ORIGINAL ARTICLES

Mental Health Policy and Service System Development in the English-speaking Caribbean

WD Abel, D Kestel, D Eldemire-Shearer, C Sewell, P Whitehorne-Smith

ABSTRACT

The countries and territories comprising the English-speaking Caribbean (ESC) have made some strides in the development of mental health policy, services and systems with the expenditure in mental health as a percentage of health budgets ranging from 1% to 7%. The ESC countries have well developed primary healthcare systems. However, mental health legislations in many countries are in need of reform. Some countries have developed an innovative community based, secondary care treatment model: treatment in the medical wards of general hospitals. These countries have made progress in integrating mental health into primary healthcare and have made psychotropic medication widely available at the primary care level. Notwithstanding the progress in some countries, greater effort is required in phasing out mental hospitals and integrating mental health into primary care in other ESC countries.

Keywords: Caribbean, mental health, mental health policy

Políticas para la Salud Mental y Desarrollo de Sistemas de Servicio en el Caribe Anglófono

WD Abel, D Kestel, D Eldemire-Shearer, C Sewell, P Whitehorne-Smith

RESUMEN

Los países y territorios que comprenden el Caribe Anglófono (CAF) han dado pasos extraordinarios en relación con el desarrollo de políticas, servicios y sistemas de salud mental, de modo tal que los gastos en salud mental en término del porcentaje de presupuestos de salud fluctúan entre el 1% y el 7%. Los países del CAF poseen sistemas de atención primaria de la salud bien desarrollados. Sin embargo, las legislaciones con respecto a la salud mental en muchos países necesitan reformas. Algunos países han desarrollado un modelo innovador comunitario para tratamientos de atención secundaria: tratamiento en las salas de los hospitales generales. Estos países han tenido progresos en cuanto a integrar la salud mental a la atención primaria de la salud, y han puesto la medicación psicotrópica ampliamente a la disposición del nivel de atención primaria. A pesar del progreso en algunos países, se requiere un mayor esfuerzo en cuanto a reducir gradualmente los hospitales psiquiátricos y acelerar la integración de la atención a la salud mental con la atención primaria en otros países anglófonos.

Palabras claves: Caribeño, salud mental, políticas de atención a la salud mental

West Indian Med J 2012; 61 (5): 475

From: Department of Community Health and Psychiatry, The University of the West Indies, Kingston 7, Jamaica.

Correspondence: Dr WD Abel, Department of Community Health and Psychiatry, The University of the West Indies, Kingston 7, Jamaica. E-mail: wendelabel@hotmail.com

INTRODUCTION

Mental health burden high, but gap wide

The Global Burden of Disease Report states that mental and neurological disorders account for 14% of the global burden of disease (1). Despite this huge burden, there exists a large treatment gap (the percentage of those who need treatment who actually do not receive treatment) which in Latin America and the Caribbean is estimated to be 58.9% for depression, 64% for bipolar disorder, 63% for anxiety disorder and 71.4% for alcohol related disorders (2).

Bridging the gap

In 2001, The World Health Organization (WHO) made several recommendations for the development of mental health services, particularly in low and middle-income countries (LAMICs) including those in the Caribbean, where large treatment gaps in mental health exist. These recommendations include: formulation of policies, programmes and legislation; provision of treatment in primary care, the availability of psychotropic medication, the involvement of families and consumers, link with other sectors and research in mental health (3).

In 2008, the WHO rolled out the Mental Health Gap Action Programme (mhGAP), a package of comprehensive interventions designed to scale up and improve mental health, particularly in LAMICs (4). Accordingly, the Pan American Health Organization (PAHO) refocussed its efforts to scale up mental health services in Latin America and the Caribbean (5). In 2009, PAHO's Directing Council, composed of Ministers of Health from the entire region, approved a strategy and plan of action on mental health, identifying specific, strategic areas for action.

The English-speaking Caribbean

The Caribbean comprises countries belonging to four language groups: English, Spanish, French and Dutch. The countries or territories of the English-speaking Caribbean (ESC) consist of 15 island states and two continental countries (Belize and Guyana) which share a common historical, geopolitical and sociodemographic context. These countries are predominantly small states with population ranging from 5000 (Montserrat) to the two largest, Trinidad and Tobago and Jamaica, with populations of 1 328 000 and 2 660 000 million, respectively. They were colonized by several metropolitan powers, Britain being the last, have inherited a system of government based on the Westminster style of government and a public sector fashioned on the British bureaucracy. Many institutions and legislative patterns have evolved out of the British colonial structures. The majority of these countries have achieved independence but some of them still exist as British Overseas Territories.

