Analysis of the pathway of developing a national mental health plan for Suriname

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by

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Abstract

The aim of this analysis was to analyze and describe the steps that have been taken in the development of the mental health policy in Suriname after the WHO AIMS. The objectives are:

1. To review the steps to be taken in developing a mental health policy and plan for a country
2. To gather information and data concerning mental health policy and plan development in Suriname
3. To draw conclusion from the experience gained that can be applied to other countries

In general, the information that was gathered from the four countries Guyana, Barbados, Trinidad & Tobago and Suriname, was compared with the WHO steps for developing a mental health policy and plan. Were these steps taken into consideration, when developing their mental health policy and plan? If not, what were the reasons why it did not happen? The checklist for evaluating a mental health plan was used in Suriname. This checklist assisted to see if the results of the recommendations given by the WHO AIMS to develop a effective and balanced mental health plan were taken into consideration.

Table 1: Comparison of mental health developments in given countries

	Guyana	**Barbados**	**Trinidad & Tobago**	**Suriname**
WHO AIMS	2007	2007	2007	2009
Mental health Policy	2008	None	None	2012
Mental Health Plan	2008	None	None	2012
Mental health coordinating body/person	Body	Person	Person	Body
Implementation of WHO steps	Yes	No	No	Yes

The mayor findings of the analysis are that Suriname as well as Guyana used the steps in developing their mental health policy and plan. Barbados and Trinidad & Tobago did not develop a mental health policy and plan. Suriname and Guyana have a mental health coordinating body at the Ministry of Health. Trinidad & Tobago as well as Barbados have a mental health focal person at the Ministry of Health of the respective countries.

It can be concluded that successfully improving of health systems and services for mental health is combining theoretical concepts, expert knowledge and cooperation of many stakeholders. The appointment of a mental health coordinating unit at the Ministry of Health is crucial for the development of mental health in a country. Furthermore, mental health is everyone's business and responsibility. Implementing the steps to be taken when developing a mental health policy and plan as recommended by WHO may be a slow process requiring the mobilization of political will. That's why it is crucial that persons responsible for this process work close with all stakeholders in relevant sectors, taking their needs into consideration and try to translate that in clear objectives. It is common knowledge that improving the quality of mental health must be accompanied by the availability of financial and human resources. Finally, a mental health policy and plan should be one document tackling all aspects of mental health of a community.

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In most of the cases mental health data is not easily accessible in countries of the Caribbean. Therefore gathering the data in this analysis required a long and appraisable commitment from those who were involved. The professionals working for the respective Ministries of Health as well as those who are working in mental health institutions have helped to make this possible.

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Dr. Shamdeo Persaud, Chief Medical Officer
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Mrs. Heather Paynes-Drakes, Mental health focal person

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Mrs. Leiza Haynes, Psychiatric Nurse

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1. Introduction

In 2009 I started with my masters program in mental health policy and services at the New University of Lisbon, Portugal. During my lectures and orientation I found out that concerning mental health development in the Caribbean Region, a lot was going on. Due to the fact that I was responsible for the initiative of my Ministry of Health, in using the WHO AIMS to assess the mental health situation of Suriname, I was wandering what happened after in countries in the Caribbean Region, similar to Suriname. Knowing that most of the countries were going for strengthening their mental health system, this analysis will help to make that visible.

Of all countries of the world (reporting), 76.5% (28) have a national mental health plan; however, their implementation levels are low(a).With this information the World Health Organization (WHO) in 2005 produced a mental health policy and services guidance package for countries with the purpose to assist policy-makers and planners to:
- develop policies and comprehensive strategies for improving the mental health of its populations;
- use existing resources to achieve the greatest possible benefits;
- provide effective services to those in need;
- assist the reintegration of persons with mental disorders into all aspects of community life, thus improving their overall quality of life.

An explicit mental health policy and plans as well as programs are an essential and powerful tool for the mental health section in any ministry of health. When properly formulated and implemented through plans and programs, a policy can have a significant impact on the mental health of the population concerned (1).

Countries in the Caribbean share a similar history in the development of their health systems. They have often cooperated to deal with many of the challenges to health which they have had to confront. However, there was need for even greater collaboration and cooperation among the countries in the Region, given the increasing threats to the economies of these countries and the presence of newly emerging and re-emerging problems in the health sector. Efforts therefore have to be focused not only in the fight against disease, but in promoting healthy lifestyles, protecting the environment and increasing the capacity of the health sector to provide quality service and value for money.

Globally as well as regionally, the burden of mental disorders is likely to have been underestimated because of inadequate appreciation of the connection between mental illness and other health conditions. Because these interactions are protean, there can be no health without mental health as stated by the WHO/PAHO. Mental disorders increase risk for communicable and non-communicable diseases, and contribute to unintentional and intentional injury. Conversely, many health conditions increase the risk for mental disorder, and co-morbidity complicates help-seeking, diagnosis, and treatment, and influences prognosis.

About 14% of the global burden of disease has been attributed to neuropsychiatric disorders, mostly due to the chronically disabling nature of depression and other common mental disorders, alcohol-use and substance-use disorders, and psychoses. Such estimates have drawn attention to the importance of mental disorders for public health. However, because they stress the separate contributions of mental and physical disorders to disability and mortality, they might have entrenched the alienation of mental health from mainstream efforts to improve health and reduce poverty. (2)

Health services are not provided equitably to people with mental disorders, and the quality of care for both mental and physical health conditions for persons suffering from these disorders could be improved. We need to develop and evaluate psychosocial interventions that can be integrated into management of communicable and non-communicable diseases.

Health care systems should be strengthened to improve delivery of mental health care, by focusing on existing programmes and activities, such as those which address the prevention and treatment of HIV, tuberculosis, and malaria; gender-based violence; antenatal care; integrated management of childhood illnesses and child nutrition; and innovative management of chronic disease. An explicit mental health budget might need to be allocated for such activities. Mental health affects progress towards the achievement of several Millennium Development Goals, such as promotion of gender equality and empowerment of women, reduction of child mortality, improvement of maternal health, and reversal of the spread of HIV/AIDS. Mental health awareness needs to be integrated into all aspects of health and social policy, health-system planning, and delivery of primary and secondary general health care. (3)

Regionally, countries are still struggling with developing mental health policies and plans. After the use of the WHO AIMS as instrument to assess the mental health situation in the Caribbean region, most countries were convinced that something should be done.

Suriname as one of the countries in the Caribbean was also fighting against issues as a strict centralized and hierarchic mental health system. A big overburdened psychiatric institution in the capital city – referred to as "mad house", no decentralized support systems, outdated legislation and human rights, minimal distribution and training of human resources, no efforts for quality improvement of psychiatric services, a lack of intersectoral collaboration, no psychotropic drug procurement and distribution, lack of mental health promotion and prevention, inadequate treatment and rehabilitation, and lack of financing (16). In 1999 the Ministry of Health requested the PAHO to assist in developing its first mental health policy document. Understandable that the focus of this document mainly would be one with a public health approach. The recommendations were towards decentralization of the psychiatric care and integration of mental health in the primary healthcare. Almost a decade after this first initiative with minimum results the Ministry again requested the WHO/PAHO to assist in developing a national plan for mental health. With the assistance of this international health organization and the availability of international expertise it was expected that in developing the document the available instruments were used.

2.0 Theoretical Framework for mental health policy

In 2005 the World Health Organization (WHO) produced the mental health policy and services guidance package named mental health policy, plans and programmes (updated version 2). One of the modules provides practical information to assist countries to improve the mental health of their populations.

2.1 Mental Health Policy & plans: WHO/PAHO guidance

Despite the wide recognition of the importance of national mental health policies and plans, data collected by WHO reveal that sixty percent (60%) of countries report having a dedicated mental health policy and seventy one percent (71%) possess a mental health plan(4). The Initiative for the Restructuring of Psychiatric Services (6), launched shortly after the Caracas Declaration by the Pan American Health Organization (PAHO) and the World Health Organization (WHO) in collaboration with a large number of countries, international organizations, and experts, actively promoted and supported mental health reform efforts in Latin America and the Caribbean, contributing to the development of national mental health policies in several countries (18).
In the module mentioned above the WHO has developed steps that should be taken to develop and implement mental health policy and plans. These steps are (1):

Step 1. Gather information and data for policy development

To start the process of developing a mental health policy and plan information is needed. This information must be based upon the mental health needs of a population. Also the existing mental health system and services must be analyzed. Examples of needs that can be looked at are prevalence and incidence studies, determining what communities identify as problems and an understanding of help seeking behavior. Knowing who delivers mental health, to whom and with what resources is an important starting point for developing a reasonable and feasible mental health policy. After the analysis of the health needs and the existing system and services, priorities must be established.

Step 2. Gather evidence for effective strategies

After establishing priorities effective strategies must be set in place. This can only be effective if it is based on evidence. Evidence can be gathered by visiting local services and reviewing the national and international literature.

Step 3. Consultation and negotiation

Consultation and negotiation can be a timely business. This process is in most times a political matter. To a lesser degree it is a matter of technical actions and resource-building. The ministry of health is key during this process. Its role is to listen to the various stakeholders and to make proposals that blend their different views with the evidence derived from national and international experience. It is required to have an active compromise of the majority of the key stakeholders in developing a mental health policy. Political support must be obtained (1).
Progress has been particularly visible in countries that have implemented policies with strong political support (18).

Step 4. Exchange with other countries

In most cases other countries has gone through the same stages. It is important to look at the experiences from other countries that may help. Experiences as well as the latest advances of more developed countries may help also. Creative experiences and lower-costs interventions as well as international experts can contribute when developing a mental health policy.

Step 5. Set out the vision, values, principles and objectives

Finishing the process as mentioned above, vision, values, principles and objectives for mental health can now be described.

Step 6. Determine areas for action

The objectives as mentioned above can now be translated into areas of action. It is important that these areas reflect a simultaneous development of mental health in the given areas. These areas can be from the Ministry of health as well as within the communities. WHO has listed a number of areas that can be involved in developing a mental health policy. These are,

- Coordinating Unit;
- Financing;
- Legislation and human rights;
- Organization of services;
- Human resources and training;
- Promotion, prevention, treatment and rehabilitation;
- Essential drug procurement and distribution;
- Advocacy;
- Quality improvement;
- Information systems;
- Research and evaluation of policies and services;
- Intersectoral collaboration.[1]

Step 7. Identify the major roles and responsibilities of different sectors

Implementing a mental health policy means that different roles and responsibilities of stakeholders must be identified. The sectors required to take these roles and responsibilities include:

- Governmental agencies (health, education, employment, social welfare, housing, justice);
- academic institutions;
- professional associations;
- general health and mental health workers;
- consumer and family groups;
- providers;
- nongovernmental organizations (NGOs);
- traditional health workers.[1]

Without adequate policies and plans, mental disorders are likely to be treated in an inefficient and a fragmented manner. Therefore, after the development of a mental health policy, the next step can be the development of a mental health plan.

The steps that were identified in developing a mental health plan were:
Step 1. Determine the strategies and timeframes
To be sure that a mental health plan is effective, strategies need to be determined for the different areas of action as mentioned above. There must be coordination for example to ensure the plan is coherent and designed to meet the objectives that have been prioritized.
For each strategy a time frame should be defined. A pitfall here for implementing a plan is the lack of needed resources and capacities.
Step 2. Set Indicators and targets
Connected to the strategies must be specific targets and indicators drawn up to later assess whether the plan has been effective or not. It is obligated that the targets are clear and explicit and state precisely what must be achieved within given timeframes. The targets must also be measurable and indicators identified with respect to how the success of each target will be assessed.
Step 3. Determine the major activities
Connected to each strategy, and for each area of action, activities must be listed to plan how the strategy will be realized. A listing of which activities, who the persons are who will execute the activities, how long and when the activities will take place as well as which activities can be done simultaneously. Expected outputs, potential obstacles and delays must be set out.
Step 4. Determine the costs, available resources and budget accordingly
Financial resources must be made available for implementation of a mental health plan. That's why it is necessary that in a mental health plan:
- The costs of each strategy as well as the total costs of the plan for each year are calculated.
- Those that are going to finance these resources have been defined.
- The time frames of the strategies and activities in accordance with what resources are available in different years is adjusted.
- The time frame and resources annually after monitoring and evaluation of the implementation of the plan has been re-adjusted.

