WHO-AIMS

WHO-AIMS Report on

Mental Health System

in the

Turks and Caicos Islands

World Health Organization

Ministry of Health
Turks and Caicos Islands

WHO-AIMS REPORT ON

MENTAL HEALTH SYSTEM

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TURKS AND CAICOS ISLANDS

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

World Health Organization

MINISTRY OF HEALTH
Turks and Caicos Islands

PAHO/WHO Turks and Caicos Islands
PAHO/WHO Regional Office
WHO Department of Mental Health and Substance Abuse (MSD)

INTRODUCTION

The Turks and Caicos Islands (TCI) is located in the Atlantic Ocean with an approximate geographical area of 430 square km (193 sq. miles).

Turks and Caicos Islands has two zones: Zone I covers Grand Turk, Salt Cay, and South Caicos, and Zone II covers Providenciales, North Caicos, and Middle Caicos. Zone II has the bigger / denser population. The population is approximately 33,202 (males: 16,524 / females: 16,678) (Social Indicators, *Department of Economics Planning and Statistics*, 2006). The proportion of the population 0-14 years is 30.2% (male: 3,528 / female: 3,401); the proportion of population between 15-64 years is 65.6% (male: 7,875 / female: 7,164), and the proportion of population 65 years and over is 4.2% (male: 475 / female: 499) (The World Factbook, CIA, 2009).

The estimated population growth rate is 8.5%, with a birth rate of 12.32 (male: 10.35% / female: 14.27%), and the death rate estimating 2.26 (male: 2.66% / female: 1.86%). Infant mortality rate is estimated at 13.89 (male: 16.02 / female: 11.64). Life expectancy at birth is 75.42 years (male: 73.12 years / female: 77.83 years). The literacy rate (*anyone, age 15 and over has ever attended school*) is estimated at 98% (male: 99% / female: 98%, est. 2001) (World Factbook, CIA, 2009).

The official language used in TCI is English. The ethnic groups that contribute to the populace are estimated as Black, 90%; and Mixed, European, and North American 10%. The primarily religious demonization is Christianity: Baptist, 40%; Anglican, 18%; Methodist, 16%; Church of God, 12%; and other, 14% (World Factbook, CIA, 2009).

Turks and Caicos Islands is classified as a middle-upper income group country (based on World Bank 2008 criteria). The proportion of health budget to GDP is 22%. The health budget is devoted primarily to public health. The per capita government expenditure on health is US$53,073,980. The treatment abroad expenditure for the year in review was US$31,154,721.2 (DEPS, 2008).
Turks and Caicos Islands has two (2) public general hospitals, which provide a total of 30 beds and cots. There are a total of 37 medical professionals (14 general physicians, 6 dentists, and 16 specialist physicians). Of this, government employs 22 professionals, while 15 are in the private sector, and working in a total of 21 health care facilities

countrywide. Therefore, there is 1 clinic / hospital and 1 physician per 1,000 persons (Social Indicators, DEPS, 2006).

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

The mental health-related data used in this report was collected in 2008 and is based on the year 2007.

DOMAIN 1: POLICY AND LEGISLATIVE FRAMEWORK

1.1. POLICY, PLANS, AND LEGISLATION

Turks and Caicos Islands' mental health policy is incorporated within the general health policy document, which was last revised in 2005. It includes the following components: (1) Integration of community mental health services with primary health care, (2) Revision and Modernization of Mental Health Legislation, (3) Improvement on Quality of Service and Care, (4) Human resources, (5) Involvement of Public and Families, (6) Advocacy and promotion, (7) Equity of access to mental health services across the islands, (8) Financing & Budgeting, and (9) Monitoring system.

There is a list of essential psychotropic medicines included in the current formulary, which includes (1) antipsychotics, (2) anxiolytics, (3), antidepressants, (4), mood stabilizers, and (5) antiepileptic.

The last revision of the mental health plan was in 2005. This plan contains the following components as the mental health policy as reflected above. Also mentioned are (1) timeframe, (2) specific goals, and (3) a few goals have been met as identified in the last mental health plan within the current calendar year (2005).

