

WHO-AIMS

WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
IN SAINT LUCIA



**World Health
Organization**



**MINISTRY OF HEALTH
SAINT LUCIA**

**WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
in SAINT LUCIA**

*Report of the Assessment of the Mental Health System in the Saint Lucia
using the WHO Assessment Instrument for
Mental Health Systems (WHO-AIMS)*

*Saint Lucia
2009*



**MINISTRY OF HEALTH
SAINT LUCIA**

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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. Additional assistance has been provided by Monika Malo.

The WHO-AIMS project is coordinated by Shekhar Saxena.

Executive summary

The island of Saint Lucia is located in the center of the Windward Island chain and it is the second largest island in that group of islands. In 2007, the population was estimated at 167,000.

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information and format the report on the mental system in Saint Lucia. The overall goal of this data collection process is to provide an evidence-based assessment of the mental health reform process and provide a benchmark for monitoring change.

Saint Lucia has a draft Mental Health Policy (2007), a “discussion-only” document titled “Revised Mental Health Strategic Plan 2007/08-2010/11,” a Disaster Emergency Plan (2000) for Mental Health, and a draft Mental Health Act (2008). Four percent of the national health expenditure is directed towards mental health—the greater proportion is oriented towards the mental hospital. There is a national insurance scheme but it does not cover mental disorders. One hundred percent of the population has free access to psychotropic medications. No human rights policy or human rights review body exist. None of the mental health treatment facilities had an external review/inspection of human rights protection of users of the mental health services; no mental health worker received training in this area.

There is no mental health authority. There is a Mental Health Reform Project in the Ministry of Health for the development of a comprehensive mental health care system. One key responsibility of this Project is to coordinate activities for the construction of an ultra modern, 104-bed mental hospital.

Mental health care is not integrated with primary health care. Mental health services are offered at 9 of the 34 health centers. Best estimates indicate that approximately 100 users were treated in the primary health care setting in 2007. Primary health care data reflecting number of users, age groups, gender, and admission status could not be validated. No day treatment facilities or community-based psychiatric inpatient units exist. Secondary-care hospitals admit patients with acute psychiatric illness in the medical wards. In the single mental hospital, there are 71.8 beds per 100,000 population and none designated for children and adolescents. The number of beds in the mental hospital decreased in the last five years. No validated patient-related data were available from the mental hospital. Best estimates for 2007 indicated that there were 840 admissions and 826 discharges for an average length of stay of 55 days per discharge.

A 3-year Patient Assessment Study at the Golden Hope Hospital provides an overview of the characteristics of 421 hospitalized patients in the period 2003-2005. The majority of patients in this cohort had a diagnosis of schizophrenia and related disorders. There was no forensic or other inpatient mental health unit. Prisoners with mental disorders are treated and monitored in the prison by staff from the mental hospital. No one on the

established mental health team participated in refresher training in psychiatry/mental health.

There were 67.2 human resources in mental health per 100,000. The entire cadre is concentrated at the mental hospital in the capital city. Community-based mental health care is provided by the mental hospital's staff in monthly-scheduled clinics in the 9 health regions. There is no psychiatric social worker.

There are no consumer or family associations. Two non-governmental agencies were involved in the development of the draft mental health policy, legislation, and advocacy activities. No coordinating bodies function as overseers for public education and awareness campaigns on mental health related issues. There are no legislative and financial provisions for people with mental disorders. Social welfare benefits are available to persons solely because of disability due to mental disorders.

No formal links exist with other relevant sectors. No primary or secondary school has a mental health counselor. The Peoples Republic of China partnered with the Government of Saint Lucia to build the new EC\$27 million mental hospital.

A formally-defined list of individual data items to be collected by mental health facilities is available. Data collection, compilation, and analysis did not appear to be time-bound routine processes in the primary health care settings. The government did not produce any national reports or publications on mental health.

In Saint Lucia, the mental health services do not provide a comprehensive range of therapeutic or rehabilitative services. There are no budgetary provisions for community-based mental health services; these services are financed from appropriations to the Golden Hope Mental Hospital. As such, limited funds are available to strengthen the delivery of services at the primary health care level. Refresher training is not available to increase competencies in a wide range of mental health-related areas including human rights. An intersectoral approach with formal and informal links to non-health sectors and civil society is not in place to mobilize support for mental health activities. Mental health data is not reported in the National Health Information System.

Like the majority of countries in the English-speaking Caribbean, Saint Lucia spends between 4-5% of its health budget on mental health services. It is the only island in the English-speaking Caribbean with an active Mental Health Reform Project in the Ministry of Health and the only one constructing a new mental health facility. The proposed formulation of a child and adolescent mental health policy is a unique feature of the mental health reform agenda in Saint Lucia.