4. Developing a mental health programme
After the development of the policy and strategic and detailed plans, it is important to have programmes that focus on the promotion of mental health, the prevention of mental disorders, and treatment and rehabilitation.

5. Implementation issues for policy, plans and programmes
There will always be issues when implementing policy, plans and programmes for mental health. Several actions are necessary in order to make possible the implementation of these strategies and interventions. While implementing mental health strategies the following action must be taken care of:
Step 1. Disseminate the policy
Stakeholders must be sensitized, so the policies must be widely disseminate by the Ministry of Health to all stakeholders involved.
Step 2. Generate political support and funding
Beside active stakeholder participation, communication activities should be executed. The main goal is to ensure enough political support and funding for the implementation of the policy.

Step 3. Develop supportive organization
For the implementation of mental health policy a competent group of professionals with public health expertise as well as mental health competencies is needed. This group should take responsibility for managing the plan and programme(s). Active participation of consumers and families in the mental health field is also necessary, and this group will ensure this intersectoral collaboration. At all levels this collaboration must take place.

Step 4. Set up pilot-projects in demonstration area(s)
One or more demonstration area(s) must be designated to execute pilot projects.
Step 5. Empower mental health providers
It is necessary the providers in a health system are empowered to deliver health interventions to the population. General health providers as well as specific mental health providers deliver mental health interventions.
Step 6. Reinforce intersectoral coordination
To successfully implement mental health policy intersectoral coordination is needed. This is the task of the mental health professionals in the ministry of health.
Step 7. Promote interaction among stakeholders
Interaction must be promoted between the ministry of health and other sectors as well as between other stakeholders.

2.2 Evolution of mental health policy & plans in the Caribbean region

Between 2006 and 2010 seventeen (17) countries and territories in the Caribbean Region have used the World Health Organization Assessment Instrument for Mental health Services (WHO AIMS) to assess their mental health systems. PAHO and WHO have cooperated with several countries on *mental health system assessments*, using the WHO-AIMS methodology and standardized instrument (6), which compiles and analyzes data on 155 indicators. To date, the countries in the Latin America and the Caribbean that have concluded this assessment are: Belize, Brazil, Chile, Costa Rica, Dominican Republic, El Salvador, Guatemala, Guyana, Honduras, Jamaica, Nicaragua, Panama, Paraguay, Suriname, and Uruguay. The assessment was in 2010 in progress in: Anguilla, Antigua and Barbuda, Argentina, Bolivia, Cuba, Ecuador, Grenada, Montserrat, Peru, Saint Lucia, Trinidad and Tobago, and Turks and Caicos. The goal was for all countries to finalize the assessment in the biennium 2010- 2011(6).
The last successful attempts at assessing the existence of mental health policies and plans development in the Caribbean region took place in 2011, when the WHO/PAHO looked at the countries that completed the WHO AIMS. This report stated that the first steps to implement WHO-AIMS took place in the second half of 2006. Since then, gradually, seventeen countries and territories have assessed their mental health systems. The whole process has culminated in November 2010. Once the Ministry of Health agreed to initiate the implementation, the Ministry would nominate a focal person to collect the information from all stakeholders. With the support of PAHO/WHO, country level meetings were held with key stakeholders such as mental health professionals, health authorities, and other partners, for presentations and discussions of the tool(7). Most of the countries in the Caribbean by then, reported that there were no mental health policy in place, except Suriname, Anguilla, Jamaica, Sint Lucia, Turks and Caicos and Barbados. The countries that were reported as having a plan in place were Belize, Jamaica, Montserrat, Suriname, Trinidad & Tobago and Turks and Caicos. In the Caribbean region though there were

initiatives to combine efforts to tackle the existing health challenges such as the growing mental health problems.

2.3 Regional Initiatives: Caribbean Cooperation in Health Initiative

The concept of the Caribbean Cooperation in Health Initiative (CCH) was introduced in 1984 at a meeting of the former CARICOM Conference of Ministers responsible for Health (CMH). The CMH saw this as a mechanism for health development through increasing collaboration and promoting technical cooperation among countries in the Caribbean. The initiative, in which seven priority areas were identified, was adopted by the CMH and approved by the Heads of Government in 1986. An evaluation of the Initiative (1992-1994), found that the priorities identified ensured that activities were focused in areas critical to improving health status in the region. Overall it was established that the Initiative was beneficial to Caribbean countries.
In 1996, the CMH mandated a re-definition and re-formulation of the CCH Initiative for the period 1997-2001. The meeting selected eight (8) health priority areas, recommended strategies for implementation, and identified some areas of common concern which required joint action. The recommendations of that meeting were accepted by CMH in 1997. The countries that have participated in the initiative include Antigua and Barbuda, Anguilla, The Bahamas, Barbados, Belize, Bermuda, The British Virgin Islands, the Caymans Islands, Dominica, Grenada, Guyana, Jamaica, Montserrat, Saint Lucia, St Vincent and the Grenadines, St Kitts and Nevis, Suriname, Trinidad and Tobago and the Turks and Caicos Islands. The head of governments of the abovementioned countries have decided that the purpose of this initiative should be to develop and implement programmes which focus action and resources on priority health issues of common concern to the Caribbean community, with particular consideration given to vulnerable groups. In other words, "Caribbean Countries helping themselves and one another to improve health in the Region." Among others like environmental Health, strengthening of the Health Systems, the emphasis on Chronic Non-communicable Diseases, Family Health, Prevention and Control of Communicable Diseases, Food and Nutrition and Human Resource Development, Mental Health including Substance Abuse is also stated as one of the most important areas of priority within the Caribbean Region.
In summary, the prioritizing of mental health as one of the regional challenges has caused government of countries to use the WHO AIMS to assess the mental health situation in their respective countries. As mentioned before some countries to date has a mental health policy and some a mental health plan approved (6).

3.0 Aim and Objectives

A common issue in the broader Caribbean and especially in the selected countries is the lack of epidemiological data regarding mental health. The only document that was available was the World Health Organization Assessment Instrument for Mental health Services (WHO AIMS) reports. The aim of this analysis is to analyze and describe the steps that have been taken in the development of the mental health policy in Suriname after the WHO AIMS.

The objective of this analysis was to find out what governments have done after the use of the WHO AIMS, the guidelines which were given to restructure mental health services and the recommendation given by the CCH to develop a mental health policy and plan in the countries Guyana, Barbados, Trinidad & Tobago and Suriname. This was done by reviewing the

mentioned steps after collecting information and data concerning the mental health situation in the assessed countries. A specific question that was asked is: did governments use the steps and guidelines that the WHO suggested in developing their mental health policy and plan.
It is intended to be of practical use and interest of ministries of health in small and middle income countries regarding the development of mental health policies and plans in four countries in the Caribbean, with focus on the development of mental health policy in Suriname.

3.1 Methodology

This study is a qualitative study. The instrument that was used to collect the information was a questionnaire consists of nine (9) open questions. The population was mental health professionals working for Ministries of Health in the given countries. In June 2011 interviews were held with these designated mental health officials in the selected countries. A letter of permission with the questionnaire attached was send to the Directors or Chief Medical Officers of the Ministries of Health. After permission, most of the time via telephone, the mental health focal persons of the Ministries, senior psychiatrists, Chief Medical Officers and Directors of Health were then contacted for an interview. Through these officials I got the information of what is happening in the field of mental health after the use of the WHO AIMS. It is assumed that participants have answered the questions honestly and to the best of their abilities. In general, the information that was gathered from the four countries was compared with the WHO steps for developing a mental health policy and plan. Were these steps taken into consideration, when developing their mental health policy and plan? If not, what were the reasons why it did not happen? For Suriname especially, the checklist for evaluating a mental health plan was used. This checklist assisted to see if the results of the recommendations given by the WHO AIMS to develop a solid and balanced mental health plan were taken into consideration.

4.0 Results of WHO AIMS and developments of mental health policy & plan in Guyana, Barbados and Trinidad & Tobago

In the Caribbean Region are some countries that are playing a major role in its health policy and policy development. These countries are beside Jamaica and Bahamas, Suriname, Barbados, Guyana and Trinidad & Tobago. The last four namely Suriname, Guyana, Barbados and Trinidad & Tobago are four major players in the development of health in general and more specifically mental health. In this analysis I had focused on these 4 countries because of their geographical location and their interference with each other. These countries have at least implemented one of the recommendations of the CCHIII to use the WHO AIMS to analyze the status quo and to collect information of how to improve the mental health system.

Table 2: Mental health indicators from selected countries

Rate /country	**Guyana**	**Barbados**	**Trinidad & Tobago**	**Suriname**
World Bank income level*	Lower-middle	High	High	Upper-middle
Population 2009 thousands **	750	269	1,328	480
Mental hospital **	1	1	1	1
Psychiatrists per 100.000 **	0,5	4	1,7	1,5
Mental health nurses per 100.000 **	0,4	39,8	32,7	14
Mental health beds **	240	537	893	300
Outpatients facilities **	2	14	31	5
% of health budget spend on mental health **	1	7	4	9
Year of last mental health policy **	NA	2004	NA	2007***
Year of last mental health plan **	NA	NA	2000	2007****
Year of last mental health legislation **	1930	1985	1975	2002*****
% of mental health budget spend in mental health hospital **	61	100	94	83

*Mental Health Atlas 2011
**WHO AIMS

In summary, all four countries have one main psychiatric hospital. The concentration of beds in one institution implies equal concentration and distribution of human and financial resources, limiting consequently the establishment of other services in the community. A national mental health policy has been formally approved in Barbados.

***In Suriname the policy of the mental hospital has been approved by the Ministry of Health as the mental health policy for the country. Only in Trinidad & Tobago a national mental health plan was formally approved by the government.

****Suriname's government again approved the psychiatric hospital's plan as the national plan for mental health.

*****All the four countries have outdated mental health legislation. Suriname's legislation was last dated 1912. In 2002 an amendment was made for voluntary admission, but the instruments to execute this amendment were never put in place.

