occupational therapists, social workers with mental health training, mental health officers including those with child & adolescent training.
- Mental Health data collection system. The PAHO had sponsored the purchase of a software to improve the system, however there is an urgent need for approximately ten (10) data entry clerks to be contracted for six (6) months to input the more than 11,000 patients data on the software at a cost of US$10,000. A request was made to PAHO but it was not supported. Efforts to identify funding from other sources have not been successful to date. Hence the reports from the officers in the regions continue to be late and inaccurate.
- Inadequate number of ambulance type vehicles for the Psychiatric Emergency, Crisis, Assertive Outreach Home Visit Teams.

There is one mental hospital which services the whole island. In times past, patients would be referred to that hospital from as far as Negril, today that has changed to a great degree. It is rarely that a patient is referred from outside of Kingston to the mental hospital. The majority of

patients are treated in their communities and sent back home. In spite of this change the mental hospital continues to receive the bulk of funding and the majority and patients continue to be treated in the community.

The Ministry of Health has officers who monitor all health facilities, there are regional review boards, a tribunal and advisory committee, which are in existence to ensure that the mentally ill are cared for and protected. Currently the Mental Health Unit has on its 2009/2010 work plan the review of the mental health act, the mental health manual and policies to ensure that they include the human rights components.

Next Steps in Strengthening the Mental Health System

Dissemination

- Representatives from PAHO, WHO
- All government Ministries
- Related NGOs and CBOs
- STATIN
- PIOJ
- UWI for information and to encourage their students to volunteer and support mental health/invest in mental health
- UHWI, Department of Community Health & Psychiatry
- National Libraries for information purposes
- Banks and Investment Houses would they be interested in investing in mental health

Plan of Action

The Mental Health Unit had started plans for the deinstitutionalization and reformation of mental health services by the writing up of a plan since 2003. The latest amendment was July 2006. Subsequent to that a three days workshop was held in November 2008 which was facilitated by Ms Devora Kestel and sponsored by the Pan American Health Organization. A document was prepared with proposed specific interventions to guide the discussions. These included the reorganization of services at BVH:

- A smaller hospital with 150 beds and a special care unit of 80 beds (mentally retarded with psychosis)
- Reorganization of community mental health services

The activities to support the interventions included:

- ✓ Conducting a situation analysis including census of all in-patients identifying age group, diagnosis, social conditions, physical illnesses, family support, time in hospital, level of supervision needed etc.
- ✓ Update plan for the redevelopment of the emergency room at BVH
- ✓ Improve and expand the training programme at BVH

- ✓ Assessment of the Golden Age Homes
  - ❖ Facility
  - ❖ Identify what if any changes will be necessary
  - ❖ Staffing requirement
  - ❖ Support service requirement
- ✓ Complete development plan for KRRC
- ✓ Identify NGOs island wide who can accommodate discharge patients at what costs
- ✓ etc.

The following participants were invited:

- ➢ Regional Technical Directors because they are responsible for all technical programmes and we need their support for the reform process to go through smoothly
- ➢ Regional Directors because they are responsible for all budgetary spending in their regions
- ➢ Regional Psychiatrists because they are responsible specifically for the mental health programme and will be responsible for its implementation
- ➢ Mental Health Supervisors, who are also responsible for the implementation of the programme
- ➢ Director of Nursing BVH
- ➢ Chief Executive Officer BVH
- ➢ Director Human Resource SERHA, BVH, MOH. These people it was felt are critical to the whole process. They need to understand the reform process and the importance of the human resource aspect.
- ➢ Representatives from the UHWI, Department of Community Health & Psychiatry

From this workshop short to medium term plan of actions were also proposed by the participants. We will identify three possible areas where WHO-AIMS data were used to plan action in the workshop.

Short Term Plans

- Establishment of a board/committee to drive the reform process
  - o Define the composition of the board/committee
  - o Identify the person to chair the board/committee
  - o Define the TOR
- Redefine the status of Bellevue Hospital and its relationship with the South East Regional Health Authority as it relates to budgetary autonomy and the official recognition of BVH integration into SERHA
- Sensitization of the various levels of staff/unions/family/support groups/advocacy groups etc.
- Prepare a registry of all NGOs and CBOs
- Seek funding for the deinstitutionalization of a number of patients from BVH
- Seek funding to build housing units to assist in the deinstitutionalization of mental health services and down sizing of BVH processes.

Medium Term Plans

- Conduct a situation analysis
- Define a training programme for Psychiatric Nurse Aides and Occupational Therapy Technicians
- Review the current organization/function of the Rainbow Centre
- Seek funding for the purchase of at least 6 ambulance type vehicles for the Emergency, Crisis, Outreach, Home Visit Teams.
- Seek funding to implementing research on prevalence of the various mental disorders.

The World Health Organization Assessment Instrument for Mental Health Systems was used to collect information on the mental health system in Jamaica in 2008. The mental health service is divided into national and regional health authorities. Mental health is integrated into general health care with all regions having most of the essential mental health components and psychotropic medication. A major weakness of the service is the child and adolescent and forensic component of the service. Most patients are treated in the outpatient community facilities at a rate of 1034 per 100,000 population. These facilities exist throughout the island in the various communities, as part of primary health care.

In Jamaica epidemiological studies show that the most prevalent disorder is that of Major Depressive Disorder. However, schizophrenia is the most prevalent disorder diagnosed and treated. The majority of clinical services are provided by nurses, which represents 8 per 100,000 under the supervision of the psychiatrists which is 1 per 100,000. There is a dearth of psychologists, social workers and occupational therapists in the island due to the unattractive remuneration in the public sector.

There is one mental hospital in the country with a bed capacity of 32 beds per 100,000 population. The number of beds in the mental hospital has decreased by 23% in the last 5 years.

Mental Health Education and Promotion is a stated priority. During the last two years there has been an active mental health promotion targeting all sectors.