Background

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was developed by the Evidence Research team of the Department of Mental Health and Substance Abuse, World Health Organization (WHO). It was developed with input from in-country and international experts as well as pilot trials in middle and low-income countries. WHO-AIMS is a comprehensive assessment tool for mental health systems that is designed to collect essential information to facilitate evidence-based improvements in policy and program directions as well as service delivery. WHO-AIMS has six domains: policy and legislative framework, mental health services, mental health in primary health care, human resources, public information and links with other sectors, and monitoring and research. Within these domains, there are 28 facets with 155 items.

Data collection

WHO/AIMS was used to collect, analyze, and report data on the mental health system and services in Saint Lucia. Data was collected in 2009, based on the year 2007.

One week was assigned for the data collection phase. (February 2009).

Process

1. The instrument's questions were divided into ten sets, each targeting a specific respondent. The item number, characteristic, and salient content of the question were retained. Each set targeted one of the following respondents: Chief Medical Officer, Permanent Secretary (Ministry of Health), Chief Pharmacist; Chief Nursing/Principal Nursing Officer, Director of Mental Health Clinical Services; Director of Mental Health Outpatient and Residential Facilities, Director of Mental Hospital, Director of Psychiatric Inpatient Unit, Director of Forensic Mental Health Services, Director of Social Services, and the Mental Health Focal Point.
2. Interviews were scheduled, through the national Mental Health Focal Point, prior to the consultant's arrival in Saint Lucia.
3. The consultant met with representatives of the Ministry of Health to explain the purpose, benefits, and contents of the WHO/AIMS as well as the procedures and requirements for its completion.
4. Personal working sessions and interviews were held with the available respondents; not all the categories of health personnel mentioned under 1) above are available in Saint Lucia.
5. The data was entered into the WHO-AIMS 2.2 Excel spreadsheet and discussed with the Non-Communicable Diseases and Mental Health Adviser, PAHO/WHO-Barbados Office.
6. The draft report was prepared and circulated to the national health authorities for comments and validation.
7. The final draft report was reviewed by the Regional Adviser for Mental Health, PAHO/WHO, Washington, D.C., prior to its submission to WHO-Geneva.

Limitations

At the national level, there was no tabulated data with key mental health indicators that reflected the scope of mental health problems, epidemiological trends, and service-user characteristics. With reference to the two major service delivery levels, the summary quantitative data from the primary health care network and the mental hospital were not of sufficient quality to provide clear knowledge and evidence of the occurrence of mental health problems, client characteristics, and trends in service utilization. There was no national report or research-level publication on mental health. Taking these limitations into consideration, the information reported herein best reflect the characteristics of the mental health infrastructure and service delivery mechanism in Saint Lucia.

Introduction

The island of Saint Lucia is located in the center of the Windward island chain, between the Caribbean Sea and the North Atlantic Ocean. It is the second largest of the Windward Islands with a total land mass of 620 sq. km. The population was estimated at 167,000 in 2007. Approximately one-third of the population lives in Castries, the capital city. The other cities are Micoud, Gros-Islet, Vieux Fort, and Soufriere. More than 80% of the population is of African descent and an estimated 90% are Roman Catholics. There were no ethnic and religious minority groups. The official language is English but a French patois is commonly spoken and understood throughout the country. The currency is the Eastern Caribbean dollar which is pegged to the United States dollar at US\$1 = EC\$2.70. Saint Lucia gained independence from the United Kingdom in 1979. It is a parliamentary democracy modeled on the Westminster system. The Governor-General, representing Her Majesty Queen Elizabeth II, is the Head of State. The Prime Minister is the head of the government and the bi-cameral parliament is a 17-member House of Assembly and the 11-member Senate.

The island continues to rely primarily on revenue from tourism as the main source of income and that industry is the island's largest employer. Revenue is also derived from the production and export of bananas, mangoes, and avocados as well as from foreign investments such as off-shore banking. Infrastructure improvements, an educated and skilled work force, together with the stable political environment continue to attract foreign investors. To date, the largest such investment is the petroleum storage and trans-shipment terminal built by Hess Oil.

Saint Lucia retains membership in the Organization of Eastern Caribbean States, the Caribbean Community (CARICOM), Organization of American States, United Nations, World Health Organization, among others.

The Ministry of Health, Family Affairs, and Gender Relations is responsible for the overall organization of resources and services for the health sector. The Permanent Secretary heads the administrative arm of the Ministry and the Chief Medical Officer, the technical arm. Public sector health services are provided through a network of primary and secondary care facilities. Primary health care services are decentralized and mainly provided through 34 health centers spread throughout the island. Secondary care is accessed at: the Victoria Hospital, the main hospital; St. Jude, a quasi-public institution; Tapion Hospital, a privately-owned hospital; and the Golden Hope Psychiatric Hospital. In 2008, the crude birth rate was estimated at 18.8 live births per 1,000 population and the crude death rate at 6.71 deaths per 1,000 population. Life expectancy at birth was estimated at 72.0 years for males and 75.8 years for females. Total fertility rate was around 2.2 children per woman and infant mortality rate around 15.0 deaths per 1,000 live births.