4.1 Guyana

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used in 2007 to collect information on the mental health system in Guyana. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This has enabled Guyana to develop information-based mental health plans with clear base-line information and targets. It was also used 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. Although there was little epidemiologic data from Guyana upon which to base assessments of mental health service need, disease burden estimates have recognized the neuropsychiatric disorders as making a larger contribution to the burden of disease, measured in Disability Adjusted Life Years (DALYs), than other diseases such as HIV/AIDS, tuberculosis, and malaria combined. Unipolar depression alone has been identified as the fifth greatest contributor to disease burden in Guyana and suicide is estimated to be the third-leading cause of death among those 15 to 44 years of age, accounting for 13% of all deaths (8). Relevant studies in the Americas indicate there is likely a prevalence of 10 to 15% of the population with a mental disorder at any one time, with 3 to 5% of the population having a severe chronic mental disorder. Given a population estimate of 750,000, this would predict that 75,000 to 112,500 Guyanese suffer from mental disorders and require some level of mental health care services. Of these, approximately 22,500 to 37,500 would be expected to suffer from severe mental illness. These projections do not include the number of patients with epilepsy and mental retardation, which are not surveyed in typical psychiatric epidemiologic studies, but are included in the population serviced by mental health care services in Guyana. The current mental health system in Guyana is fragmented, poorly resourced, and not integrated into the general health-care system. Care of the mentally ill is provided under the legislative framework of the **Mental Health Ordinance of 1930,** which is antiquated and fails to make provisions for the protection of the rights of people with mental disorders. Persons with mental disorders are reported to suffer discrimination in their communities, the workplace, educational institutions, judicial services and the health-care system. Safeguards to protect individuals with mental illness from involuntary admission and treatment and mechanisms to oversee treatment practices within health facilities are lacking. There are no independent review bodies established to protect the human rights of users of mental health services. Stigma against the mentally ill is reported to be pervasive and considered by stakeholders to be expressed by the public as well as by many health professionals, the police, and policy makers and administrators alike. It is considered to be one of the greatest barriers to the development of modern mental health services in Guyana. Mental health services are inadequate and not available or accessible to the vast majority of the population. Although at least one medication from each class of psychotropic drug is available at all mental health facilities as well as most primary and secondary care facilities in Guyana, there are no guidelines or protocols for the use of psychotropic drugs, and few health or specialized mental health workers have received any training in the rational use of these medications. There are minimal numbers of general health human resources with the necessary mental health competencies to provide mental health care services at any level of general health care services. In addition, few adequately trained specialized mental health professionals are available within mental health services. At the time of this assessment there were 3 psychiatrists in the public sector in Guyana, 2 based in Georgetown and one at the National Psychiatric Hospital. Besides these physicians, mental health staff has variable levels of training, and often lack the competencies required to provide adequate quality mental health care. Guyana's total of 3 full-time equivalent

psychiatrists translates into 0.5 psychiatrists per 100,000 population (equal to 5 per million) significantly below the world reference average of 4.2 per 100,000 (8). By these standards, Guyana's mentally ill are markedly underserved. Available public mental health services are predominantly institution-based. Tertiary level services are provided by one 240-bed mental hospital - the National Psychiatric Hospital - which provides both inpatient and outpatient services. Care provided at the mental hospital is primarily custodial and heavily reliant on pharmacologic intervention. The majority of mental hospital beds are filled by long stay patients who do not necessarily require institutional care. There is one 4-bed short-stay community-based psychiatric unit in the country's tertiary heath care facility, the Georgetown Public Hospital Corporation (GPHC), which provides emergency and acute care services. There are few community-based services and minimal services available at primary care level. There are no national or institutional standards for mental health care, facilities or human resources. The National Psychiatric Hospital (NPH) is in substantial disrepair and significantly below the standard of facilities that provide for physical health care, raising concern about equitable treatment of the mentally ill. There are no standards, protocols, policies or guidelines for the use of psychotropic medications; the assessment, treatment, monitoring, and ongoing evaluation of patients with mental disorders; the charting of patient information; or the maintenance of health records. There is little national mental health data available for mental health service monitoring and evaluation. As a consequence, datasets of sufficient quality are not available to inform service utilization or to provide quality assurance for mental health care. Informal mental health services are poorly developed and limited to substance abuse ambulatory support and counseling services for male individuals with substance abuse problems provided by two non-governmental organizations (NGOs) in the capital city of Georgetown. There are no mental health consumers/users, volunteer, family or advocacy groups in Guyana. This is unfortunate as these groups can play valuable roles in prevention/promotion, advocacy and rehabilitation efforts within the mental health care system. However, there are many non-health professional and nonprofessional groups in Guyana, including teachers, community leaders, traditional/spiritual healers, herbalists, religious leaders, law enforcement (police), ambulance attendants, NGOs, and the media, who could potentially play a role in the promotion of mental health in their communities. Despite the continued challenges and resource constraints noted above, there have recently been substantial efforts made to improve mental health in Guyana. The Government of Guyana has demonstrated a strong commitment to improving the mental health of its population. In Guyana, mental health has specifically been identified as an essential component of health reform. In the Ministry of Health's National Health Plan 2003-2007, mental health was highlighted as a priority area for development. The profile of mental health has been raised further in the recently drafted Health Sector Strategy 2008-2012 in which mental health is identified as one of the seven priority health areas. The National Health Sector Strategy identifies 7 priority programs selected to facilitate the achievement of comprehensive, accessible health services in keeping with the Ministry's commitment to the Millennium Development Goals, National Development Strategy and Poverty Reduction Strategy programs. The priority programs are Family Health; Chronic Non-Communicable Diseases**;** Accidents, Injuries and Disabilities; HIV, TB and Malaria; Communicable Diseases including neglected diseases and emerging diseases; Mental Health; Health Promotion and Risk Reduction. The specific targets identified in Mental Health are the development and implementation of prevention and management services for suicide, depression and substance abuse in first contact (primary) clinical care. In 2008 Guyana launched its national mental health strategy 2008-2015. The identified areas in the WHO AIMS as well as other key strategic areas were considered. The Government of Guyana believes that good mental health is fundamental for the

wellbeing of people (9). As the honorable minister of health Dr. Lesley Ramsammy said at the launching: *"The problem is not going to get better, unless we do something to stop the ravages of mental health now".* The investment in developing this strategic agenda helped Guyana to not only put mental health on the agenda, but also helped to attract donors and other who were willing to help to see what Guyana really wants. Considering the WHO-AIMS data and the strategic context provided above, the objectives of the NMHS are:

1. Promote the mental health of the population, reducing the burden of diseases caused by mental problems and mental disorders.
2. Promote and protect the human and civil rights of the mentally ill and ensure consumer rights.
3. Provide equitable access to quality evidence-based mental health care and services to all people in Guyana including vulnerable populations (i.e., women, children, the elderly, indigenous peoples, people with physical or mental disability, the homeless, etc.), by defining a package of services and integrating the services at all levels of the public health system
4. Ensure health care providers are adequately trained to provide primary health care level care (first responder type of mental health services) and more specialized care at higher levels of the health system.
5. Link the mental health service with the general health sector, ensuring community participation and access, and link the mental health services with other sectors, particularly with the social security services and justice system.
6. Provide an appropriate comprehensive range of therapeutic hospital and community-based treatments with a focus on the rehabilitation and recovery from mental illness and dental distress.
7. Provide appropriate standard setting, accountability and monitoring and evaluation of the mental health services in Guyana.

The WHO AIMS for Guyana was conducted in 2008 and was an initiative of the Ministry of Health's Department of Chronic Disease. The main barriers in using the tool were a lack of information due to the scattered system of collecting data. Data was easy accessible at central level meaning information collected by the national mental health hospital as well as the Georgetown Public Hospital Cooperation (GPHC) was available. But it was difficult to get the information if collected by other stakeholders in mental health.
The Ministry of Health as the initiator was responsible for the implementation of the findings. As a result of the awareness that came with the WHO AIMS the Ministry started the process of developing a strategic framework for mental health. Stakeholders met in different meetings and they produced the National Mental Health Strategy. While the areas of action after the WHO AIMS were very specific, the areas in the National mental Health strategy were broader and more organized in a certain framework.

Table 3: Comparison of the WHO AIMS and the NMHS.

Areas of action (WHO AIMS)	Priority areas (NMHS)
	1. Management and Governance
Development of community-based mental health care services	2. Package of Comprehensive Mental Health Services
Development of a suicide prevention strategy for Guyana	3. Mental Health Advocacy, Promotion, Prevention and Rehabilitation Programs and Services
	4. Human Resources Training
	5. Essential Drug procurement and Distribution
Development of a functional plan for the National Psychiatric Hospital that promotes the deinstitutionalization of mental health care and the recovery of persons with mental illness.	6. Quality Improvement
	7. Collaboration and Partnership
	8. Strategic Information, including surveillance and Information System
Revision of the current mental health legislation of Guyana to meet international and PAHO/WHO standards	9. Legal Framework and Human Rights
	10. Financing

Source: Herman Jintie, 2011
In comparing the areas of action from the WHO AIMS with the priority Areas of the NMHS, the latter is more attention for specific issues within their mental health system.

It was agreed by the Ministry of Health and the stakeholders that a financial plan was added to the strategy. This was needed so the Ministry could know what the financial consequences were and also potential donor could easily buy into the plan.

Some of the improvements in mental health in this NMHS are (9):

1. **Management and governance**
- A mental health unit was established at the Ministry of Health, responsible for the development, implementation, M&E, planning, standard setting, training and budget input.
2. **Comprehensive package of mental health services**
- A comprehensive Package of Mental Health Services (with the WHO *MH*gap as the minimum) was defined and implemented as part of the Comprehensive Package of Publicly Guaranteed Health Care Services
  Some community-based mental health services were developed and implemented.A patient ward within Georgetown General Hospital Inc. was developed and created, but it was burned down. Only a few beds is being held at the hospital for psyche patient at this time.
3. **Mental Health Advocacy, Promotion, Prevention and Rehabilitation**
- A national mental health awareness (mental health literacy), mental health promotion and anti-stigma and anti-discrimination programs were developed and implemented.
- A National Suicide Prevention Strategy was developed and implemented.
- A national multi-sector, public sector/civil society capacity was built to develop and implement a coordinated alcohol and substance abuse prevention and rehabilitation programs
4. **Human resources and training**
- No improvement was made concerning human resources development and training in mental health.
5. **Essential Drug Procurement and Distribution**
- The supply of essential psychotropic compounds was enhanced and national guidelines for their clinical use were established
6. **Quality Improvement**
- Discussions were started to develop and implement quality improvement mechanisms for mental health care.

7. **Collaboration and partnership**
- Continuous efforts were made to build the PAHO/WHO partnership to provide technical support and to promote technical collaboration between CARICOM countries and countries of the Region
- Advocacy for stronger CARICOM collaboration in mental health within the framework of the CCHIII was executed
- The initiatives with Dalhousie University to coordinate a collaboration with international institutions, such as MacMaster University, George Washington University and agencies, such as SAMSA to support the development of mental health programs in Guyana has been continued.
8. **Strategic Information, including surveillance and Information System**
- The development of an appropriate surveillance system to track mental health problems and mental health disorders, including substance abuse and suicide is still a challenge
- The development of a monitoring and evaluation strategy for the National Mental Health Policy and Plan is still in planning.

- The development and implementation of an appropriate health information systems that will support clinical care and provide essential mental health data for planning and quality assurance purposes at all levels of the health care system is not yet being accomplished.

9. Legislative Framework and Human Rights

- The revision of the current mental health legislation of Guyana to meet international and PAHO/WHO standards is in process.

10. Financing

- The mobilization of financial resources in order to provide more and better quality mental health services is still challenging.

In the domains where there were improvements as well as in domains where there were no improvements, the most important and critical issues were:

1. Suicide; despite of the many initiatives and policy on this matter, the suicide rates are still increasing.
2. The care of the homeless; the numbers of the homeless people are still rising despite of the activities of governmental as nongovernmental organizations.
3. Drugs and other substance abuse; despite of the attention and actions concerning the use and misuse of drugs and alcohol nationally, the numbers are still increasing.
4. Revision and update of the essential drug list and availability of psychotropic drugs at all levels. Because of the costs of psychotropic drugs the essential drugs list was not revised and updated yet. Also it is still challenging to have psychotropic drugs available at all levels.
5. Human resources in mental health. Because of the exodus of health workers it is still challenging for the government to have enough mental health workers available.

Table 4: World Health Organization steps for development of a mental health policy taken in Guyana

WHO steps	Steps taken in Guyana	
1. Assess population needs	Yes	
2. Gather evidence for effective policy	Yes	
3. Consultation and negotiation	Yes	
4. Exchange with other countries	Yes	
5. Set out the vision, values, principles and objectives	Yes	
6. Determine areas of action	Yes	
7. Identify major roles and responsibilities of different stakeholders	Yes	
8. Conduct pilot projects	Yes	

Source: Herman Jintie

Guyana has boldly taken all the steps into consideration when they developed their mental health policy and plan.

4.2 Barbados

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information and format the report on the mental health system in Barbados. The overall goal of collecting, analyzing, and discussing this information was to provide an objective, evidence-based assessment of the country's mental health system. Barbados gained political independence from the United Kingdom in 1966. It's bi-cameral Parliament consists of a Senate and a House of Assembly. The Queen, the head of state, is represented by the governor-general. In 2007, the population of Barbados was estimated at 269,000 persons. The country is divided into 11 parishes. The Ministry of Health is responsible for the population's health. The country's level of taxation ensures the availability of government-funded public services. As such, Barbadian nationals have easy access to a comprehensive government-funded health care system which offers preventive and curative services.