These countries are making the demographic transition with approximately 30% of the population under the age of 14 years and the over 60-year age group is growing disproportionately at a fast rate (5). This transition has implications for mental health service development. These countries of the ESC face unique challenges relating to their small size, such as limited capacity for diversification, isolation, economic volatility, limited economies of scales and higher per capita costs of public services which ultimately may limit their capacity to provide specialized health services such as mental health care (6). Notwithstanding these challenges, the countries of the ESC have developed mental health policies, systems and programmes over the past fifty years to address the treatment gap and reduce the burden associated with mental disorders.

In this paper, we assessed the status of mental health services and system development in the ESC. We extracted data on mental health policy, service and systems from the country profiles published by WHO-Assessment Instrument for Mental Health (WHO-AIMS) which is used to evaluate mental health services and systems (7–9). Fifteen countries and territories in the ESC completed the WHO-AIMS, of these, three are listed as upper income (Antigua and Barbuda, Barbados and Trinidad and Tobago), the majority is listed as middle-income and one country, Guyana, is listed as low-income. The Bahamas and the Cayman Islands did not complete WHO-AIMS and are not included in this analysis.

In addition, we conducted a desk review and an Internet search was also done on Medline using PubMed to review other data sources such as service utilization data, peer reviewed journals and data published by regional and international organizations.

Policy development in the English-speaking Caribbean

The formulation and implementation of a comprehensive mental health policy is critical to the development of mental health services and systems. A good policy framework provides a mechanism through which countries define the vision for mental health, establish priorities and plans and coordinate all programmes and services in order to improve mental health and reduce the burden. Globally, 40% of countries have no mental health policy and 30% of countries have no mental health programmes (10).

The first coordinated attempt to streamline mental health policy in the Caribbean occurred in 1973 at the Fifth Conference of Health Ministers held in Dominica in which recommendations were made to revise legislation, to integrate mental health into general healthcare, to establish acute units in general hospitals and to develop drug and alcohol programmes (11).

In 1990, PAHO convened a mental health conference in Caracas, Venezuela, to address mental health policy in Latin America and the Caribbean and although the ESC was not formally represented, the recommendations (The Caracas Declaration) have influenced the development of mental health policies in the Caribbean (12).

Table 1: Mental health statistics for the English-speaking Caribbean: finances, capacity, support and awareness

Mental Health Statistics for the Caribbean English-speaking Caribbean Countries															
DESCRIPTION	**Anguilla**	**Antigua and Barbuda**	**Barbados**	**Belize**	**BVI**	**Dominica**	**Grenada**	**Guyana**	**Jamaica**	**Montserrat**	**St Kitts and Nevis**	**St Lucia**	**St V&G**	**TCI**	**T&T**
Population (in 2009) in thousands	13.6	85.9	269	301	27.5	71.2	107.4	750	2660.7	4.8	44	167	100	33.2	1328
Total expenditure															
on health (% GDP)*	4.2	2.9	5.7	1.9	3.5	3.8	3.2	5.6	2.2	7.1	2.1	3.6	3.7	3.5	2.4
(% health budget)	4%	UN	7%	2%	3%	3%	5%	1%	10%	2%	1%	4%	5%	4%	5%
Training in MH Care															
Psychiatrist	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No	Yes
Nurses	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Medication															
Psychotropic Medication	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Access to Psychotropic Medication	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Associations–MH															
Consumer Family Association	No	No	No	15	No	No	No	No	Yes	No	No	No	No	No	No
Public Health Awareness															
Campaigns	Yes	Yes	No	No	No	No	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes

Data in this table were taken from the WHO AIMS Report; *Data from PAHO Basic Indicators 2009 (28).
BVI – British Virgin Islands; St V&G – St Vincent and the Grenadines; TCI – Turks and Caicos Islands;
T&T – Trinidad and Tobago; UN – unknown

Current mental health policies

Globally, 51–69% of LAMICs report the existence of a mental health policy, compared with 71% of high income countries (10).