There is no separate mental health disaster / emergency preparedness plan; instead, all mental health related preparedness is incorporated in the Health plan. However, there is a National Disaster Preparedness Plan developed by the Ministry Home Affairs and Public Safety that is reviewed periodically.

The last piece of mental health legislation was enacted in 1904, which was revised in 1999. However, a more modernized and up-to-date draft legislation was written in 2005, and is still being reviewed. Procedures and standardized documentation exist in the majority of the components of the mental health legislation.

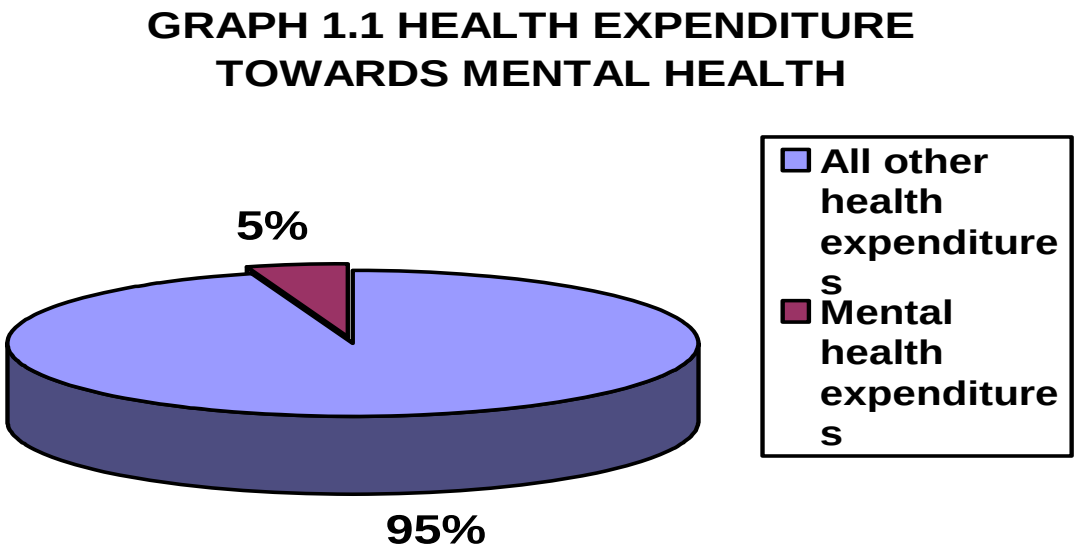
Although there are no specific mental health / psychiatric hospitals, the Health Practitioner's Board is the current national review body that has the authority to (1) oversee regular inspections in mental health facilities (i.e., outpatients psychiatric and psycho-therapeutic clinics), (2) review involuntary mental health-related admission and discharge procedures (i.e., such procedures are facilitated in the two general hospitals), and (3) review complaints investigation processes. Additionally, Health Practitioner's Board has the authority to impose sanctions (e.g., to ensure human rights procedures are implemented, the Board has the authority to withdraw accreditation, impose penalties, etc).

1.2. FINANCING OF MENTAL HEALTH SERVICES

Approximately, 2% of health care expenditures by the Ministry of Health are for mental health. Of all the expenditures spent on mental health, 90% are spent towards treatment aboard, since there are no mental hospitals or in-patient mental health facilities. In terms of affordability of mental health services, 100% of the nationals have free access to essential psychotropic medicines. However, for those (usually non-nationals) that have to pay for their medicines out of pocket, the cost of antipsychotic medication is US$0.22 per

day; and the cost of antidepressant medication is US$0.10 per day. All mental disorders are covered either by Ministry of Health or by social insurance scheme, following an official medical / mental health evaluation.