The Mental Health Policy and the draft Mental Health Reform Plan are dated 2004. In addition, there is a draft Minimum Standards of Care protocol to serve as a regulatory tool for the treatment and rehabilitation of persons with substance abuse problems. There is a proposed Manual on Disaster Preparedness dated 2001. The Mental Health Act is dated 1985 and is enshrined in Chapter 45 of the Laws of Barbados.

In 2007, approximately 7% of the national health budget was directed towards the Psychiatric Hospital. There were additional expenditures on mental health services but these could not be quantified since they were integrated with the budgets for the Queen Elizabeth Hospital (for operation of the community inpatient unit) and the Barbados Drug Services (for the purchase of psychotropic medicines). No data is available to estimate the extent of use and out-of-pocket spending on private mental health services. The population has free access to essential psychotropic medicines of each therapeutic class (anti-psychotic, anti-depressant, mood stabilizer, anxiolytic, and anti-epileptic medicines). Health regulations authorize primary health care physicians to prescribe and/or continue prescription of psychotropic medicines.

The Senior Consultant Psychiatrist is the technical officer providing leadership, collaborating with the Ministry of Health on matters relating to policy and development in the area of mental health. No human rights review body exists and none of the mental health service delivery facilities has had an external human rights review. None of the human resources in mental health received training in the set of basic human rights for the protection of patient with mental disorders.

In keeping with the National Mental Health Policy of Barbados, the process of integrating mental health care with primary health care has started with the provision of community based services within the polyclinics and the general hospital. These services are delivered through once-weekly clinics in 8 polyclinics, 3 satellite clinics and the prison; the outpatient psychiatric clinic at the Queen Elizabeth Hospital is held twice weekly; the Psychiatric Hospital held mental health clinics six days per week. There are no physician based primary health care clinics. There is a day-treatment program for children with severe developmental challenges. Two community residential facilities (half-way houses) exist for persons with mental disorders. In addition, there are two facilities for persons with substance abuse and drug addiction problems.

There is an 8-bed community based psychiatric inpatient unit at the Queen Elizabeth Hospital and a 537-bed Psychiatric Hospital. No beds are reserved for children and adolescents. The Psychiatric Hospital reserves 80 beds for forensic patients. In 2007, 12 patients remained in the

Psychiatric Hospital at Her Majesty's Pleasure. At the end of December 2006, there were 508 patients in the Psychiatric Hospital.
In terms of monitoring and research, there are no national or institutional-based reports on mental health. There is no national mental health information system and no formal mechanism for the annual reporting of mental health data. Consequently, an accurate profile, including age, sex, and diagnoses of *all* users of public and private mental health services in 2007, was unavailable. The available data for 2007 indicate that the majority of patients discharged from the Psychiatric Hospital carried a diagnosis of schizophrenia and related disorders (39%) and mental and behavior disorders due to psychotropic substance abuse (29%) (10).
In 2007, 212 persons worked in public mental health facilities and private practice. There were 4.08 psychiatrists per 100,000 populations. None of the primary health care physicians, nurses, or non-doctor/non-nurse primary health care workers received a least two day refresher training in any aspect of mental health/psychiatry.
There are no user/consumer or family associations. There is no coordinating body to oversee public education and awareness campaigns on mental health and mental disorders. The National Council on Substance Abuse coordinates activities related to substance abuse and drug addiction. Persons are eligible to receive social welfare benefits due to a mental or physical disorder; the number of persons receiving social welfare benefits solely due to a mental disorder was unavailable since the data was not disaggregated to reflect this distinction. Formal collaborative programs to address the needs of people with mental disorders exist between the agency responsible for mental health and other health and non-health agencies. No provisions are in place to employ persons with severe mental disorders through activities outside the mental health facility (10).

The next steps towards a reform of the mental health system in Barbados after the WHO AIMS was used had three priority areas: 1) formal appointment of a mental health coordinator at the level of the Ministry of health; 2) development of an integrated mental health information system; and 3) revision of the Mental Health Act of 1985.
The WHO AIMS for Barbados was published in 2009 based on the data of 2007 and was an initiative of the Ministry of Health in collaboration with PAHO/WHO. The main barrier in using the tool was the availability of information due to the lack of an existing information system. Data was easy accessible at central level meaning information collected by the national psychiatric hospital was available. But it was difficult to get the information if collected by other stakeholders in mental health.
The Ministry of Health and PAHO/WHO were the initiators but the Ministry of Health was responsible for the implementation of the findings (10).

Evaluation of steps that should be taken to strengthening the mental health system in Barbados is shown in the following table:

Table 5: Next steps for strengthening the mental health system in Barbados

DOMAIN	NEXT STEPS IN STRENGTHENING THE MENTAL HEALTH SYSTEM	STATUS 2011
Policy and Legislation	• Complete the process to amend the Mental Health Act • Develop the Minimum Standards of Care for mental health institutions • Prepare a user-friendly version of the Mental Health Policy • Review and finalize the draft Mental Health Reform Plan to include time-lines • Continue work on the Minimum Standards for Substance Abuse units	• Still in process • Not yet started • Not yet accomplished • Not accomplished • Accomplished
Mental Health Services	• Continue the process to integrate mental health with primary health care • Strengthen and improve the services offered through the community mental health clinics • Continue the evaluation of existing services for substance abuse units (half-way houses and approved homes) to assess efficiency of services and make recommendations for improvement • Revise programs and plans to de-institutionalize long stay patients through the Alternate Care of the Elderly program offered by the Ministry of Health.	• Partly accomplished • Partly accomplished • Accomplished • Partly accomplished
Mental Health in Primary Health Care	• Develop treatment protocols for primary health care clinics • Train mental health workers in the basic set of human rights for the protection of persons with mental illness	• Not accomplished • Not accomplished
Human Resources	• Appoint formally a mental health coordinator in the Ministry of Health • Increase the number of psychiatric social workers • Increase the number of human resources in mental health to manage outpatient mental health clinics • Develop a mobile mental health team	• Accomplished • Not accomplished • Not accomplished • Accomplished

	for management of emergencies and home visits.	
Public Education and Links with Other Sectors	• Formalize relationships with stakeholders in the health and non-health sectors	• Partly accomplished

Of the three priority areas as mentioned in the WHO AIMS only one was fully accomplished after three years. The established mental health commission has succeeded in the formalization of a mental health focal person. The establishment of a mental health information system could not be accomplished, due to a lack of cooperation and financial constraints. The content of a mental health system should be well understood. At the time of the survey a significant amount of energy was directed towards the drafting of new mental health legislation. The old act of 1985 which had to be revised could not be, because the draft had to be presented as a document with comments. The regulation prohibited to draft legislation by others than formally designated drafters. These drafters will use the comments that will be presented by the mental health focal persons after consultation with stakeholders. One of the areas that needed improvements was the development of a mental health information system that fits into the national health information system. This has also not been accomplished. The steps that were stated to strengthen the mental health system were not fully accomplished because of:

1. Lack of consensus and commitment from all stakeholders;
2. Too high expectations for mental health in general and the existing human resources that has to execute the desired goals in particular;
3. Lack of financial resources to implement the all steps that were agreed on;

Table 6: World Health Organization steps for development of a mental health policy taken in Barbados

WHO steps	Steps taken in Barbados	
1. Assess population needs	Yes	
2. Gather evidence for effective policy	Yes	
3. Consultation and negotiation	To some extent	
4. Exchange with other countries	To some extent	
5. Set out the vision, values, principles and objectives	Yes	
6. Determine areas of action	Yes	
7. Identify major roles and responsibilities of different stakeholders	To some extent	
8. Conduct pilot projects	No	

Source: Herman Jintie

In the process of developing the mental health policy the steps consultation and negotiation, exchange with other countries and identifying of major roles and responsibilities of different stakeholders were not fully explored due to no interest from the stakeholders side and no perseverance from the side of the government.

4.3 Trinidad & Tobago

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in the Republic of Trinidad and Tobago for the year 2007. The goal for collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This will enable Trinidad and Tobago to develop information-based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.
There is a mental health policy/plan (Cabinet approved 2000 mental health policy/plan) and an emergency/disaster preparedness plan for mental health. Mental health services are not covered by social insurance. There is a human rights review body in the country and issues related to the human rights protection of mentally ill people are addressed regularly (11).

The Ministry of Health of Trinidad and Tobago is the mental health authority body in the country. Thirty-one outpatient mental health facilities treat 27.8 users per 100,000 general population. Day treatment facilities treat 1.8 users per 100,000 general population. There are 2 community-based psychiatric inpatient units in the country for a total 0.001 beds per 100,000 population. None of these beds in community-based inpatients units are reserved for children and adolescents. There is one mental hospital (MHs) in the country for a total of 68 beds per 100,000 population. The patients admitted to the mental hospital belong primarily to schizophrenia, schizophreniform and delusional disorders (45 %).
Violations of human rights are not practiced in this mental hospital. Less females access health care in this institution. 100% of mental health facilities had at least one free psychotropic medicine of each therapeutic class available in the facility.
Primary health care staff receives little training in mental health and interaction with mental health services is rare.
There are 45 human resources working in mental health for 100,000 population. Rates are particularly low for social workers and clinical psychologists. There are 4 occupational therapists working in mental health. Most psychiatrists work for the government in the facilities. There is an uneven distribution of human resources in favor of the mental hospital and the capital city. Decentralization of the services are slowly been taken up by the Regional Health Authorities. Consumer and family associations in mental health are in their initial stages.
There is no coordinating body to oversee publication and awareness campaigns in the field of mental health. Legislation provisions for employment and housing exist, but are not enforced. There is formal interaction between mental health service and departments/agencies responsible for HIV/AIDS, reproductive health, substance abuse, military and criminal justice.
Data are collected and complied by facilities to a variable extent. Facilities produce internal reports based on the information, but no official report has been published and distributed by the government based on these data or internal reports. Limited number of the research carried out in the country focused on non-epidemiological clinical/questionnaires assessments of mental disorders, services research, psychosocial interventions/psychotherapeutic interventions, and pharmacological interventions (11).

Table 7: Considering the WHO-AIMS data and the context given by the situations, areas for action were:

Domain	Action	Accomplished
1	• Enactment of a Mental Health Policy for the country, Trinidad and Tobago at the earliest opportunity.	No
	• Updating of the 1975 legislation.	No
2	• Accelerate the decentralization of care from the main hospital (MHs) to more community/residential facilities.	No
3	• A vigorous Primary Health Care Training Programme for Health Care Professionals and supporting staff in Mental Health. This could be short term, medium term and long term.	No
4	• Increase the number of "school psychologists" in our primary and secondary schools.	No
5	• Facilitate family associations.	No
6	• Encourage external monitoring of facilities by experts in mental health.	No
	• Further training to be encouraged in Data entry – Medical Records – to the pervade entire system	No
	• Networking with the Community Care Department, which facilitates Community residences for chronic patients. Placement of these patients/clients would then become more smooth	No

Trinidad & Tobago has not taken any action after the use of the WHO AIMS to tackle their mental health system.

Table 8: World Health Organization steps for development of a mental health policy taken in Trinidad & Tobago

WHO steps	Steps taken in Trinidad & Tobago	
1. Assess population needs	Yes	
2. Gather evidence for effective policy	Yes	
3. Consultation and negotiation	Yes	
4. Exchange with other countries	In some extent	
5. Set out the vision, values, principles and objectives	Yes	
6. Determine areas of action	Yes	
7. Identify major roles and responsibilities of different stakeholders	Yes	
8. Conduct pilot projects	Yes	

Source: Herman Jintie

Of the actions that were mentioned in the WHO AIMS only a few were accomplished after four years. The key factor meaning having a mental health focal person in the Ministry of Health was

seriously under pressure. He not only had mental health as his responsibility, but took also care of chronic disease as well as public health and new projects within the ministry. The Ministry was not able to secure a mental health coordinator. This has resulted in an overburdened official who could not focus on mental health with its challenges.
One of the big issues was the enactment of the mental health policy and the updating of the legislation. These important issues were not accomplished as well as all the other actions that were mentioned in the WHO AIMS.