Mental Health reform is included in the twelve priority areas under the National Health Reform agenda. A major component of the island's health reform is the construction of a

new mental health facility to provide comprehensive services including acute, rehabilitative, and community care.

Domain 1: Policy and legislative framework

The Ministry of Health's *draft* National Mental Health Policy is dated 2007. The proposed policy encompasses nine principles: equity and accessibility; human rights; integration; quality services; evidence-based care; community involvement and participation; rehabilitation; inter-sectoral collaboration; and mental health prevention and promotion. These principles embody the following elements: 1) strengthening community mental health services; 2) downsizing the mental hospital; 3) strengthening the mental health component in primary health care; 4) involvement of users and families; 5) advocacy and promotion; equity and access to mental health services; 6) quality improvement; and monitoring systems. Financing options are not included in the draft policy. Data were collected to inform the formulation of a draft Child and Adolescent Mental Health Policy.

Plan

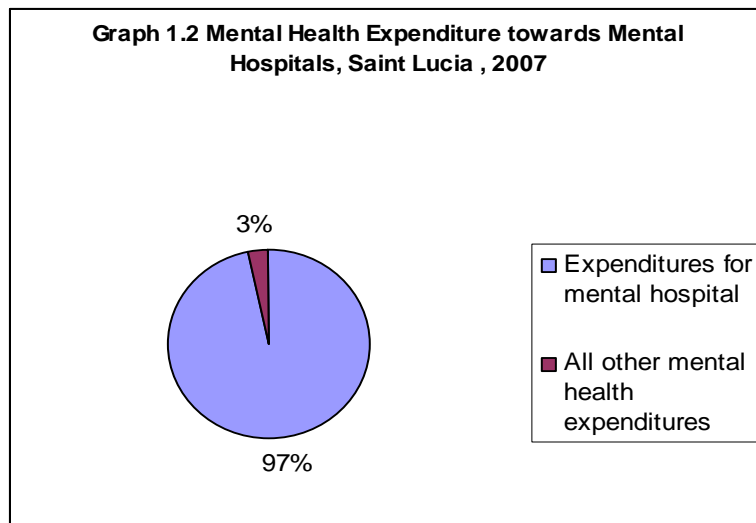
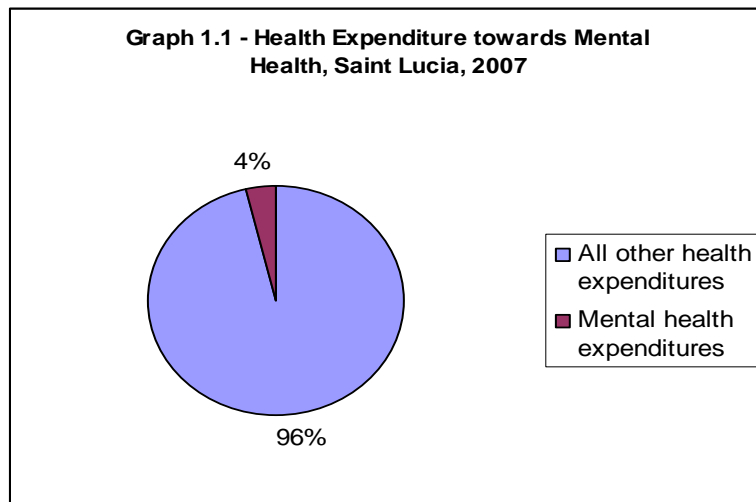
The Revised Mental Health Strategic Plan 2007/08-2010/11 is a document for “*discussion only*.” The priority areas under the Plan are: organization of services; inter-sectoral collaboration; legislation and human rights; mental health promotion and prevention. This version of the plan assumes national support for mental health reform through: human resources and training; quality improvement; financing; essential drug procurement and distribution; advocacy; and information systems. A budget is not mentioned in the revised Plan. There is a Disaster Emergency Plan (2000) for mental health.

Legislation

The legislative framework for care for the mentally ill was enacted in 1895 and revised in 1957. In 2008, the *draft* Mental Health Act was submitted to, and is pending approval from the Attorney General's Chambers. The draft Act provides for the care, treatment, and rehabilitation of persons who are mentally disordered; sets out different procedures to be followed in the admission of such persons; establishes a Mental Health Review Board; and provides for other related matters. Sections of the Bill are dedicated to: voluntary and involuntary admissions to the psychiatric facility; powers of a police officer and mental health officer; discharge of patient from the psychiatric facility; establishment of a psychiatric hospital; community mental health services; establishment of a mental health review board; appointment of an inspector of mental health care; treatment of patient; detention of patient; care and administration of property of mentally disordered persons; offences; and transitional and miscellaneous provisions. The draft does not consider a provision for accreditation of professionals and facilities. No procedures and standardized documents are contemplated in the proposed Act.