Of the fifteen countries and territories in the ESC profiled in the WHO-AIMS, eight (57%) countries have developed mental health policies and in three of these the policies exist in a draft form. These policies have focussed on mental healthcare in the community, the treatment of the mentally ill in general hospitals and the provision of psychotropic drugs. Consistent with LAMICs, in general, the level of implementation of policy is low in these countries.

Mental health legislation

Legislation is a key component in driving policy and should be incorporated into the policy framework. The majority of these countries inherited legislations from the British colonial government and the existing legislation in the majority of the countries is over 50 years old and in need of revision. These findings are similar to that in LAMICs in which mental health legislations are outdated and do not adequately address modern methods of treatment and human rights issues (10).

Expenditure on mental health

In order to reduce the large burden and treatment gap associated with mental disorders, there must be adequate financing of mental health. A dedicated mental health budget determines the extent to which a country can effectively implement and sustain mental health policies, programmes and services.

Worldwide, the majority of countries spend less than 1% of health budget on mental health (10, 13). Researchers have noted a correlation between the economic status of the country and expenditure on mental health, with the expenditure being highest in high-income (6.8%) and middle-income (5.1%) countries, but lowest (1%) in low-income countries worldwide (10, 14).

The average expenditure on mental health as a percentage of health budgets among ESC countries is 3.7% with a range of 1–6%. Five of the countries report expenditure within the range recommended by WHO (9).

The expenditure in countries listed as high income is Antigua and Barbuda (4%), Barbados (7%) and Trinidad and Tobago (4%). Jamaica, which is listed as middle-income, reports an expenditure of 6%. The expenditure in mental health is an approximation, as in many countries mental health exists as part of the general healthcare system and

Table 2: Mental health statistics for the English-speaking Caribbean: policy, systems and infrastructure

	Mental Health Statistics for the Caribbean English-speaking Caribbean Countries														
DESCRIPTION	**Anguilla**	**Antigua and Barbuda**	**Barbados**	**Belize**	**BVI**	**Dominica**	**Grenada**	**Guyana**	**Jamaica**	**Montserrat**	**St Kitts and Nevis**	**St Lucia**	**St V&G**	**TCI**	**T&T**
Legislation/Policy/Plan															
Mental Health Policy	Yes	No	Yes	Yes	No	No	Yes	Yes	Yes	No	No	Yes	No	Yes	Yes
Mental Health/ Disaster Awareness Plan	No	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes
Mental Health Legislation	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Human Rights Policies	No	No	No	Yes	No	No	No	Yes	Yes	No	No	No	No	Yes	Yes
Financing of MH Services															
MH Expenditure (% of health budget)	UN	4%	7%	2%	3%	3%	5%	1%	6%	2%	5%	4%	5%	5%	4%
Healthcare System Cost	F	F	F	A	F	F	F	F	F	F	F	F	F	F	F
Medication Cost	F	F	F	F	F	F	F	F	A	F	F	F	F	F	F
Organization of MH Services															
Mental Health Authority	Yes	No	No	No	Yes	No	No	Yes	Yes	No	No	Yes	No	No	No
Mental Health Director	No	No	No	No	No	No	No	Yes	Yes	No	No	No	No	No	No
Primary Healthcare Centres	No	29	14	Yes	10	yes	Yes	Yes	Yes	No	Yes	UN	Yes	7	Yes
Mental Health Unit	No	No	No	Yes	No	No	No	Yes	Yes	No	No	No	NO	Yes	No
Mental Health Facilities															
Mental Health Outpatient Facilities	No	No	11	8	No	No	No	2	139	5	No	9	No	11	31
Community Based Residential Facilities	No	2	2	No	No	No	No	No	13	No	No	No	No	No	8
Mental Hospitals	No	1	1	1	No	No	1	1	1	No	1	1	1	No	1
Beds															
No. of Beds in Mental Hospitals (per 10 000)	No	17	22	No	No	No	15	2.5	4	No	No	5	16	No	8.1

Most data in this table were taken from the WHO-AIMS Report.