These actions that were stated to strengthen the mental health system were not fully accomplished because of:

1. Lack of focus of the ministry of health and its overloaded mental health coordinator;
2. Too high expectations for mental health in general and the existing human resources that has to execute the desired goals in particular;
3. Lack of public awareness concerning mental health in general and support of the public in decentralizing psychiatric health;
4. Lack of competencies of primary health worker in dealing with mental health issues at a local level;
5. Lack of political support in restructuring the mental health system;
6. A high stigma within the system as well as outside of the system;

5.0 Pathway of developing a Mental Health Policy and plan for in Suriname

The Government of Suriname is committed to protecting and improving the health of its people. As society changes, so do health needs. The Ministry of Health of Suriname recognizes the challenges that require upstream policy responses. The new National Mental Health Plan for 2012 – 2015 provides the required vision and direction for the development and management of all aspects of mental health over the next five years.

Suriname is striving to protect, promote, maintain and improve the health of the people. WHO refers to mental health as a broad array of activities directly or indirectly related to the mental well-being component included in the WHO's definition of health: "A state of complete physical, mental and social well-being, and not merely the absence of disease". Health is related to the promotion of well-being, the prevention of mental disorders, and the treatment, rehabilitation and care of people affected by mental disorders.

The Ministry of Health is striving in 2015 to have a greater focus and investment in improving mental health while continuing to treat mental disorders effectively, paying particular attention to reducing the existing treatment gap.

The components of this Mental Health Plan were developed under the direction of the Ministry of Health (MOH) and the Psychiatric Centrum Suriname (PCS), in collaboration with the Pan-American Health Organization/World Health Organization (PAHO/WHO) and other partners.

The development of the Mental Health Plan for Suriname began during 2009, after the implementation of the World Health Organization-Assessment Instrument for Mental Health Systems (WHO-AIMS). National level consultations began during the same year, with a workshop that included the participation of a large number of stakeholders: representatives from Ministry of Health, Ministry of Social Affairs, Ministry of Justice and Police, Ministry of Defense, General Hospital, Primary Health Care institutes, Bureau of the Homeless, Bureau of public health, health insurance companies, and different faith and non-faith based NGOs involved with substance abuse. This workshop aimed to identify components to develop a plan of action and identify gaps and priorities for implementing an integrated approach for mental health.

Among the relevant issues identified during the workshop were legislation and human rights, distribution and training of human resources, quality improvement of psychiatric services, intersectoral collaboration, psychotropic drug procurement and distribution, promotion, prevention, treatment and rehabilitation, and financing. Three strategic priority areas (with respective key activities) have been emphasized as the main ones driving the reform process. These are the areas detailed below in the action plan for 2012 – 2014:

- decentralization of psychiatric care,
- integration of mental health into primary health care and
- strengthening the mental health information system.

Three more workshops were held within a time frame of a year to finalize the plan with the cooperation of the same stakeholders. The participants worked on the specific activities connected to the objectives that were developed.

These priorities are currently part of the Ministry of Health, National Health Sector Plan 2011-2018.

Right after these workshops the ministry of health supported by the Pan American Health Organization (PAHO) initiated a consultation with a much bigger group of stakeholders, known as the Paranam exercise. The consultation process was facilitated jointly by a team consisting of Ministry of Health and Pan-American Health Organization technical staff. The first consultation workshop took place in January 23rd-24th, 2011 in Paranam, Suriname. It provided input for the development of the Health Sector Plan, with the participation of all the stakeholders of the sector through structured discussions and exercises.

First, a joint SWOT analysis (a strategic planning method used to evaluate the Strengths, Weaknesses, Opportunities, and Threats involved) was executed whereby key stakeholders and actors in the health sector worked together to identify the strengths, weaknesses, opportunities and threats that the health sector currently faces. This open process allowed and encouraged inter-disciplinary dialogue and cooperation, strengthening the scope of the SWOT for the health sector in Suriname.

Using group work and discussion forums, 'problem trees' were created to illustrate a cause and effect relationship, and ultimately identify the root causes of each issue identified in the previous exercise. The problem trees were then converted to 'objective trees' as a means to coordinate the strategic response to the identified issues. These tools will be further used to inform and support the final drafting of the strategic agenda of the National Health Sector Plan and have also been used for the National Mental Health Plan.

The results of the exercises mentioned above reconfirm the appropriateness of the earlier identified priorities.

A wide spread representation of organizations were part during the developing process. Governmental and nongovernmental organizations that were represented are: Ministries of Health, Social Affairs and housing, Finance and planning, Bureau for Public Health, Psychiatric Hospital, Primary Health Institutions, General and Rural Hospitals, Consumers and family members Organizations, Substance Abuse and Rehabilitation Organizations, National and International Health Agencies, Health Insurance Companies, Home for the Elderly and College of Nursing.

5.1 Demographic and health data

Table 7: Basic Data on Geography, Population, Economic Sectors and Forms of Government

Location	Northern South America, bordering the North Atlantic Ocean, between French Guiana, Brazil and Guyana	
Area and topography	163,820 sq km mostly rolling hills; narrow coastal plain with swamps	
Population (total)	524.143 (ABS, mid-year 2009)	
Population 0-19	198.028 (ABS, 2009)	
Population per sq. km	3.2	
Life expectancy	69.9 years (71.9/67.7 f/m)	
Climate	Tropical; moderated by trade winds; two rainy seasons; and two dry seasons	
Main towns	Paramaribo (capital), Nieuw-Nickerie, Albina,	
Ethnic groups	Hindustani – 27.4% Creole – 17.7% Maroon – 14.7% Javanese – 14.6% Mixed – 12.5%	Indigenous – 3.7% Chinese – 1.8% White – 0.8% other – 0.5% unknown – 6.6% (ABS, Census 2004)
Religions	Christian – 40.7% Hindu – 19.9% Islam – 13.5% Other – 10.2% Unknown – 15.7% (ABS, Census 2004)	
Languages	Dutch (official), Sranan Tongo (Surinamese), Sarnami (a dialect of Hindi), Javanese, Chinese, Portuguese, English and a number of Maroon and indigenous languages	
Form of government	Constitutional democracy	

Suriname is in full demographic transition, with moderate birth and death rates, decreasing fertility rates, increasing life span, and moderate-to-low natural growth. The mid-year population in 2009 was 524,143 and the overall 2007 life expectancy at birth was 71.9 years for females and 67.7 years for males(11). In 2008, the crude death rate was 8 per 1,000 and the crude birth rate was 19 per 1,000. The 2007 average total fertility rate was 2.4 births per woman. The population annual growth rate was 1.3% in 2009 (up from 1.2% for 2006-2008).

In addition to urbanization and aging, in-country migration is another important trend in shaping the demographic dynamics and the population structure, particularly the segment under 30 years of age.

Suriname is composed of the following predominant groups: Hindustani (East Indians; 27.4% of the population); Creoles (17.7%); Maroons (descendents of runaway slaves from Africa; 14.7%); Indonesians (principally Javanese; 14.6%); Amerindians (3.7%); Chinese (1.8%); Mixed (12.5%); Others (7.6%) (11).

With 90% of the country covered in Amazon rainforest, settlement patterns have split the society into urban, rural coastal and rural interior with disproportionate access to resources for the latter group due to remoteness. The Government has expressed interest in creating strategies aimed at developing the rural coastal and rural interior areas, enhancing the quantity and quality of basic services as well as the creation of employment opportunities.

5.2 The health system

The leadership and governance of the health sector is the responsibility of the Ministry of Health, which is tasked with health care policy design, legislation and adherence; implementation; supervision and surveillance; accessibility and availability of services throughout the country, including medicines and health products; and the general care of the population and the social security system.

The health system consists of subsystems (Regional Health Systems, Medical Mission, and private providers), with different modes of financing, membership, and delivery of health care services, with each subsystem specializing in different population segments, depending on geographic location, employment, income level, ability to pay, and social status.

According to the National Health Accounts 2006, the resources in the Health Sector came from the Ministry of Finance (37.5%), followed by private firms (34.1%), and household out-of-pocket expenditures (20%). According to these figures public expenditure needs to be increased to meet international standards in order to ensure an adequate supply of health services. High out-of-pocket payments mean that financial affects on households could lead to an increased risk of poverty.

The health care system is organized based on the principles and values of Primary Health Care (PHC), however there is wide spread acknowledgement of the need to address the epidemiological profile, extending the first level of the health system to protect and promote the health of defined communities and to address individual problems and public health at an early stage (11).

MOH is working towards a renewal of PHC, with an emphasis on increased outreach and strengthening the referral system through the ‘gatekeeper’ status of General Practitioners (GPs) and primary care workers that has earmarked the movement towards PHC. Also there is a push towards the empowerment of the front line PHC health workers to diagnose and treat patients in the early stages of disease as a measure of cost effectiveness and to address the burden of disease. Primary care or first point of consultation in the country is provided by the Medical

Mission Primary Health care Suriname (MZPHC) in the interior, Regional Health Services (RGD) in the rural coastal areas, and either Regional Health Services or General Practitioners (Huisarts) in the more densely populated urban region (Wanica, Nickerie and Paramaribo).

The Medical Mission Primary Health care Suriname (MZPHC) is comprised of a group of religious NGOs, funded by the government, who provide first-level care for residents of the rural interior living in traditional settings along the main rivers, many only reachable by river or small aircraft. The field of operation is the rural interior of Suriname including the districts Brokopondo, Sipaliwini and part of Para (See Map). The geographical working area of the Medical Mission stretches over a 130.000 square kilometres area populated by approximately 60,000 people in the hinterland (11).

The MZ runs 56 primary health clinics and health posts that provide an average of 60,000 patient-visits annually (3 visits per post per day). Six general practitioners supervise the clinics and health posts (an average of 9 clinics per GP). Three of these clinics function as Health Centers with beds: Marowijne - Stoelmanseiland Hospital (15 beds), Djoemoe Hospital (16 beds), and Health Centre Brownsweg (6 beds) (11).

The Regional Health Services (RGD) is a state foundation which offers health care via public primary care facilities that are staffed by general physicians and health practitioners who provide primary care services to residents of Suriname's coastal areas. Persons who are classified as "the poor and near-poor" by the Ministry of Social Affairs (SOZAVO) utilize the RGD services the most. State Health Insurance Foundation (SZF) enrolees also may choose an RGD doctor as their general practitioner (11).

RGD manages 43 Health Care Facilities with about 64 general practitioners working for them. Three of these health posts have beds: Coronie Hospital (8 beds), Commewijne – Health Centre Ellen (1 bed), and Health Centre Albina (9 beds) (11).

Private clinics operate mainly in the urban areas and are supported through private insurance schemes or out-of-pocket money (OOP). Most GPs in the country are in private practice. The GPs provide services to people who are covered by the SZF, Ministry of Social Affairs, Private Insurers, Private Companies or self-paying patients.

Five hospitals operate in the country, four in Paramaribo and one in Nickerie. One psychiatric hospital (PCS) operates in Paramaribo. The Lands Bedrijf Academisch Ziekenhuis (AZP), the academic hospital, is the only hospital in Paramaribo with an emergency department (SEH) in the hospital in Nickerie has and emergency department. The other hospitals offer basic specialist care, somewhat broader in dimension. Academisch Ziekenhuis (AZP) and the 'sLands Hospitaal (LH) are government hospitals and Diakonessen Ziekenhuis and Sint Vincentius Ziekenhuis (SVZ) are private hospitals.

The loss of skilled labor due to out-migration has been significant, with the Netherlands remaining the preferred destination. The external migration of skilled professionals is affecting several sectors of the society, particularly health and education, resulting in acute shortages of human resources and the deterioration of some public services.