Financing of mental health services

The budget for mental health is represented as a line item in the General Health Care budget. The level of funding for mental health services is determined largely by recurrent costs. In 2007, the total expenditure on health was EC\$62.0 million and of this, EC\$2.56 million was expended on mental health services. The greater proportion of the mental health expenditure (EC\$2.48 million) was for the mental hospital. The National Insurance Scheme does not cover mental disorders or mental health problems of clinical concern. There was no national data that showed the extent of use private mental health services providers and out-of-payment spending on these services. One hundred percent of the population had free access to essential psychotropic medicines in the categories of anti-psychotics, antidepressants, anxiolytics, mood stabilizers, and anti-epileptic drugs.



Human rights

There was no human rights policy or human rights review body to assess the human rights protection of users of mental health services in the country. However, the 2007 Draft Mental Health Act embodies many of the Principles for the Protection of Persons

with Mental Illness and the Improvement of Mental Health Care that was adopted by the United Nations General Assembly Resolution 46/119 of 17 December 1991. None of the mental health treatment facilities had an external review/inspection of human rights protection of patients. None of the mental health staff had at least a one-day training, meeting, or other type of working session on human rights protection of persons with mental illness.

Domain 2: Mental health services

Organization of mental health services

There was no national or regional mental health authority in the country. The Ministry of Health was responsible for organizing, delivering, and evaluating mental health services. Institution-based treatment was the dominant model for psychiatric care. The care and treatment of persons with mental disorders were not integrated into general health care. There was no integrated and comprehensive package of care through the primary health care network. Best estimates indicated that only a small percentage of the population received mental health care through the primary health care system. The trained staff attached to the mental hospital delivered community-based care.

There is a Mental Health Reform Project in the Ministry of Health for the development of a comprehensive mental health care system. A key responsibility of the Project is the coordination of activities for construction of the new mental health hospital. The new ultra-modern mental health facility will have a bed capacity of 104 beds, representing a 13% reduction over the bed capacity at the operating mental hospital.

Mental health outpatient facilities

There were no mental health outpatient facilities. The mental health team from the Golden Hope Hospital conducted monthly satellite mental health clinics in the 9 health regions. Patients had access to at least one psychotropic medicine of each therapeutic category (antipsychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicine). The quantitative information regarding the number of users treated through the community mental health clinics by diagnostic categories, age groups, and sex could not be validated. There was no national data base, national/regional surveys or reports against which the information could be compared and reconciled.

The available information indicated that around 100 persons were treated through the primary health care system in 2007.

Day treatment facilities

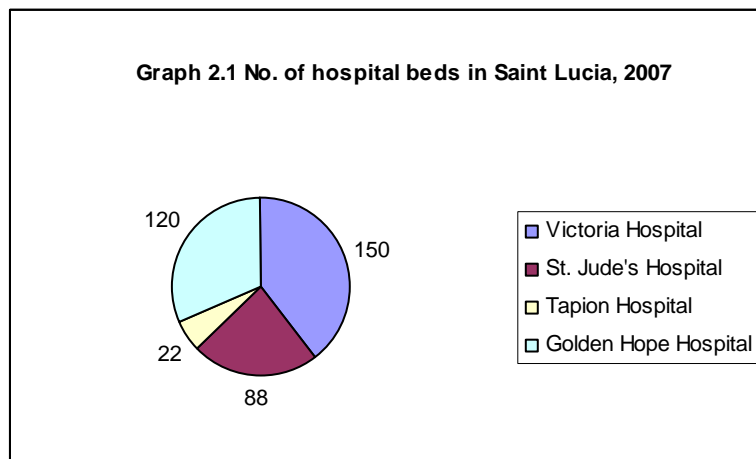
There was no day treatment facility in the referenced year. Turning Point, a 20-bed drug and alcohol detoxification and rehabilitation center, was not operational.

Community-based psychiatric inpatient unit

No community-based psychiatric inpatient unit existed in the country. There were 3 general hospitals in the island: 1 public, one quasi-public, and the other private. Patients with acute psychiatric disorders were admitted to their general medical wards. None had beds designated for patients with mental disorders. No data was available from the 150-bed public Victoria Hospital as to the number of patients admitted with mental disorders. The 88-bed St. Jude's Hospital, a quasi-public institution, admitted 102 patients with psychiatric disorders on its medical ward in 2007. No beds were designated for children and adolescents with mental disorders. Fifty-three percent of the admissions to St. Jude's Hospital were females. Around 1-20% of the patients were restrained and/or secluded at least once. Forty percent of the discharge diagnoses fell in the diagnostic group mental and behavioral disorders due to psychoactive substance use; 33% in other mental disorders; 16% in neurotic, stress related and somatoform disorders; and an average of 5.5% each in mood (affective) disorders and schizophrenia and related disorders. All or almost all patients received one or more psychosocial interventions. On average, patients spent 3 days per discharge. St. Jude's Hospital had access to at least one psychotropic medicine of each therapeutic class (antipsychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic).