Graph 1: Health Expenditure Towards Mental Health Services



Source: Social Indicators (2006), DEPS, TCI

1.3. HUMAN RIGHTS POLICIES

The Human Rights Commission, in collaboration with the Health Practitioner's Board, has the authority to oversee inspections in all outpatient mental health facilities and impose related sanctions accordingly. Currently, outpatient mental health facilities are government-operated. Nonetheless, the Human Rights Commission has the authority to review / inspect the rights of mental health patients being admitted to the general hospitals and the community-based psychiatric / mental health outpatient clinics. Human rights legislation has been enacted, which would make such reviews mandatory for all mental health facilities. No mental health related human rights training was implemented for year in review (2007), since the human right commission was only legislated during 2008. However, there are plans for the relevant human rights training of the mental health, medical, and nursing professionals, having responsibility for mental health patients being admitted to general hospitals and clinics.

DOMAIN 2: MENTAL HEALTH SERVICES

2.1. ORGANIZATION OF MENTAL HEALTH SERVICES

Although, there is no legislated national mental health authority, the Mental Health Unit, within the Primary Health Care Department, Ministry of Health, acts as this national authority, which advises the government (through the Ministry of Health) on mental health policies and legislation.

The Mental Health Unit is involved in service planning and monitoring and quality assessment of mental health services throughout the six (6) government-operated islands. Mental health services are organized into catchment / services areas. It provides psychiatric, psychological, and community outreach services and interventions at the seven (7) health clinics, two (2) counselling and psychological services offices, and periodically at the two (2) hospitals.

2.2. MENTAL HEALTH OUTPATIENT FACILITIES

Turks and Caicos Islands has 11 outpatient mental health facilities (7 – health clinics, 2 – counselling and psychological services offices, and 2 – hospitals). Although services are provided for children and adolescents, there are no facilities specifically assigned for children and adolescents only. These 11 facilities treat 0.33202 users per 100,000 population. Of all users treated in mental health outpatient facilities, 67% are female and 27% are children / adolescents.

The users treated in outpatient facilities are primarily diagnosed with mood disorders (26%); and neurotic, stress related, and somatoform disorders (24%). Other common disorders are mental and behavioural disorders due to psychoactive substance use (19%); schizophrenia, schizotypal and delusional disorders (19%); and epilepsy, organic mental disorders; mental retardation; behavioural and emotional disorder with onset usually occurring in childhood and adolescence; and disorders of psychological development (12%).

The average number of contacts per user is approximately 3.58. Eighty-two percent (82%) of all outpatient facilities provide follow-up care in the community. The same team that provides the community mental health outreach also does the mobile mental health. In terms of available treatments, all or almost all (81-100%) patients in outpatient facilities last year (2007) received one or more psychosocial interventions through the mental health nurse and / or the clinical psychologist. All (100%) outpatient facilities have at least one psychotropic medicine of each therapeutic class (antipsychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility or at a near-by pharmacy all year long.

2.3. DAY TREATMENT FACILITIES

There are no day treatment facilities currently available in the country.

2.4. COMMUNITY-BASED PSYCHIATRIC INPATIENT UNITS

There are no community-based psychiatric inpatient units available in the country. All mental health cases (i.e., adults, adolescents, and children) that require in-patient mental health care are admitted to the general hospitals. After a thorough medical and psychiatric / psychological assessment, the patient is either admitted for short-term care or sent abroad for further institutionalized treatment, management, and care should it become necessary (i.e., The Bahamas, Jamaica, and The United States of America). On occasion, expatriates are sent to their respective countries for mental health treatment.

2.5. COMMUNITY RESIDENTIAL FACILITIES

There are no community residential facilities available in the country. All mental health cases (i.e., adults, adolescents, and children) that require residential mental health care are admitted to the general hospitals. After a thorough medical and psychiatric / psychological assessment, the patient is either admitted for short-term care or sent abroad for further institutionalized treatment, management, and care should it become necessary (i.e., The Bahamas, Jamaica, and The United States of America). On occasion, expatriates are sent to their respective countries for mental health treatment.

2.6. MENTAL HOSPITALS

There are no mental hospitals available in the country. All mental health cases (i.e., adults, adolescents, and children) that require hospitalization are admitted to the general hospitals. After a thorough medical and psychiatric / psychological assessment, the patient is either admitted for short-term care or sent abroad for further institutionalized treatment, management, and care should it become necessary (i.e., The Bahamas, Jamaica, and The United States of America). On occasion, expatriates are sent to their respective countries for mental health treatment.