The majority of health workers are mainly concentrated in the coastal urban areas, particularly in Paramaribo. The mix and distribution of human resources in the country is as follows:

- In primary care 64 general practitioners work for RGD in 43 clinics in the coastal area; 6 general practitioners work for MZ supervising 56 primary health clinics in the interior; and 191 private general practitioners work in 146 private clinics, most of them located in Paramaribo and Wanica. 140 medical specialists work in the hospitals. The distribution of human resources between urban and rural areas is disproportionate with 5 GPs per 10,000 people in the coastal areas and 1 GP per 10,000 in the interior (11).

- Approximately 83% of the registered nurses work in secondary care facilities located in the two main urban centers and the rest (28%) work in primary care, teaching, nursing homes, and public health. Only 1.4% of the nurses are employed by the Medical Mission in association with its primary care program in the interior.

5.3 Mental health needs of the population

Estimation of mental health needs in Suriname is very difficult, because of the lack of epidemiological data. As stated by the Minister of Health Dr. Celsius Waterberg in the mental health plan 2112-2016 the following issues were vital and challenging for the development of a mental health plan for Suriname; HIV/AIDS, TB, NCD's, suicide, homelessness, alcohol/drugs, domestic violence, gambling, traffic accidents and others. These issues were seen in conjunction with mental health in general. This means that mental health issues represent a significant public health challenge for Suriname. Also a significant increasing need for mental health services can be seen in the reports of the mental hospitals year evaluations 2006-2010.

The number of admissions to the mental hospital during the period 2006-2010 has been increasing constantly. This increased can be explained by the fact that there is more awareness in the population about mental health issues in general, in terms of considering mental health disorders as an illness that can be treated with appropriate care.

In 2010 there were 926 patients admitted at the hospital. The most common reason for admission was psychosis de-compensation (74% of patients admitted), followed by primary addiction (8.5%), mood disorders (5.3%) and suicide attempts (5.1%) (11).
Below (Figure 1) is a summary of the number of admissions to the mental hospital during the period 2006-2010.

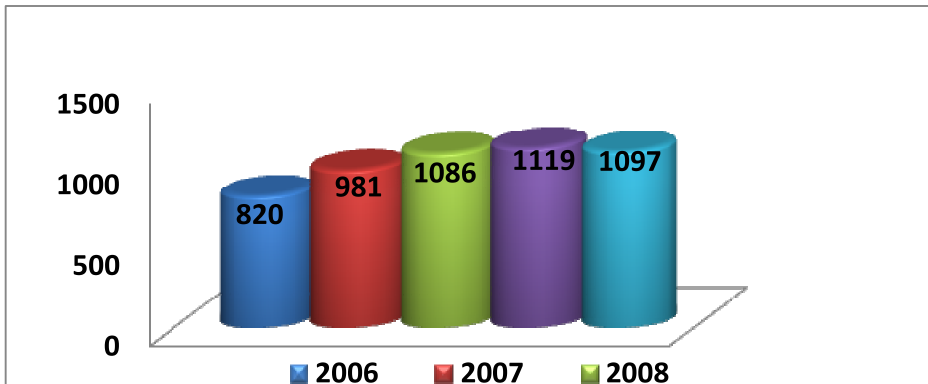

Figure 1: Amount of patients admitted in psychiatric hospital 2006 -2010. Source Psychiatric Hospital Annual Report 2010.

In terms of outpatient consultations, the information available is limited to the outpatient clinic located at the PCS, where in 2010 there were 14,244 outpatient visits (13).

Figure 2 below, shows the number of outpatient visits during the period 2006-2010

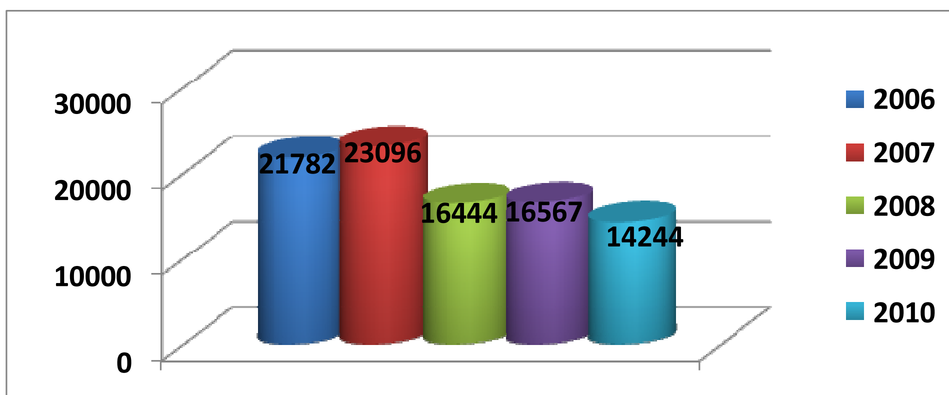

Figure 2. Number of outpatient visits from 2006-2010. Source Psychiatric Hospital, 2010.

Another important service offered by the PCS in recent years is the outreach clinic. The establishment of this service required a reorganization of the traditional modalities of work, by re-training its personnel (from assisting and treating patients in hospital to moving out of the premises, visiting patients at their homes), defining new working shifts, investing in transportation, etc. These visits take place mostly at patients' homes. The results of these efforts are promising, as shown in Figure 3, below.

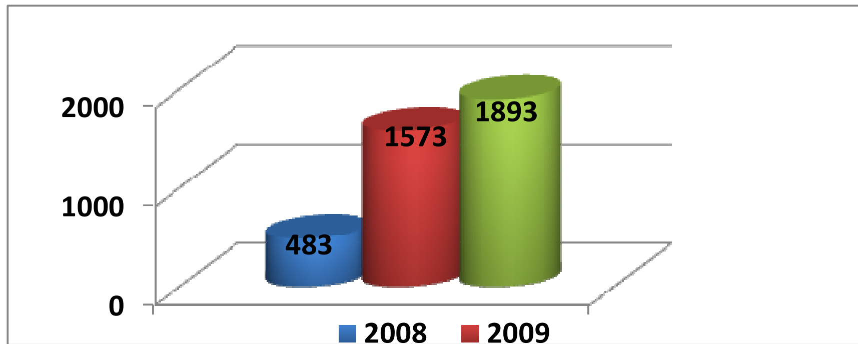

Figure 3. Number of outreach visits 2008-2010. Source Psychiatric Hospital, 2010.

The trend shown in Figure 3 above, implicates the beginning of the decentralization process already going on at PCS. Many of those home visits in 2010, for instance, have taken place in Nickerie, where the regular presence of a psychiatrist has been supplemented with the presence of a psychiatric nurse mainly in charge of home visits.

The decrease of the number of outpatient visits at the PCS can be explained by the establishment of similar services located in other premises: general hospitals (psychiatrists holds mental health clinics weekly) and Nickerie (psychiatrists visit on biweekly basis).

Unfortunately, there is no information regarding number of patients seen in these facilities.

The considerable increase of the outreach clinic activities is another explanation of smaller number of outpatient visits at the PCS.

Currently, people with addiction receive treatment in PCS as well as in different faith-based organizations. Although total numbers of people receiving treatment is not available, it is being considered by the society as a relevant problem that requires due attention.

In PCS, the number of people being treated for detoxification during the last three years is as follow: 80 persons were admitted in 2008; 85 were admitted in 2009 and 79 were admitted in 2010. The most common reason for these admissions is addictions (drugs and/or alcohol), followed by double diagnosis (addictions and psychiatric disorders) and addiction and trauma (13).

The increase in the number of suicides since 2000 (67) to more than doubled by 2009 (138), evidences another area of serious concern. By ethnic group, Hindustanis have the highest suicide rates of 66.2%, followed by Creoles 11.5% in 2008 and 72% and 10%, respectively in 2009 (14). Many suicides were intentional self-poisoning with pesticides (15). The number of suicides by sex is presented in Figure 4, below.

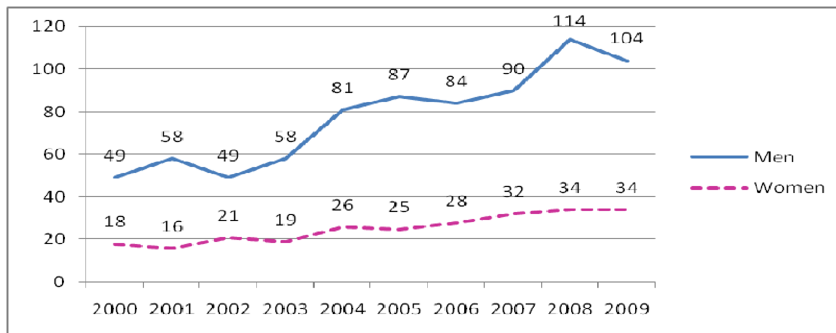

Figure 4: Suicides by sex 2000-2009. Source: Mortality Reports, BOG, 2010

The country's capacity to effectively address these problems requires renewed efforts to tackle the increased numbers of suicide.

6.0 Results

Using the steps for development of a mental health policy and the checklist for evaluating the mental health policy and plan in Suriname resulted in the following findings.

6.1 WHO Checklist for evaluating the mental health policy and plan

The mental health plan for Suriname has been finalized at the end of 2011 and ready to be launched. Looking at the process that has been followed, the following analysis can be made.

Table 9: World Health Organization steps for development of a mental health policy in Suriname

WHO steps	Steps taken in Suriname	
1. Assess population needs	Yes	
2. Gather evidence for effective policy	Yes	
3. Consultation and negotiation	Yes	
4. Exchange with other countries	Yes	
5. Set out the vision, values, principles and objectives	Yes	
6. Determine areas of action	Yes	
7. Identify major roles and responsibilities of different stakeholders	Yes	
8. Conduct pilot projects	Yes	

Source: Herman Jintie

From all the steps that were mentioned in the WHO checklist for the steps to be taken in developing a policy for a country only two of them were not fully visible during the process as describe in the chapter preceding. It was not really necessary to assess the population needs, because the Ministry of Health used the existing data from the mental health institutions PCS and BOG. The Ministry of Health already has set out its vision, mission, principles and objectives in its general health strategic policy document; it was not needed to repeat this.

Table 10: WHO checklist (1)

WHO CHECKLIST FOR EVALUATING A MENTAL HEALTH PLAN	
1 = yes/ to great degree/ 2 = to some extent / 3 = no/not at all/ 4 = unknown	
Process issues	
1a. Was there a high-level mandate to develop the plan (e.g. from the Minister of Health)?	1
1b. At what level has the plan been officially approved and adopted (e.g. the Department of Mental Health, Ministry of Health, Cabinet, Minister of Health)?	1
2. Does the plan include strategies and activities that are consistent with an existing and up-to-date policy?	1
3. If no policy is available, does the plan include strategies and activities that are consistent with another official document(s) stating the direction(s) for mental health? Please provide relevant document(s).	1
4. Are strategies and activities written in a way that commits the governments (e.g. do they state “will” instead of “should”)?	1

5. Has the plan been informed by: – a situation analysis? and/or – a needs assessment?	1
6. Have effective strategies that have been utilized within the country and in other countries with similar cultural and demographic patterns been examined and integrated where necessary?	1
7. Has a thorough consultation process taken place with the following groups: – representatives from the health sector, for example, including planning, pharmaceutical, human resource development, child health, HIV/AIDS, epidemiology and surveillance, epidemic and disaster preparedness divisions? – representatives from the Finance Ministry? – representatives from the Social Welfare and Housing Ministry? – representatives from the criminal justice system? – consumers or their representatives? – family members or their representatives? – other nongovernmental organizations? – private sector? – any other key stakeholder groups? If so, please list them.	1 1 1 1 1 1 1 1 1

Table 11: WHO checklist (2)

WHO CHECKLIST FOR EVALUATING A MENTAL HEALTH PLAN	
1 = yes/ to great degree/ 2 = to some extent / 3 = no/not at all/ 4 = unknown	
Operational issues	
8. Have comprehensive strategies been identified for each priority area for action?	1
Looking at strategies:	
9. *Time frames:* – are time frames provided for each strategy? – are the time frames reasonable and feasible?	 1 1
10. *Indicators:* – are there indicators for each strategy? – if so, are the indicators appropriate for measuring the particular strategy?	 1 1
11. *Targets:* – are there targets for each strategy? – if so, are the targets realistic?	 1 1
Looking at activities:	
12. Are clear activities defined for each strategy?	1
13. Is the person/group/organization responsible for each activity identified?	1
14. Is it clear when each activity will start and finish?	3
15. Are the outputs for each activity outlined?	3
16. Have potential obstacles been identified?	3
17. Costs and funding: – have the costs for achieving each activity been calculated? – is the funding for each activity available and allocated?	 3 3