BVI – British Virgin Islands; St V&G – St Vincent and the Grenadines; TCI – Turks and Caicos Islands; T&T – Trinidad and Tobago; MH – mental health; UN – unknown; F – free; A – aided

except for salaries, it is very difficult to disaggregate the figures and give an exact figure for mental health expenditure.

Mental health services

Among the factors limiting the development of mental health services are lack of political will, inequitable distribution of resources and a lack of human resources (15). The key components of good community services include inpatient care, outpatient services, mobile outreach teams, long term residential and occupational rehabilitation services (16).

The literature strongly suggests that an adequate balance of community-based and hospital-based services offers the most comprehensive range of mental health services (17).

Mental hospitals

About 80% of mental health beds in low and middle-income countries are in mental hospitals (17) despite the fact that mental hospitals are outdated institutions, are associated with higher costs of care compared to community treatment, human rights violations and run contrary to the principle that persons should be treated as close as possible to their families

in the community. Factors contributing to their existence are bureaucratic inertia, resistance to phasing out mental hospitals and a lack of understanding of the primary care integration process (18).

Nine of the 15 countries profiled report the existence of a mental hospital. Previous research has shown that over 66% of their population was chronic, homeless patients who require supervised housing (8).

The number of mental hospital beds per 10 000 population ranges from 22/10 000 (Barbados) to 2.5/10 000 (Guyana). The Bahamas, which did not complete the WHO-AIMS, has five beds per 10 000. In Barbados and Trinidad and Tobago, which are ranked as high-income countries, the mental health services are highly centralized around large mental hospitals.

Two countries have achieved varying degrees of success in phasing out the mental hospital. Belize phased out its mental hospital in 2008 (19). In Jamaica, there has been a 50% reduction in the population of the mental hospital over the past 50 years as a result of systematic implementation of community mental health services (20).

Community-based care is the most effective strategy for treating persons with mental disorders; there is obviously a need to decrease the number of beds in mental hospitals in the ESC and shift the care to community-based secondary care and community facilities.

Treatment in the medical ward of general hospitals

The treatment of patients in the open medical ward is an innovative, secondary care level community mental health service which has evolved as a common practice in the ESC (21). Studies done in Jamaica indicate that the outcome of patients treated in the open medical ward is far superior to those treated in acute psychiatric units and mental hospitals (22). Several factors have contributed to the evolution of this model of care in open medical wards. Firstly, the limitations imposed by the size and limited resources of many of these countries do not make the establishment of mental hospitals and discrete psychiatric units viable. Secondly, in the majority of countries, the practice grew out of an explicit policy decision and thirdly, The University of the West Indies has trained doctors and psychiatrist to work in primary care settings and to treat the mentally ill in the medical wards of general hospitals.

Integration of mental health into primary healthcare

The ESC region has a well-developed primary healthcare service. The provision of mental health care in the community and the integration with primary care is an effective strategy to make mental health available and accessible to a wide cross-section of the population (23).

In the country profiles, details on the type and quantum of service available in primary care was scant, we suspect partly because of the limitation of WHO-AIMS, but also due to a lack of understanding of the models of community mental health and the integration of mental health into primary care.

Eight of the countries profiled report having mental health outpatient facilities. Four countries report the existence of community-based residential facilities and a similar number of countries report the availability of day treatment facilities, the majority of which are based in mental hospitals.

Models of community-based service vary widely; in Jamaica, there is an integrated collaborative model of care (8). In Trinidad and Tobago, there is a large mental hospital and there is sectorization of services in some areas (24). Barbados has a large mental hospital and two community-based residential facilities.

Generally, in most countries where there is no mental hospital such as Belize, mental health services are co-located in primary care settings, often existing as a vertical service with relatively little integration with primary care; in these settings, primary care staff undertake limited mental health tasks. The relatively well-developed primary care infrastructure in the ESC provides an opportunity for integration of mental health into primary healthcare.

Services to vulnerable groups

Despite the demographic realities, vulnerable populations such as children, adolescents and the elderly are underserved. Similarly, the homeless population, persons with comorbid psychiatric disorders and persons who abuse drugs have low access to treatment.

Human resources in mental health

Limited human resources in mental health pose a major barrier to mental health service provision (18). The WHO reports that the median number of psychiatrists worldwide in low-income countries is 0.01 psychiatrist per 10 000 and in high-income countries it is 0.92 psychiatrist per 10 000 (9).