The private 22-bed Tapion Hospital had no beds designated for mental health services. No information was available as to the scope of mental health care that was delivered in that setting in 2007.

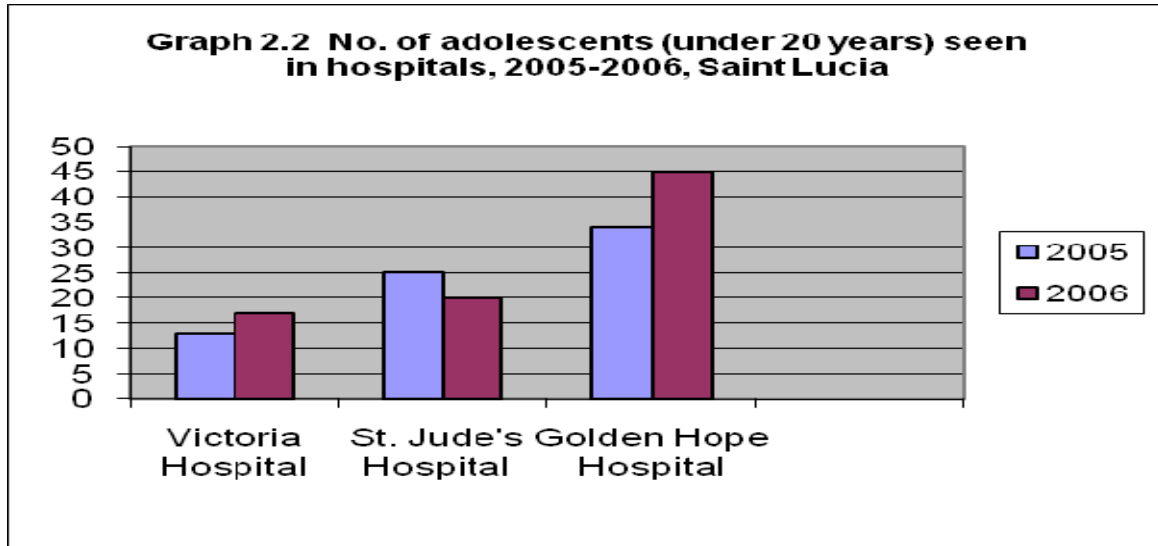
Four hospitals accounted for a total of 380 hospital beds and 32% of these beds were located in the Golden Hope Hospital, the psychiatric institution.



The national Mental Health Reform Project commissioned a situational analysis for the period 2005-2006 on Child and Adolescent Mental Health¹. The purpose of the analysis was to inform the formulation of a Child and Adolescent Mental Health Policy. In the absence of data on child and adolescent mental health, the information from the analysis

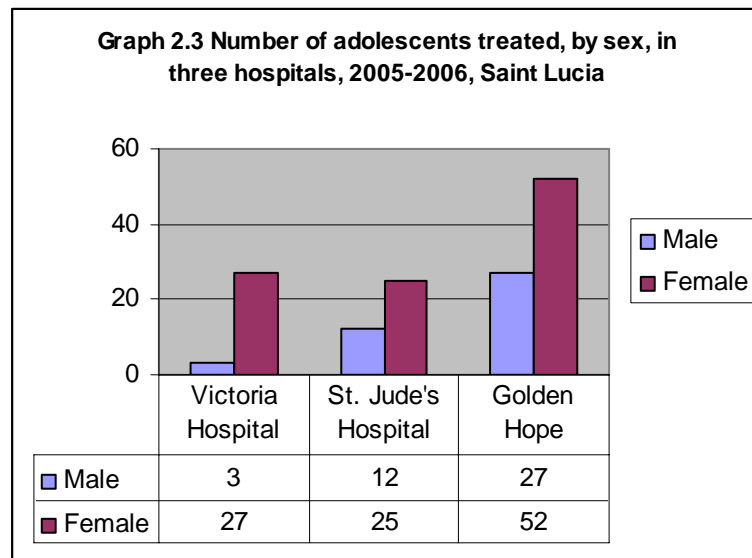
¹ Ministry of Health, Mental Health Reform Project, Situational Analysis, Child and Adolescent Mental Health, Draft Report, 2007.

is instructive. Graph 2.2 shows the number of persons in the under 20-year age group that were treated for psychiatric disorders in three hospitals in the period 2005-2006.



Note: The data for Victoria Hospital pertains to admissions in the age group 13-19 years; for St. Jude's, and Golden Hope hospitals, the age group is, 0-19 years.

Two pediatric admissions with mental health related diagnoses were reported for Tapion Hospital in the period 2005 and 2006; their ages and gender were not stated.



Note: The gender was not stated for 8 adolescents who were treated at St. Jude's Hospital in the period 2005-2006.