Table 12: WHO Checklist (3)

WHO CHECKLIST FOR EVALUATING A MENTAL HEALTH PLAN
1 = yes/ to great degree/ 2 = to some extent / 3 = no/not at all/ 4 = unknown

Content issues	
18. Does the plan include relevant strategies and activities for coordination and management? (a) Are the composition and functions clearly defined for: – the mental health coordinating body? – the mental health focal point? (b) Is an adequate infrastructure in place/planned (including computers, Internet access and administrative support)? (c) Are regular meetings of the coordinating body scheduled? (d) Has a system of reporting to a high-level ministry of health official been set up for the mental health coordinating body? (e) Are coordination and management strategies and associated activities: – relevant? – evidence-based? – realistic and possible to implement? – adequately funded?	3 3 3 3 3 3 3 3 3 3
19. Does the plan include relevant strategies and activities for financing? (a) Is it clear how services will be funded? (b) Is the plan clear as to whether/how user charges will be made? (c) Are financing strategies and associated activities: – relevant? – evidence-based? – realistic and possible to implement? – adequately funded? 20. Does the plan include relevant strategies and activities for legislation and/or regulations on human rights? (a) Where legislation and/or regulations are to be developed, have clear strategies/activities been specified for: – the process of drafting the law(s)/regulations? – defining the content of the law(s)/regulations? – implementing the law(s)/regulations? (b) Where a review body to protect human rights is to be established, are clear strategies/activities specified for its establishment? (c) Are there any other strategies to protect and promote the rights of people with mental disorders? (d) Are the strategies on human rights and legislation and associated activities: – relevant? – evidence-based? – realistic and possible to implement? – adequately funded?	3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3
21. Does the plan include relevant strategies and activities for organization of services? (a) Are there strategies and associated activities for the provision of services at primary, secondary and tertiary levels, with continuity between them? (b) Are there strategies and associated activities for deinstitutionalization? (c) Are there strategies and associated activities for developing community mental health services? (d) Has provision been made for psychosocial rehabilitation services at all levels of the health system? (e) Are the strategies on organization of services and associated activities: – relevant? – evidence-based? – realistic and possible to implement? – adequately funded?	1 3 1 1 2 1 1 1 1
22. Does the plan include relevant strategies and activities for promotion, prevention, and rehabilitation? (a) Are there clear strategies and associated activities for the promotion of mental health?	3 3

(b) Are there clear strategies and associated activities for the prevention of mental disorders? (c) Are the strategies on prevention, promotion and rehabilitation and associated activities: – relevant? – evidence-based? – realistic and possible to implement? – adequately funded?	 3 3 3 3 3
23. Does the plan include relevant strategies and activities for the procurement and distribution of essential medicines? (a) If psychotropic medicines currently are not included on the Essential Drugs List, is there a strategy and associated activities to include them? (b) Does the plan incorporate strategies and associated activities to improve reliability of the supply and distribution system at relevant levels of health service where treatment is to be provided? (c) Are there strategies and relevant activities for monitoring the continuous provision and assessment of psychotropic medicines? (d) Are the strategies on the procurement and distribution of medicines and associated activities: – relevant? – evidence-based? – realistic and possible to implement? – adequately funded?	3 - 3 3 3 3 3 3
24. Does the plan include relevant strategies and activities for advocacy? (a) Is there a strategy with associated activities to support (technically and/or in practical terms) consumer groups, family groups and nongovernmental organizations? (b) Is there a strategy and associated activities to involve consumers and family representatives in policy and service planning? (c) Are the advocacy strategy and associated activities: – relevant? – evidence-based? – realistic and possible to implement? – adequately funded?	3 3 3 3 3 3 3
25. Does the plan include relevant strategies and activities for quality improvement? (a) Is there a strategy and associated activities for assessing quality? (b) Is there a strategy and associated activities for ongoing quality control of mental health facilities (e.g. standards)? (c) Is there a strategy and associated activities for accrediting facilities based on quality? (d) Are both hospital and community mental health facilities included in quality assessment? (e) Are the strategies on quality improvement and associated activities: – relevant? – evidence-based? – realistic and possible to implement? – adequately funded?	3 3 3 3 3 3 3 3 3
26. Does the plan include relevant strategies and activities for information systems? (a) Have a strategy and linked activities been defined for: – reviewing the current mental health information system, and/or – improving the current mental health information system? (b) Does the strategy or linked activities include the systematic collection of mental health data from a range of sources at different levels of the health system (e.g. general hospitals, primary health care, and community levels)? (c) Is it clear how the information will feedback into: – policy development, mental health planning and service delivery? – clinical practice? (d) Are the strategies on information systems and associated activities: – relevant? – evidence-based? – realistic and possible to implement?	1 1 1 1 3 3 1 1 1

– adequately funded?	1
27. Does the plan include relevant strategies and activities for human resources development and training? (a) Is there a well-defined strategy with associated activities for assessing available personnel and competencies at different service levels? (b) Is there a strategy to improve the number of providers for mental health? (c) Are there relevant management strategies and activities to address: – recruitment? – retention? – deployment of staff? (d) Has provision been made for ongoing education, training and skills development? (e) Is there a strategy/relevant defined activities to introduce changes to undergraduate and graduate curricula of health and allied health workers? (f) Is there a strategy for training health providers to develop the appropriate competencies at the levels of: – informal community services? – primary health care services? – general hospital care? – specialist care? (g) Are the strategies on human resources and associated activities: – relevant? – evidence-based? – realistic and possible to implement? – adequately funded?	2 2 1 3 3 3 3 3 3 1 1 2 1 2 2 2
28. Does the plan include relevant strategies and activities for research and evaluation? (a) Are there strategies for improving capacity to conduct research and evaluation? (b) Will the research address practical issues for the country? (c) Has provision been made to evaluate the policy and plan? (d) Are research and evaluation strategies and defined activities: – relevant? – evidence-based? – realistic and possible to implement? – adequately funded?	2 2 1 3 1 2 1 2
29. Does the plan include relevant strategies and activities for intrasectoral collaboration? (a) Is a structure planned/in place through which intrasectoral collaboration could take place? (b) Is collaboration with the following departments within the health sector included in the plan: –planning? –pharmaceuticals? –human resource development? –child health? –HIV/AIDS? –epidemiology and surveillance? –epidemic and disaster preparedness divisions?	2 3 3 3 3 1 1 1 1
30. Does the plan include relevant strategies and activities for intersectoral collaboration? (a) Is a structure planned/in place through which intersectoral collaboration could take place? (b) Is collaboration with the following government departments included in the plan? – social services? – justice? – education? – housing? – corrections? – police?	2 3 1 3 3 3 3 3

6.2 Analysis of the main findings

The findings of this analysis conclude that developing and implementing mental health policy and plans as well as restructuring a mental health system in a country is a complex process. Countries with no baseline mental health information were recommended by the CCH to use the WHO AIMS. All the assessed countries have used this instrument as a starting point to develop their mental health system. During this process many factors have been considered and the needs of multiple stakeholders have been taken into account. The WHO also had the policy, plans and programmes modules available to assist countries in their struggle to make solid and balanced mental health policies, plans and programmes.
This analysis showed also that the recommended essential steps to be taken in developing a mental health policy, were considered.
Guyana being the country that is far more ahead in this process, can be seen as the example of how a country can use the WHO AIMS as a baseline study to implement changes in a mental health system. All the suggested steps were taken into consideration by Guyana in developing their mental health policy and plan. Trinidad & Tobago and Barbados, being the least to use the findings of the WHO AIMS, are still struggling with their mental health system. None of these two countries has significantly moved from the state they were in when the WHO AIMS was used.
Although Suriname has followed all the steps in developing their mental health policy document, looking at the content of this plan the following can be said.

6.2.1 Process issues

In 1999 as already stated the Ministry of Health has its first mental health plan. From time to time and at different level the need was mentioned to have a national plan for mental health which has to cover all topics i.g. suicide, homelessness, domestic violence, psychiatric disorders, etc.
In 2007 the WHO AIMS was used to gather information concerning mental health services. The Ministry of Health adopted this momentum to work on a mental health plan for the country. Stakeholders were already involved in the process, so it was not that difficult to get them on board. The Ministry of Health appointed a focal group consist of a representative from the Ministry, one from PAHO and one from the psychiatric hospital. These persons got the task to assist the Ministry in the development of a national plan and to advise in mental health issues. Even though there was mandate at the top level, this mandate was never formalized. It took two years to develop the plan. By the time it was ready to be published two of the members were not working for the Ministry anymore. This plan is officially been approved by the Ministry of Health.

Table 13: Main strengths and weaknesses of the process

Strengths	Weaknesses
The plan include strategies and activities that are consistent with an existing and up-to-date national health policy	
The strategies and activities are written in a way that commits the governments and stakeholders	
The plan been informed by a situation analysis done in conjunction with the PAHO.	

Because of the input and expertise of PAHO effective strategies that have been utilized within the country and in other countries with similar cultural and demographic patterns been examined and integrated where necessary.	
The consultation process has taken place with the following groups: – representatives from the health sector departments planning, child health, HIV/AIDS, epidemiology and surveillance, epidemic and disaster preparedness divisions. – representatives from the Finance Ministry – representatives from the Social Welfare and Housing Ministry – consumers or their representatives – family members or their representatives – other nongovernmental organizations	The following groups were not consulted: -representatives from the health sector departments pharmaceutical and human resource development -representatives from the criminal justice system -private sector

6.2.2 Operational issues

As mentioned above, the different consultation initiatives involving different stakeholders offered the opportunity to share information and produce deep discussion regarding the needs that the current mental health system situation presents. The result was agreement on the three priority strategic areas of action for a two years plan that should be implemented in order to advance a needed reform process.

1. Decentralization of psychiatric care
   The psychiatric hospital is situated as stated, in the coastal area, in the capital city with a population of approximately 250,000. The city is easy accessible for those who live in this area, but for those living in the interior, the hospital can only be reached by boat or air. As a consequence many persons suffering from mental disorders remain untreated. Especially in the east, west and south, basic mental health treatment facilities must be developed. The agreed objectives and activities here were stated as follow:

    a. Establish cooperation among key stakeholders: MOH (PCS, NZR, SNB), Regional Health services, Medical Mission and other community based organizations.
    b. Inventory of infrastructure
    c. Reorganizing and reallocating mental health Human Resources & Services
    d. Human resources training

2. Integration of mental health in primary care
   The primary health care system is organized and evenly distributed throughout the country. There are primary health care policlinics in the coastal area as well as in the interior. These clinics provide basic healthcare.