In the ESC, the number of psychiatrists per 10 000 in the population ranges from 0.06 (Belize) to 0.4 (Barbados). The smallest country, Montserrat, reports having a visiting psychiatrist (9). It is noteworthy that Belize, despite having the lowest number of psychiatrist per capita, was able to phase out the mental hospital and to develop community mental health services; this was achieved by investing in the training of community mental health nurses (18). Barbados and Trinidad and Tobago, which report 0.4 and 0.17 psychiatrist per 10 000, respectively – which fall within the high range for the region – do not have well-developed community mental health services and most of the psychiatrists in these countries work in the mental hospital. The number of psychologists, occupational therapists and social workers is low and greater effort is needed to train these categories of workers.

The role of regional training institutions

The University of the West Indies is a regional institution, established in 1948 with the primary objective to meet the training needs of the ESC. It is a multi-campus university with medical schools in Jamaica, Trinidad and Tobago, Barbados and The Bahamas.

Since its inception, The University of the West Indies has played a major role in the training of primary care physicians who are able to deliver services in small states with limited specialist medical services. The university medical undergraduate programme has incorporated the teaching of psychiatry and other behavioural disciplines into its curriculum. This exposes medical students to psychiatry in the emergency room, inpatient and community settings in order to ensure that they acquire the requisite knowledge and skill competencies to be able to detect and treat common mental disorders in a primary care setting (25). The University of the West Indies also has a postgraduate programme for training psychiatrists; the objective of this programme is to train psychiatrists to work in and meet the needs of the ESC.

The training of nurses

The training of nurses has also been critical to the delivery of mental health services in the ESC. Mental health is also incorporated into the undergraduate training programme of nurses. Most countries have specialized mental health nurses who work in the community. These nurses undertake several tasks including assessment of patients, treatment of patients in primary care settings, ambulatory services, medication monitoring and they are also engaged in mental health outreach activities and promotion. Additionally, in countries where there is no psychiatrist, they work closely with health personnel in primary and secondary care settings providing ongoing support and advice. The specialized nurses working in mental health have been noted to be a low cost high impact solution to the shortage of human resources in mental health in Jamaica (21). These nurses have played a critical role in the shifting of care to the community in most countries including Belize and Jamaica (19, 21).

Limited human resources result in inadequate mental healthcare. Greater emphasis needs to be placed on the training of specialized mental health nurses to provide mental healthcare, especially in the community, in the ESC. As indicated previously, these nurses are able to deliver a wide range of mental health services and are ideally suited to address the lack of human resources in mental health, especially in countries where there is a shortage of psychiatrists. In many countries, several barriers have limited the effectiveness of these nurses such as resistance to granting them prescription privileges and releasing them to work in the community.

The University of the West Indies has also played a critical role in the development of newer categories of healthworkers, the community health aides. These persons are considered to be critical gatekeepers of the health service and play a major role in the delivery of mental health services at the community level (26).

Refresher course

Continued training of healthcare workers is important to reinforce skills. Five countries report that they conduct refresher courses in mental healthcare for staff but the majority of countries do not have a programme for continuing training of staff (9).

Access to psychotropic drugs

The provision of psychotropic drugs at all levels of the health system is critical in reducing the treatment gap. All countries report that psychotropic medication is available and that patients have access to psychotropic medication. In most countries, these drugs are available free of cost and in Jamaica and Belize they are subsidized.

The involvement of consumers and families

Increasingly, consumers of mental health services are playing a greater role in mental health. They are involved in policy development, training, service design, evaluation and research (27). Only three countries in the ESC report the existence of consumer family associations. This is a reflection of the low activity levels among civil organizations and the high levels of stigma in regards to mental illness in these countries.

The role of the Pan American Health Organization

The Pan American Health Organization has played a catalytic role in mental health development in the region, contributing to placing mental health on the regional agenda; it provides technical cooperation in the region, assisting countries with policy development, legislative reform and capacity development. The Pan American Health Organization has assisted countries in the completion and monitoring of the WHO-AIMS. The Pan American Health Organization has been working actively in the area of mental health in emergencies, supporting countries of the region that are prone to natural disasters in order to strengthen their capacities to respond properly to future emergencies or disasters that they may face. The Pan American Health Organization/WHO has also actively undertaken initiatives to promote sharing and exchanging of experiences among countries in the region.