2.7. FORENSIC AND OTHER RESIDENTIAL FACILITIES

There are no forensic inpatient and other residential facilities available in the country. All prison inmates having a mental disorder that require hospitalization are admitted to the general hospital and accompanied by a prison officer for the duration of such admissions. However, after a thorough medical and psychiatric / psychological assessment, the patient is either admitted for short-term care or sent abroad for further institutionalized treatment, management, and care should it become necessary (i.e., The Bahamas, Jamaica, and The United States of America). On occasion, expatriate inmates are sent to their respective countries for mental health treatment.

2.8. HUMAN RIGHTS AND EQUITY

There are no community-based inpatient psychiatric units or mental hospitals. However, approximately 80% of all admissions to the general hospital for a mental disorder are involuntary. Between 10-15% of patients had to be retrained or secluded within the last year. As a standard protocol, the next-of-kin is contacted (if not escorting the patient) and an authorized signature is obtained should retraining becomes necessary.

DOMAIN 3: MENTAL HEALTH IN PRIMARY HEALTH CARE

3.1. TRAINING IN MENTAL HEALTH CARE FOR PRIMARY CARE STAFF

For the year in review (2007), there has been no mental health training or refresher courses for any of the medical doctors, nurses, and support or ancillary primary health care staff.

3.2. MENTAL HEALTH IN PRIMARY HEALTH CARE

There are only physician-based primary health care (PHC) clinics in TCI, and they all have assessment and treatment protocols for key mental health conditions. Additionally, mental health professionals are often consulted on these assessment / treatment protocols. On average, at least two (2) referrals to a mental health professional are made bi-monthly, and on occasions, there are more than three (3) referrals per month. As for professional interaction between primary health care staff and other care providers, the majority of primary care doctors (between 51-80%) have interacted with a mental health professional at least thrice during the last year (2007). Similarly, the majority of the PHC facilities (between 51-80%) have had interaction with either a complimentary, alternative, or traditional practitioner.

3.3. PRESCRIPTION IN PRIMARY HEALTH CARE

Non-medical doctors and non-nurse primary health care staff are not authorized or licensed to prescribe psychotropic medications. However, primary care nurses are allowed to refill prescriptions. In emergencies, however, the nurse-in-charge (Public, Community, or Mental Health Nurse) is authorized to prescribe psychotropic medications after consultation with or guidance from a medical doctor / psychiatrist, especially in cases where the medical practitioner is not resident to that island. On the other hand, all primary health care physicians are authorized to prescribe without restrictions. However, all or almost all of these physicians consult / collaborate with the mental health professionals. As for availability of psychotropic medicines, all or almost all physician-based clinics (between 81-100%) have at least one psychotropic medicine of each therapeutic category (antipsychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility or at a nearby pharmacy all year long.

DOMAIN 4: HUMAN RESOURCES

4.1. NUMBER OF HUMAN RESOURCES IN MENTAL HEALTH CARE

The TCI Government employs all 4 registered human resources working in mental health facilities. The breakdown, according to profession, is as follows: 1 psychiatrist, 1 clinical psychologist, 1 Psychologist and 1 mental health nurse.

The psychiatrist, mental health nurse, and the clinical psychologist work in government-operated outpatient facilities (i.e., community health clinics and offices) and the general hospitals. In terms of staffing in mental health facilities, the existing medical staff (e.g., resident physicians, public health, and community health nurses) at the clinics also facilitates the mental health clinics.

Although there are no community-based psychiatric inpatient facilities or mental hospitals available in TCI, any mental health case that requires inpatient mental health care are admitted to the general hospitals. After a thorough medical / psychiatric / psychological assessment, the patient may be sent abroad for further treatment, management, and care should it be required.

All mental health professionals regularly visit both the urban and rural mental health cases throughout TCI (i.e., weekly, bi-monthly, and monthly visits are made).

4.2. TRAINING PROFESSIONALS IN MENTAL HEALTH

There were no professionals graduated in 2007 in academic and educational institutions (i.e., no psychiatrists, nurses, psychologists, or other). Due to the limitations of human resources, there has been no emigration of mental health professions. Additionally, there has been no refresher training in the rational use of drugs, psychosocial interventions, and child/adolescent mental health issues during 2007.