Community residential facilities

There were no community-based group homes, hostels, or half-way houses for persons with mental illness.

Mental Hospital

The 120-bed Golden Hope Hospital was the sole mental hospital in operation in 2007. One hundred percent of beds for patients with mental disorders were concentrated in the mental hospital. No beds were reserved for children and adolescents. The hospital had access to at least one psychotropic medicine of each therapeutic category (antipsychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic). An analysis of the reported quantitative data for 2007 revealed inconsistencies. As such, the number of admissions and discharges from the mental hospital by diagnostic categories, age groups, and sex are not included in this report. However, best estimates indicated that, in 2007, there were 840 admissions and 826 discharges for an average length of stay of 55 days.

In the absence of quality data from the mental hospital, relevant information from a 3-year Patient Assessment Study at the Golden Hope Hospital is reported herein to provide insight about inpatient characteristics over a 3-year period, 2003-2005.² The report is an analysis of secondary data extracted from the data record or case file for each of the inpatients who were institutionalized in the period 2003-2005. The report reviewed 421 inpatient records of which 57.7% (243) belonged to females. The age-range of the patients varied between 13 years to 85 years. Teenagers (less than age 20 years) comprised 4.3% of the distribution and females accounted for 4.0% of this age group. Sixteen point two percent of the inpatients were first time admissions to Golden Hope Hospital while 80.2% were re-admissions and 3.6%, not stated. The diagnoses on admission to the mental hospital were primarily from the following three diagnostic categories: schizophrenia and related disorders 68.2% (287); mental and behavioral disorders due to psychoactive substance abuse, 11.9% (50); mood (affective disorders), 9.9% (39). Diagnoses were not coded with either the DSM-IV or ICD-10 classifications. Psychotropic medicines were administered to approximately 95.5% of the patients and 33.5% received psychotherapy.

A second Patient Assessment Survey was conducted in 2006.³ Among the study's many objectives, was the identification of factors that may present barriers to alternative community-based placements. The study included persons in the mental hospital for more than three months and all patients who had three or more admissions in the past two years (around 2004), for a total of 92 participants. The study found that the median length of stay was 3.7 years, 75% of the patients had been hospitalized for around 14 years; and one individual had been hospitalized for 55 years. Sixty-nine point six percent of this cohort (64) had schizophrenia as their primary diagnosis followed by substance misuse, 8.7% (8). One of the report's conclusive finding is that long-term hospitalization was not

² Golden Hope Hospital, Patient Assessment Project Report, 2003-2005, Ministry of Health, Saint Lucia 2007.

³Golden Hope Hospital, Patient Assessment Project Report, Ministry of Health, St. Lucia, 2006.

due to psychiatric symptoms alone. A combination of clinical factors, behavioral tendencies, social problems, frequent use of inpatient hospital services, and the unavailability of a wide range of community-based supports and services prevent or delay discharge.

Forensic and other residential inpatient units

There was no forensic or other inpatient mental health unit in the country. Prisoners with mental disorders are treated and monitored in the prison by staff from the Golden Hope Hospital.

Human rights and equity

The data from the Patient Assessment Study, 2003-2005 assessed the patients' legal status at last admission. The analysis revealed that the 51.3% of the cohort was brought to Golden Hope Hospital with the aid of the police and 26.8% received family assistance in transporting them to the hospital. It was estimated that between 11-20% of patients were secluded or restrained at both St. Jude's Hospital and Golden Hope Hospital.

All of the psychiatric beds (100%) are located in the largest city. Inequity of access to mental health services based on service location, language, ethnicity, or religion is not an issue in Saint Lucia.

Domain 3: Mental health in primary health care

Training in mental health care for primary care staff

Some of the doctors in Saint Lucia were educated in countries outside of the CARICOM Region. Data was unavailable with respect to the number of hours devoted to psychiatry in their respective training programs. Registered nurses received 208 hours of mental health theory and clinical practice in a 3-year training program. The training program for mental health aides consisted of 225 hours and 11% (24 hours) was dedicated to mental health-related subjects. In terms of refresher training, none of the primary health care doctors, nurses, or non-doctor/non-nurse primary health care workers received at least two days of refresher training in psychiatry/mental health.

Mental health in primary health care

There were 34 physician-based primary health care clinics throughout 9 health regions; mental health services are offered in one clinic per health region. There was no properly structured and adequately resourced mental health service in the primary health care system. The locus of mental health care was in the mental health hospital. The burden of care rested primarily on the two hospital-based psychiatrists and mental health nurse practitioners. No quantitative or qualitative yardstick was available to assess accurately service utilization, scope, and service continuity. Mental health data was not integrated in the patient's overall general health care files at the primary health care level. None of the primary care clinics had assessment and treatment protocols for key mental health conditions. Between 21-50% of full-time primary health care physicians made an average of at least one referral per month to a mental health professional. As for professional interaction between primary health care staff and other health care providers, around 21-50% interacted with a mental health professional at least monthly. None of the physician-based primary health care clinics or mental health facilities had interaction with a complementary/alternative/traditional practitioner. No non-physician-based primary health care centers existed.