Regional collaboration in health

Countries of the ESC are part of the Caribbean Community (CARICOM) which is an economic grouping. There are several opportunities for cooperation in health. At the level of the Ministries of Health, the Chief Medical Officers meet every year and have endorsed a number of regional mental health strategies. Additionally, CARICOM and PAHO have independently and jointly facilitated a number of mental health policy initiatives. The University of the West Indies has supported several strategic initiatives; it has played a

leading role in the development of mental health policies in several countries and it has been involved in regional consultations and policy development and in-service training of health professionals to better function in primary healthcare.

CONCLUSION

Small size and limited capacity have impacted on the development and implementation of mental health policies and plans, services and systems in the ESC. Although great progress has been made in the development of mental health policy, services and systems, the level of policy implementation remains low and there is a need to scale up services for mental disorders.

Countries of the ESC need to urgently address the human rights issues in regards to the treatment and care of the mentally ill. Greater effort is needed to ensure that mental health legislation incorporates fundamental human rights principles and promotes and protects the human rights of persons with mental disorders. These countries should be guided by the Convention on the Rights of Persons with Disabilities and other principles enunciated in regional and international human rights instruments to ensure that legislations are compatible with modern mental health standards and regional and international human rights conventions.

There exists a well-developed primary healthcare system in most of these countries. This offers tremendous opportunity to develop an integrated community and home-based model of service delivery. Innovative programmes such as the treatment of the mentally ill in medical wards and the training of mental health nurses to deliver services have enabled these countries to expand care into the community despite the limited resources. However, greater effort is needed to phase out mental hospitals in countries where they exist and expand community mental health services.

One strategy that should be employed for the development of community mental health services is the integration of mental health into primary care. In order to facilitate this process, there needs to be greater sensitization of decision-makers and a determination of the best model suited to a particular country given the constraints of size and resources. Furthermore, the formulation of legislation should be done to facilitate treatment in the community, more attention should be focussed on the training of primary healthcare staff in mental health, task shifting in primary healthcare, the re-orientation of mental health staff to undertake a more collaborative role in primary healthcare, the development of treatment protocols to be used at the community level and the development of a home-based package of care.

Greater effort is also needed to engage consumers as they can play a role in advocacy and other areas of service delivery; mental health services to vulnerable people needs to be scaled up.

Regional partners provide a great opportunity for collaboration in the development of mental health services and greater effort is needed to involve them to provide technical support to countries.