4.3. CONSUMER AND FAMILY ASSOCIATIONS

Although there are no consumer- and family-based mental health associations in TCI, the government, through the Ministry of Health, encourages both consumers and their families to get involved in the formulation of mental health policies, plans, or legislation in the past two years.

In terms of any mental health case (i.e., adults, adolescents, and children) that requires inpatient mental health care, and is admitted to the general hospitals, families and relatives are educated on the diagnoses and treatment protocols. Additionally, they are encouraged to be supportive of their inpatient relatives, thus, optimizing the recovery process.

DOMAIN 5: PUBLIC EDUCATION AND LINKS WITH OTHER SECTORS

5.1. PUBLIC EDUCATION AND AWARENESS CAMPAIGNS ON MENTAL HEALTH

The Ministry of Health, through its Mental Health Unit, is the coordinating body to oversee public education and awareness campaigns on mental health and mental disorders. Government agencies, NGOs, and professional organizations have all promoted public education and awareness campaigns in the last five years. These campaigns have targeted children and adolescents, women, trauma survivors, and other vulnerable minority groups. In addition, there have been public education and awareness campaigns targeting professional groups including teachers and healthcare providers.

5.2. LEGISLATIVE AND FINANCIAL PROVISIONS FOR PERSONS WITH MENTAL DISORDERS

Currently, there are no existing specific legislative and financial provisions, which protect and provide support for persons with mental disorders. Neither is there any provisions concerning protection from discrimination solely on the account of a mental disorder. In addition, no legal provision exists – provisions concerning priority in state housing and in subsidized housing schemes for people with severe mental disorders. At the present time, there is no legislative or financial support for discrimination in housing.

5.3. LINKS WITH OTHER SECTORS

In addition to legislative and financial support, there are formal collaborations with the ministries, departments, and agencies having responsibilities for child and adolescent health, education, welfare, and criminal justice. In terms of support for child and adolescent health, there is no part- or full-time mental health professional attached to the school system, nor is there any school-based activity(ies) to promote mental health and prevent mental disorders. Regarding mental health activities in the criminal justice system, the percentage of persons with mental retardation is currently unknown. The corresponding percentage for psychosis (drug-induced) is about 2-5%.

There is contact for at least one prisoner per month with a mental health professional. As for training, no police officers, prison officers, judges, and lawyers have participated in educational activities on mental health in the last five years. In terms of financial support for users, there are no mental health facilities that have access to programmes outside the mental health facility that provide outside employment for users with severe mental disorders. Finally, 10% of all people who receive social welfare benefits do so for a mental disability.

DOMAIN 6: MONITORING AND RESEARCH

During the year (2007) in review, there had been no formally defined list of individual data items that ought to be collected by all mental health facilities. For future considerations, however, there will be a list which will include the number of general hospital beds, admissions, involuntary admissions, length of stay of all mental health related cases, and their diagnoses.

The primary health care department usually receive some data from the 11 mental health facilities. Based on this data, a small internal report is published, which included comments on the data. In terms of research, there has been no official mental health related research done in the country.

FUTURE AREAS FOR MENTAL HEALTH IN TURKS AND CAICOS ISLANDS

WHO-AIMS data will serve as a baseline for the future development and capacity building for the mental health care system including community based mental health care in TCI. This data will help to improve the mental health system and to provide a baseline for monitoring changes annually. This will enable the TCI Government to develop information-based mental health plans with clear base-line information and targets. Also, it will monitor the progress of implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care, and rehabilitation.

