# AUDITOR GENERAL'S DEPARTMENT
# PERFORMANCE AUDIT REPORT

## MINISTRY OF HEALTH (MOH)

## MANAGEMENT OF MENTAL HEALTH SERVICES

## REHABILITATION AND REINTEGRATION OF THE MENTALLY ILL

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The Department is headed by the Auditor General, Pamela Monroe Ellis, who submits her reports to the Speaker of the House of Representatives in accordance with Section 122 of the Constitution of Jamaica and Section 29 of the Financial and Administration and Audit Act.

This report was prepared by the Auditor General's Department of Jamaica for presentation to the House of Representatives.

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# Auditor General's Overview

The Bellevue Hospital (BVH) is the primary specialist mental health care institution in Jamaica and the largest of its type in the English speaking Caribbean. The operation of BVH is funded directly through the Ministry of Finance and resources are managed independently by its Board of Directors. The Government of Jamaica (GOJ) spent on average $1.2 billion each year, between 2010-11 and 2014-15, to fund the treatment and care of patients at BVH; however, most of the funding was spent on caring for patients who have been institutionalized at the Hospital for years. Jamaica is a signatory to the United Nations Convention on the Rights of Persons with Disabilities (CRPD). The Convention protocols recommend that persons with mental illness have the right to be treated in the least restrictive settings and the right to integration into normal communities. Deinstitutionalization of patients is widely supported by various studies and stakeholders, as it promotes a better quality of life and aids in the rehabilitation of those with mental disorders. The institutionalization of patients after they have been discharged could therefore be deemed as a violation of their rights.

As at February 2016, 673 patients institutionalized at BVH were considered stable and can be reintegrated into normal communities, to better facilitate their rehabilitation. However, these patients remained institutionalized although they were discharged from the Hospital. In 2006, Cabinet approved a Submission for the reform of Jamaica's mental health system. The reform plan included the relocation of patients from BVH to low cost community-based living facilities. This approach was successfully adopted by other countries and recognized as best practice. However, MOH did not develop a strategic plan with specific targets for the implementation of the reform and the associated costs. International Convention requires that persons with mental illness should be protected against any form of inhumane treatment and discrimination. However, in the case of MOH the mechanisms to allow for independent monitoring of patients in mental health care facilities as well as the investigation of complaints from patients and their relatives were not functioning as intended. Also, MOH could not demonstrate that data collected on mental health diagnosis was effectively utilized in the management of mental health services and the promotion of awareness.

The recommendations made in this report aim to address the issues highlighted and MOH should seriously consider these for implementation. I wish to express my sincere thanks to the management and staff of the MOH and BVH for the cooperation and assistance given to my staff, during the audit. I must say special thanks to my staff and all stakeholders who afforded us time from their busy schedule to share their views.

Pamela Monroe Ellis, FCCA, FCA, CISA
**Auditor General**

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# Key Statistics

| | |
|---|---|
| ***$1.2 Billion*** | *Average annual budget and expenditure at BVH, representing three per cent of MOH recurrent budget each year.* |
| ***18,685*** | *Average patient caseload each year at primary health care facilities.* |
| ***4,336*** | *Average number of out-patients treated at BVH each year between 2010 and 2015.* |
| ***790*** | *Average number of in-patients at BVH each year between 2010 and 2015.* |
| ***73%*** | *On average, schizophrenia was the leading mental health disorder between 2010 and 2015.* |

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# Summary

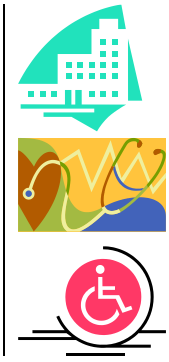
The Ministry of Health (MOH) Mental Health Unit is charged with the responsibility to develop policies and standards, review and monitor programs and make recommendations for legislative amendments to ensure that Jamaica's mental health governance framework is aligned with international best practices and standards. The Unit is also tasked with the responsibility *"to develop policies and plans to address the promotion of mental health, the prevention of mental disorders and the development of a comprehensive range of services to facilitate early detection, treatment and rehabilitation across the lifespan, for affected persons"*.