REFERENCES

1. Murray CJL, Lopez AD. The global burden of disease: a comprehensive assessment of mortality and disability from diseases and injuries, and risk factors in 1990 and projected to 2020. Cambridge, Mass: Harvard University Press; 1996.
2. Kohn R, Saxena S, Levav I, Saraceno B. The treatment gap in mental health care. Bull World Health Organ 2004; **82:** 858–66.
3. World Health Organization. World health report 2001. Mental health: new understanding new hope. Geneva, Switzerland: World Health Organization; 2001.
4. World Health Organization. Mental Health Gap Programme. Scaling up care for mental, neurological and substance abuse disorders. Geneva: WHO; 2008. [Accessed July 3, 2012]. Available from: http:/www.who.int/mental_health/mhgap_final_english.pdf
5. Pan American Health Organization. Health in the Americas 2007 Regional Report. Washington DC: PAHO.
6. Medina Cas S, Ota R. Big government, high debt and fiscal adjustment in small states. IMF Working Paper 08/39. Washington, DC: International Monetary Fund; 2008. [Accessed July 3, 2012]. Available from: http://www.imf.org/external/pubs/ft/wp/2008/wp0839.pdf
7. Kestel D, Lazer L, Demf N, Sevberonf S, Lora A, Saxena S. Mental health system and services in Albania. Epidemiologia e Psychiatria Sociale 2006; **15:** 195–202.
8. Abel WD, Richards-Henry M, Wright EG, Eldemire-Shearer D. Integrating mental health into primary care: an integrative collaborative primary care model – the Jamaican experience. West Indian Med J 2011; **60:** 483–9.
9. World Health Organization. WHO–AIMS report on mental health systems in the Caribbean region. Geneva: WHO; 2011. [Accessed July 1, 2012)]. Available from: http://www.who.int/mental_health/evidence/mh_systems_caribbeans_en.pdf
10. Saxena S, Pratap S, Garrido M, Saraceno B. World Health Organization's mental health atlas 2005: implications for policy development. World Psychiatry 2006; **5:** 179–84.
11. Pan American Health Organization. Mental health policy framework for the Caribbean. Technical Report. Washington, DC: PAHO; 2007.
12. Levav I, Restrepo H, Guerra de Macedo C. The restructuring of psychiatric care in Latin America: a new policy for mental health services. Journal of Public Health Policy 1994; **15:** 71–85.
13. World Health Organization. Mental health atlas. Geneva, Switzerland: World Health Organization; 2005. [Accessed July 9, 2012]. Available from: http://www.who.int/mental_health/evidence/atlas/global_results.pdf
14. Jacob KS, Shoran P, Mira I, Cumber-Garrison M, Sedate S, Mari JJ et al. Mental health systems in counties: where are we now? Lancet 2007; **370:** 1061–77.
15. Chisholm D, Flisher AJ, Lund C, Patel V, Saxena S, Thornicroft G et al. Scale up services for mental disorders: a call for action. Lancet 2007; **6:** 1241–52.
16. Saxena S, Thornicroft G, Knapp M, Whiteford H. Resources for mental health: scarcity, inequity, and inefficiency. Lancet 2007; **370:** 878–89. Epub September 4, 2007. DOI: 10.1016/S0140-6736(07)61239-2.
17. McKenzie K, Patel V, Araya R. Learning from low income countries: mental health. BMJ 2004; **29:** 1138–40.
18. Sarceno B, van Ommeren M, Batniji R, Cohen A, Gureje O, Mahoney J et al. Barriers to improvement of mental health services in low-income and middle-income countries. Lancet 2007; **370 (Suppl 9593):** 1164–74. Epub September 4, 2007. DOI: 10.1016/S0140-6736(07)61263-X.
19. World Health Organization. Belize: prioritising mental health services in the community. Geneva: WHO; 2009. [Accessed July 9, 2012]. Available from: http://new.paho.org/hq/dmdocuments/2009/Belize-Country-Summary-March-2009.pdf
20. Abel W, Sewell C, Thompson E, Brown T. Mental health services in Jamaica: from institution to community. Ethnicity and Inequalities in

Health and Social Care 2012; **4:** 103–11. DOI: 10.1108/17570981111249248.
21. McKenzie K. Jamaica: community mental health services. In: Caldas de Almeida JM, Cohen A, eds. Innovative mental health programmes in Latin America and the Caribbean. Washington, DC: PAHO; 2008: 79–92. [Accessed July 5, 2012]. Available from: http://publications.paho.org/english/Jamaica_CD_183.pdf
22. Hickling FW, Abel W, Garner P, Rathborne J. Open general medical wards versus specialist psychiatric units for acute psychoses. Systematic Review. Cochrane Database Syst Rev 2007; CD003290. DOI: 10.1002/14651858.CD003290.pub2
23. Cohen A. The effectiveness of mental health services in primary care: the view from the developing world. Geneva: World Health Organization; 2001.
24. Caribbean Community. An assessment of the community mental health service in Jamaica and Trinidad and Tobago. Technical report. CARICOM; 2003.
25. Hickling FW, Morgan KA, Abel W, Denbow CE, Ali Z, Nicholson GD et al. A comparison of the objective structured clinical examination results across campuses of the University of the West Indies (2001 and 2002). West Indian Med J 2005; **54:** 139–43.
26. Garret EJ, Kumar AK, Standard KL. Approaches to primary healthcare in the Commonwealth Caribbean. Educ Med Salud 1981; **15:** 232–48.
27. Chamberlin J. User/consumer involvement in mental health service delivery. Epidemiol Psychiatr Soc 2005; **14:** 10–4.
28. Pan American Health Organization. Health situation in the Americas: Basic indicators 2009. Washington, DC: PAHO; 2009. [Accessed July 5, 2012]. Available from: http://new.paho.org/hq/dmdocuments/2009/BI_ENG_2009.pdf