Next Steps for Planning Mental Health Action:

The following are to be considered as a result of the WHO-AIMS data provided above:

1. Development of a plan that promotes the deinstitutionalization of mental health care and the recovery of persons with mental illness.
2. Development of a suicide prevention strategy for TCI.
1. Development of integrated services between primary health, mental health services, and other support services (i.e., Human Services, Education, Youth, Law Enforcement, etc).
3. Development of self-contained community-based mental health care services for each island.
2. Implementing a workshop on Mental Health Legislation and Human Rights.
4. Revision of TCI's current mental health legislation to reflect international and PAHO/WHO standards.
3. Training of community and primary care health workers to provide therapeutic, community-based mental health care and management.
4. Training programme to facilitate on-going continue education for the mental health professionals, support staff, and complimentary professionals (i.e., medical doctors, regular nurses, and other medical support staff).

The following outlines the proposed future considerations for the Mental Health System in TCI:

1. Policy and Legal Framework

Turks and Caicos Islands would benefit from modernized mental health legislation, a legislatively sanctioned programme or plan for mental health including a policy on the enacted of a national mental health body, child and adolescent mental health, etc. The annual mental health report should include standardized information on the trends in mental health services, the expenditure, best practices, and future research plans. The Mental Health Unit should publish this annual report yearly.

The proposed national body should be comprised of shareholding technocrats from health, justice, human services, and civil society; and it should be legislatively responsible for governing the implementation of all mental health related polices. There should be regular visits and evaluation of all mental health services using pre-established criteria set-up by the TCI mental health legislation, under the supervision of the Ministry of Health and Health Practitioner's Board, to assure protection of patients' human rights. The Mental Health Unit should play a more active role to guarantee adequate treatment for mentally handicapped and psychotic patients in prisons. There should be ongoing research to assess the extent of mental health situation in the country, including the high-risk communities.

2. Mental Health Services / Human Resources

Mental health services are still limited throughout the entire TCI. There should be at least one mental health nurse stationed on each of the islands (i.e., one on North Caicos, Middle Caicos, South Caicos, and Salt Cay), and at least two on the more densely populated islands of Grand Turk and Providenciales. Additionally, there should be a psychiatrist stationed in each zone; and a psychologist in Zone I and two psychologists in Zone II.

There are no mental hospitals. However, mental health patients in need of hospitalized care are often hosted by the general hospitals. There needs to be at least one mental health nurse on duty around the clock as regular nurses in each hospital. Most regular nurses lack the training needed to properly facilitate the care of the mentally ill.

A cost benefit analysis should be conducted to evaluate mental health admissions at the general hospitals, cared for by trained mental health professionals (i.e., psychiatrist, psychologist, mental health nurse, psychiatric social worker, etc) and mental health treatment abroad. It is important to develop follow-up studies to evaluate and compare the locally based patients care and treatment with that of overseas residential facilities.

Also, it is paramount to develop structured training on human rights for all health professionals working in mental health. All mental health services should be regularly assessed by the national mental health body to investigate the protection of patients' human rights according to clear and pre-established criteria delineated by the modernized mental health legislation under supervision of the Mental Health Unit.

3. Public Education and Link with Other Sectors

The Mental Health Unit should have access to local educational, prevention, and health promotion events in order to facilitate the exchange of experiences among the participants and to prepare material accordingly.

It is imperative to propose legislation and financially support a) the legal provisions to encourage employers to hire a certain percentage of employees with severe mental disorders and b) protection for people with mental disorders from discrimination.

It is necessary to estimate the mental health actions conducted in several areas: treatment and prevention in primary and secondary schools; actions to promote employment for people with severe mental disorders; the percentage of prisoners with major mental disorders and mental retardation; mental health care activities in the criminal justice system; training for police officers, prison officers, lawyers, and judges; and programmes for employment opportunities.

4. Monitoring and Research

Data about involuntary admissions should be compiled at each of the hospitals. Similarly, efforts to compile data about outpatient care at the various health clinics – number of patients, diagnosis, sex, and age of patients – should be a priority in the mental health information system.

The private sector mental health services should also be included in the mental health information system; i.e., statistics should be collected on any one being treated for a mental health related issue and who is prescribed psychotropic medications. This would give a better picture of the scope of the national mental health situation.

5. Dissemination

All government ministries, departments, and agencies should receive a copy of this report, since mental health is a national concern and priority. Additionally, copies should be made available to the general public via various means; i.e., electronically, whether via email or the World Wide Web.

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