Prescription in primary health care

Primary health care physicians are allowed to prescribe and continue prescription for psychotropic medications without restriction. Nurses and non-doctor/non-nurse primary health care workers are not allowed to prescribe psychotropic medications. The primary health care centers where satellite mental health clinics are held had access to at least one psychotropic medication of each therapeutic category (antipsychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines).

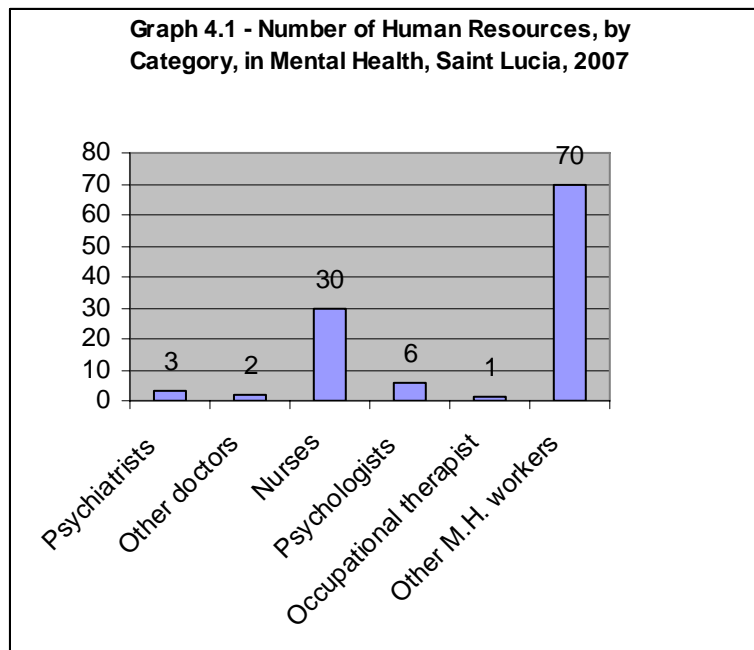
Domain 4: Human resources

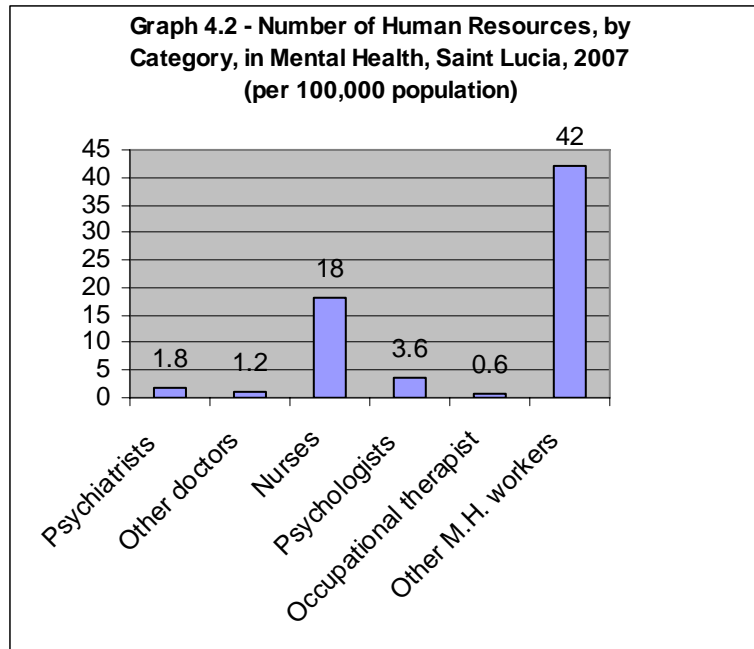
Number of human resources in mental health care

The total number of human resources in the only mental health facility is 67.2 per 100,000 population. The breakdown according to profession per 100,000 is as follows: 1.8 psychiatrist, 1.2 other medical doctors (not specialized in psychiatry), 18.0 nurses, 3.6 psychologist, 0.6 occupational therapist, and 42.0 other health or mental health workers. Four nurses were titled as “mental health nurse practitioners.”

No full-time trained mental health staff was assigned to primary health care services. Staff from the mental hospital conducted mental health clinics once per month in the primary health care setting. One of the three psychiatrists in the island was employed full-time at St. Jude’s Hospital. The other two were assigned to the government services providing care and treatment at both the mental hospital and at the 9 community health clinics. Three psychologists were dedicated to solely to private practice. The cadre of trained mental health nurses was assigned to the mental hospital.