We sought to determine if MOH has effective strategies and programmes for the rehabilitation of the mentally ill to aid in their reintegration. Our assessment was limited to the Bellevue Hospital (BVH). The audit also sought to establish if MOH is monitoring effectively, the treatment and care of patients in mental health facilities. The key findings are outlined in paragraphs 1 to 4.

## Key Findings

### Rehabilitation and Reintegration

**1. Many mentally ill patients are institutionalized at BVH because they were abandoned by their families. Institutionalization of patients after they have been discharged is counterproductive to their rehabilitation and reintegration[1], and could be deemed as a violation of their rights[2].**



795 In-patients at BVH as at February 2016

673 *85%* Patients do not require hospitalization

41 Severely mentally retarded patients reside at BVH

[1] Various studies and stakeholders support the deinstitutionalization of persons with mental illness as it promotes a better quality of life and better aids in their rehabilitation.

[2] Jamaica is a signatory to the United Nations Convention on the Rights of Persons with Disabilities (CRPD). The Convention protocols recommended that persons with mental illness have the right to be treated in the least restrictive settings and the right to integration into normal communities.

i. **As at February 2016, 673 (85 per cent) of the 795 in-patients at BVH were considered stable based on their clinical assessments. BVH informed us that these patients have been discharged and should have been at home with their families.** BVH objective is to return patients to their highest functional levels in the communities in the shortest possible time[3]. Upon admission, patients are placed in acute wards for up to 28 days, and then transferred to sub-acute wards for further treatment and clinical assessment for up to five months. Once found to be stable, they are discharged after the maximum six-month period for hospitalization. The Hospital classified length of stay greater than seven months as chronic; however, BVH did not maintain records on actual length of stay for each patient. Our review of a sample of the records for 107 patients showed that 13 have been institutionalized for periods between 21 and 35 years, 27 between 10 and 20 years, while 51 were at the mental hospital for periods between one and nine years. We were unable to determine the length of stay for 16 patients in our sample as the admission dates were not reflected in their records. We observed that 87 of these patients remained institutionalized although their record showed they were discharged from the Hospital. The institutionalization of patients prevented BVH from admitting new patients for in-hospital treatment on 494 occasions[4], between June 2013 and January 2016. We observed from our review of the sample of records for the 107 patients that BVH social workers made contacts with relatives of 35 patients, but were not successful in reintegrating them in their communities. MOH noted that the proposed amendments to the Mental Health Act of 1997 will allow for the reform of mental health service in Jamaica and ensure conformity with international human rights and standards.

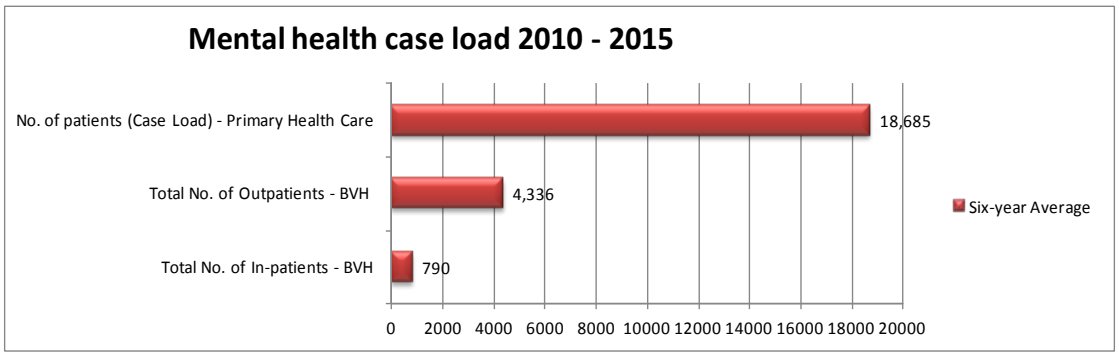
ii. **The operation of BVH is funded directly through the Ministry of Finance and resources are managed independently by its Board of Directors.** Over the last six years, 2010-11 to 2015-16, the budget provided to BVH averaged three per cent of MOH recurrent budget. BVH budget increased from $1.3 billion in 2010-11 to $1.6 billion in 2015-16. BVH actual annual expenditure, inclusive of out-patient cost, averaged $1.2 billion between 2010-11 and 2014-15; while, the number of in-patients averaged 790. We were unable to determine the actual cost per in-patients as BVH did not provide detailed accounting records to facilitate our analysis. Not withstanding this, the average annual expenditure and number of in-patients suggested expenditure per patient of $1.5 million[5].