   The agreed objectives and activities here were:

    a. Training PHC staff in management and treatment of specific MH disorders

b. Development of guidelines and protocols for primary care staff concerning their role in mental health care
c. Organization of supervision and referral system
d. Availability and accessibility of essential psychotropic medication at PHC facilities

3. Strengthening the mental health information system
   Data collection, monitoring and evaluation are key components of the mental health system that need to be reinforced. Other sections of this report present some data that is available mainly at the PCS level, with limited national comprehensive information regarding mental health issues. National detailed information on the population needs (and existing resources) would allow an evidence-based approach to answer those needs. The agreed objectives and activities here were:
   a. Development of forms for data collection
   b. Integration of mental health into the health information system
   c. Developing evaluation and monitoring systems at central level
   d. Promotion of mental health research

Table 14: Main strengths and weaknesses of operational issues

Strengths	Weaknesses
Comprehensive strategies have been identified for each priority area for action	It is not clear when the activities will start or finish because the planning was made for two years and the activities were planned for the first or second year
The strategies have timeframes provided for each strategy which are reasonable and feasible.	Potential obstacles have not been identified
For each strategy there are appropriate indicators for measuring the particular strategy	Costs and funding: – the costs for achieving each activity have not been calculated – the funding for each activity is not specifically available and allocated
Each strategy has realistic targets	
There are clear activities defined for each strategy	
Each activity has a identified organization or group responsible for the implementation	
The output for each activity was outlined	

6.2.3 Content issues

As stated before, the Ministry of Health did not formally install a mental health coordinating body. Even though it was stated in the plan that a critical success factor is an existing coordinating unit or a mental health focal person at the Ministry of Health, nothing was done to have that supporting system in place. There is someone who is advising the Ministry concerning mental health issues but it was never formalized. So, the plan does not include strategies and activities for coordination and management. Also there are no strategies and activities to finance or fund the plan as well as none for legislations and regulations on rights of people with mental disorders.
Other strengths and weaknesses on the content of the plan are as followed:

Table 15: Main strengths and weaknesses of content issues

Strengths	Weaknesses
The plan includes relevant strategies and activities for organization of services at primary and secondary level	No strategies on tertiary level with no continuity between primary, secondary and tertiary level
The strategies on organization of services and associated activities are: – relevant – evidence-based – realistic and possible to implement – adequately funded	There are no strategies for deinstitutionalization, developing community mental health services, psycho social rehabilitation services at all levels of the health system
The plan include relevant strategies and activities for information systems. The strategy and linked activities been defined for: – reviewing the current mental health information system, and/or – improving the current mental health information system The strategy or linked activities include the systematic collection of mental health data from a range of sources at different levels of the health system, from general hospitals, primary health care The strategies on information systems and associated activities are: – relevant – evidence-based – realistic and possible to implement – adequately funded	The plan does not include strategies and activities for promotion, prevention and rehabilitation
The plan include some relevant strategies and activities for human resources development and training namely a strategy to improve the number of providers for mental health, strategy for training health providers to develop the appropriate competencies at the levels of: – primary health care services – specialist care	The plan does not fully include relevant strategies and activities for the procurement and distribution of essential medicines
The plan includes relevant strategies and activities for research and evaluation that are for improving capacity to conduct research and evaluation. The research addresses practical issues for the country.	The plan does not include relevant strategies and activities for advocacy
The plan includes relevant strategies and activities for intrasectoral collaboration. The following departments within the health sector are included in the plan: –planning –human resource development –child health –HIV/AIDS –epidemiology and surveillance –epidemic and disaster preparedness divisions	The plan does not include relevant strategies and activities for quality improvement
	It is not clear how the information will feedback into: – policy development, mental health planning and service delivery – clinical practice
	The plan include not some relevant strategies and activities for human resources development and training

	namely no well-defined strategy with associated activities for assessing available personnel and competencies at different service levels, no management strategies and activities to address: – recruitment – retention – deployment of staff, No provision been made for ongoing education, training and skills development, no strategy for training health providers to develop the appropriate competencies at the levels of: – informal community services – general hospital care
	The following departments within the health sector are not included in the plan: –pharmaceuticals
	The following government departments are not included in the plan – social services – justice – education – housing – corrections – police

Doing this analysis for the mental health policy and plan for the Ministry of Health you're working for was not always easy, but challenging. Looking at other policies and plans in the region was even more challenging. The main facilitating factors in doing this analysis were:

- The fact that having a history of working in the Caribbean and knowing a lot of persons and officials has been a facilitating factor for making connections and having access to the health systems in the different countries,
- Doing the research by self has been facilitating also. Traveling to the different locations, seeing officials of ministries of health helped in finding the right information,
- Being a nurse and taking into consideration the basic procedures in making connection had helped to overcome,
- A cooperative Ministry of Health in Suriname and the mental health staff of the psychiatric hospital has also contributed to this analysis,
- A lot has been done concerning mental health in the region lately. Mental health has been on the Caricom agenda for the past few years. So, there is political will to move things ahead. This has worked in favor of this analysis.

The main barriers were:

- The low numbers and few types of workers who are trained and supervised in mental health care. These persons are scarce and overburdened. Making an appointment with them was not easy.

- The frequent scarcity of visionary leadership in mental health. Leadership is most of the time aged and burned-out. Young and driven leadership is very scarce.

- Resistance to invest in mental health and redirecting of resources especially financial and human resources. Governments do not always put the money where their mouths are.

- Population-wide sensitization of the importance of mental health policy development means substantially more attention from politicians, healthcare leadership, health planners and health advocacy. Mobilization and recognition of these formal and non-formal resources in the country is still absent.

7.0 Discussion and conclusion

The specific circumstances of developing and implementing mental health policy and plans may vary enormously from one country to another.
The use of the WHO Assessment instrument for Mental Health Systems (WHO-AIMS) has helped the countries surveyed to analyze their mental health situation. The showcase of the strengths but also the weaknesses of the system have nevertheless resulted in an awareness of the importance and need of restructuring of mental health systems at least with those who used the instrument.
Nevertheless, this showcase and steps for strengthening of the system that were recommended, were not enough to trigger policy makers, mental hospitals and others to react. The proposed developments within and outside of the system were very challenging, but there was more needed. Guyana, Barbados, Suriname and Trinidad & Tobago, four (4) countries in the Caribbean region, have their own characteristics, but the similarities in the development of mental health are assumed to be more important, making comparisons of interest. Trinidad & Tobago and Barbados for instance did not move farther than the action plan following the WHO AIMS. There where intentions to move ahead but many factors were responsible for not being able to restructure the mental health system.
It is important to note that the fewer resources a country has, the greater its need to develop and implement policies, plans and programs. However, countries with fewer resources frequently do not follow an explicit plan, either because no plan has been formulated or updated, or simply an existing plan has not been implemented (17).
Bringing developments and changes in the mental health situation of a country needs more that an analysis of the actual state. It need advocacy and awareness of first those who are in the system and secondly those who are outside of the system. It needs also partnership and in most cases financial support. Most governments are still not sensitive enough for change in mental health and mental health systems in their respective countries.
Instruments like the WHO AIMS and the module policy, plans and programmes can be used whenever a government decides to develop mental health services in a country. Although there are guidelines this analysis shows that governments are not fully using these instruments and guidelines. Successfully improving of health systems and services for mental health is combining theoretical concepts, expert knowledge and cooperation of many stakeholders.

Governments are also not convinced enough of building a sufficient and competent mental health workforce in their countries to deliver the desired services to their populations (1).
One of the main findings is that the appointment of a **mental health coordinating unit** at the Ministry of Health is crucial for the development of mental health in a country. A mental health focal person is not enough. The example of Guyana is there. Trinidad & Tobago as well as Barbados has a focal person, but nothing major has been done. Suriname at the other hand has one coordinating body, although not formalized, and it has been able to move things ahead. This coordinating body needs political support to bring major changes in mental health. Politicians, governments, non public sector as well as the general public must admit that developing or restructuring a mental health system needs cooperation and coordination at the highest level. The coordinating unit must have clear tasks and responsibilities as well as financial support from the government. There must be an allocated budget directed to this body, so they can operate and

move things ahead. For Guyana, it is still to be considering having a mental health coordinator per region or district, because of the population density and the remoteness of the country.

Developing a mental health policy and plan for a country needs more than sitting behind a desk and put the desired activities on paper. It is clear that the government and even those who are outside the governing systems must be aware that **mental health is everyone's business and responsibility**. Each and everyone needs to demonstrate the centrality of mental health in their community and must be willing to tackle issues as stigma and discrimination (1). For each country, therefore, it is necessary to take the prevailing conditions in consideration. Much remains to be done to effectively meet the mental health needs of children, adolescents, adults, and the growing number of older adults in the region (18). It is therefore recommended that in the process of developing a mental health policy and plan at all levels, stakeholders must partake, so health needs of all will be met. Governmental agencies, non governmental agencies, community based organizations, consumers associations, family members as well as the private sector must be involved. In Suriname the Ministry of Health made efforts to have them all on board, but missed some. Guyana has successfully involved all stakeholders. It is still a challenge for countries to have and keep all stakeholders on board during the whole process.

Implementing the steps as presented in the module policies, plans and programmes may be a slow process requiring the mobilization of **political will**. It may take five to ten years before outcomes are achieved in the population (1). The whole process nevertheless is producing positive mental health outcomes. Indeed, Guyana, four years after the launching of their strategic mental health plan, have not moved that far as expected, but developments are taking place.

The professionals in charge of policy, plans and programmes will have to **develop several skills**. Definitely skills in the areas of epidemiology, management, planning, budgeting, negotiation and lobbying will be developed. The process requires moving between theory and practice, while interacting with real people and their circumstances (1). That's why it is crucial that persons responsible for this process work close with all stakeholders, taking their needs into consideration and try to translate that in clear objectives. In Guyana as well as in Suriname responsible persons at the Ministry of Health have taken their time to go through the process thoroughly, attracting and consulting stakeholders to cooperate.

Furthermore, in many countries **mental health legislation** does not meet international standards and is grossly inadequate (18). This is also a fact in the assessed countries, but only Guyana has plans to change that. Even Suriname did not pay attention to this issue in their plan.

It is not unusual for **other sectors** to set different priorities and not to visualize mental health as relevant to their work. The situation is exacerbated by insufficient knowledge and the stigma associated with mental disorders which occur in most societies. Professionals in ministries of health should frequently meet professionals from other ministries. In Guyana as well as in Suriname it was a hard pull to have these sectors on board. It was important to know their priorities and to find common ground on mental health policy. Stakeholders involvement as well as the empowerment and enactment of legislation on human rights and mental health rights is still a big challenge.

It is common knowledge that improving of mental health must be accompanied by the availability of **financial and human resources**. The available resources are as insufficient as they are inequitably distributed (18). Taking therefore into account the financial and human resources for mental health available in Suriname and Guyana it is obvious that there is a lot to be done. It is clear that government as well as donors must put the money where their mouths are. If not, policies and plans will have to be kept in cabinets and be used to upgrade the mental health status of their populations.

In this new century, the region needs to embrace an ambitious reform agenda focused on expanding access to **the continuum of mental health services**, including promotion, prevention, and rehabilitation, with a special emphasis on the most vulnerable populations (18). It is therefore recommended that a mental health policy and plan should be one document tackling all aspects of mental health of a community. It is recommended that in one document the vision, the mission, values and principles, priority areas of actions and the strategic lines are outlined. The Ministry of Health from Suriname has different documents in which the policies and plans are formulated. There is a separate document for HIV/AIDS, homelessness, domestic violence, suicide, NCD's and mental health from the scope of the psychiatric hospital. Guyana has such a policy and plan. Most of the plans from the Surinamese government have no financial chapter attached. Guyana's has a budget attached to its plan. This is useful for financing purposes for governments as well as for potential donors.

Another important target of reform efforts is **improvement of the quality of mental health care** (18). Suriname did not include quality improvement in its plan. It is therefore recommended that improvement of the quality of mental health care is included in the national mental health plan.

Drawing upon the literature reviewed, by own accumulated experience as a mental health advisor at the Ministry of Health Suriname and being exposed to different mental health systems in the Caribbean and over the world, I have recognized a series of commonly occurring challenges and obstacles to develop mental health policy and plans. At the same time I have identified related steps and solutions which may work in responding positively and effectively to barriers that were stated in this analysis. I therefore recommend that ministries of health that are interested in planning and implementing mental health systems and policy give careful consideration to anticipating the challenges identified here, and to learning the lessons we in this part of the world have learned so far.

Appendixes

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2. Questionnaire

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Additional readings

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Definitions

Mental health policy / An organized set of values, principles, objectives and areas for action to improve the mental health of a population.

Mental health plan / A detailed preformulated scheme for implementing strategies for the promotion of mental health, the prevention of mental disorders, and treatment and rehabilitation.

Mental health stakeholders / Persons and organizations with some interest in improving the mental health of a population. They include people with mental disorders, family members, professionals, policy-makers, funders and other interested parties.