The only mental health facility (Golden Hope Hospital) is located in the largest city. Staffing per bed for this facility, per 100,000 population, was: 0.03 psychiatrist; 0.02 other doctors (not specialized in psychiatry); 0.25 nurses, 0.06 other mental health staff (psychologists and occupational therapist); and 0.58 for other mental health workers. There was no psychiatric social worker.





Training professionals in mental health

One mental health nurse practitioner graduated in 2007. No psychiatrist emigrated from the country within five years of completion of training. No mental health professional attended at least two days of refreshers training on the rational use of psychotropic drugs, psychosocial interventions, or child/adolescent mental health issues.

Consumer and family associations

There were no user/consumer or family associations. Two NGO's in the country were involved in the development of the draft mental health policy, draft legislation, and advocacy activities.

Domain 5: Public education and links with other sectors

Public education and awareness campaigns on mental health

No coordinating bodies existed in the country to oversee public education and awareness campaigns on mental health-related issues. Public education and awareness campaigns were launched by the government, non-governmental organizations, and international agencies. The target audiences included the general public, children, adolescents, women and vulnerable groups. No specific public education and awareness campaigns on mental health were aimed at professional groups.

Legislative and financial provisions for people with mental disorders

In the reference year, there were no legislative provisions concerning: a) a legal obligation for employers to hire a certain percentage of employees that are disabled; b) protection from discrimination (dismissal, lower wages) solely on account of mental disorder; c) priority in state housing and in subsidized housing schemes for people with severe mental disorders; and d) protection from discrimination in allocation of housing for people with severe mental disorder. Part II (Fundamental Provisions), Section 9 of the draft Mental Health Act states that: “A person shall not be unfairly discriminated against because of his or her mental health status.”⁴

Links with other sectors

There were no formal collaborative programs that addressed the needs of people with mental health issues between the Ministry of Health and any other department or agency. The Peoples Republic of China partnered with the Government of Saint Lucia to build the EC\$27 million ultra-modern mental hospital. The Revised Mental Health Strategic Plan (2007/08-2010/11) recognizes that the successful implementation of the Plan will require input from stakeholders such as government departments and local government agencies; public and private sector agencies; civil society organizations, consumers/family/carers; and international/regional organizations. None of the primary or secondary schools had either a part-time or full time mental health counselor. Guidance counselors were assigned to secondary schools and education districts. There were no school-based activities to promote mental health and prevent mental disorders. The proportion of prisoners with psychosis was estimated at 14%; less than 2% had mental retardation. The single prison had at least one prisoner per month in treatment contact with a mental health professional within the prison. Some police officers (21-50%) and no judges and lawyers participated in educational activities in the last five years. The mental hospital had access to programs that provided outside employment for institutionalized patients with severe mental disorders. In 2007, 2.6% of clients who received welfare benefits qualified solely because of a disability due to mental disorders.

Domain 6: Monitoring and research

A formally-defined list of individual data items that ought to be collected by all mental health facilities existed. The mental health satellite clinics did not routinely collect and compile data by number of users treated, number of user contacts, and diagnoses. The government health department received data from the mental hospital but no report covering mental health data was available from or published by the government. No mental health professional was involved in mental health research or was any mental health research conducted in the last five years. There were no mental health publications on the country or region in indexed journals.

⁴ Government of Saint Lucia, Mental Health Bill (draft), 2007

NEXT STEPS IN STRENGTHENING THE MENTAL HEALTH SYSTEM

- Commission the mental health facility
- Expand the community mental health program from four teams to eight teams
- Implement ongoing public education campaigns
- Continue the program to reform the mental health services

The World Health Organization Assessment Instrument for Mental Health (WHO-AIMS) was used to collect information on the mental health system in Saint Lucia. The Assessment provides a relatively complete picture of the mental health system in the country.

The provision of mental health services is the responsibility of the Ministry of Health. No mental health authority exists in the Ministry of Health but there is a Mental Health Reform Project that is charged with the development of a mental health care system. Four percent of the national health expenditure is directed towards mental health with the greater proportion going to the mental hospital. The population has free access to psychotropic medications. A 3-year Patient Assessment Study at the Golden Hope Hospital provides an overview of the characteristics of hospitalized patients in the period 2003-2005. The majority of patients in this cohort had a diagnosis of schizophrenia and related disorders. Mental health care is not integrated into primary health care. A new, ultra-modern, 104-bed mental hospital was completed in 2009. The cadre of public-sector mental health workers is concentrated in the mental hospital.

Mental health services are accessed through the mental hospital, general hospitals, and nine health centers. There are no day treatment facilities, community-based psychiatric inpatient unit, forensic unit, or facilities for children and adolescents with mental disorders.

Access to reliable mental health data presents a challenge since there is no coordinated information system to collect and collate hospital and primary health care data for systematic analysis at the national level.

A clearer and more comprehensive picture of the mental health system has emerged. This will inform priority-setting and reformulation of strategic initiatives for mental health reform in Saint Lucia.