[3] BVH website

[4] BVH Nursing Administrative Monthly Reports

[5] A costing conducted by BVH in 2000 to justify the transfer of patients from BVH to community-based residential facilities revealed that, at that time, it cost the GOJ $15.8 million to care for 44 patients per annum, representing $360,000 per patient each year. The transfer of the 44 patients would have cost $20 million in the first year and $6 million thereafter, resulting in a savings of approximately $10 million each year.

iii. **MOH neither makes specific budgetary allocation to mental health nor maintains actual expenditure for this activity. Consequently, we were unable to determine whether allocations between BVH and primary health care facilities were consistent with MOH intention to encourage mental health reform.** MOH only provided information on the total expenditure for community-based mental health services for 2014-15. The information revealed that only five per cent of the mental health expenditure of $1.3 billion, for that year, was spent on community-based mental health care, which treated on average 78 per cent of mental health patients each year between 2010 and 2015. BVH expenditure was 95 per cent of the total mental health expenditure, although the number of patients who received treatment at BVH over the period averaged only 22 per cent.




**Source:** AuGD analysis of data provided by MOH and BVH

**2. Persons with mental illness are often treated in community out-patient primary health care facilities as part of MOH thrust to reform mental health in Jamaica. However, the institutionalization of patients has perpetuated for many years, largely because of the lack of strategic direction by MOH to continue the reform agenda as outlined in a 2006 mental health reform plan.**

i. **Recognising that deinstitutionalization and community-based mental health care promote better outcomes for patients and present cost efficiency, MOH developed a Cabinet Submission in 2006 for the reform of Jamaica's mental health system and the relocation of patients from BVH.** Cabinet approved the Submission in March 2006. The reform plan included the development of community mental health services and the relocation of patients from BVH to 24 supervised and supportive living facilities. However, to date, none of the various infrastructural developments to facilitate the relocation of patients from BVH and improvement in community-based care has been implemented; despite MOH receiving a grant of $18.6 million in 2011, to finance a pilot project. The pilot project should have involved the renovation of three supervised living facilities to accommodate 44 patients. Further, MOH did not develop a complete strategy with specific targets for the implementation of the mental health reform plan in the medium to long-term, and the associated costs.

## Monitoring

**3. The mechanism, established under the Mental Health Act, to allow for independent monitoring of patients in mental health care facilities; and the investigation of complaints from patients and their relatives was not functioning as intended.**

i. **We found no documentary evidence that the regional review boards were carrying out their functions to receive and investigate complaints from patients and their relatives, and conduct periodic reviews at least once in every six months of patients in mental health facilities.** For example, during our review of patient records at BVH we found allegations made by five patients, about issues relating to poor service delivery and inappropriate conduct of staff towards patients. However, we saw no documentary evidence that these complaints were received and investigated by the South East Regional Health Authority (SERHA) Review Board, which is responsible for BVH. International convention requires that all persons with mental illness should be protected against any form of inhumane treatment and discrimination. The inactivity of the review boards was also demonstrated by the failure to hold meetings to develop strategies to effectively execute and evaluate their functions. We reviewed the appointments of the regional review boards since April 2010 and observed that MOH was consistent in establishing the review boards, except for the period August 10, 2012 to December 16, 2014.

**4. MOH could not demonstrate that data collected on mental health diagnosis was effectively utilized in the management of mental health services and the promotion of awareness.**

i. We reviewed MOH website, annual reports and strategic plan to assess the extent to which the information on mental health cases and diagnosis was used to inform the public of the prevalence of the various types of mental disorders. However, the information was not available. In addition, we were unable to determine the extent to which MOH used historical data to inform the management of mental health services. MOH indicated that *"the process of collection and submission of the mental health data has many challenges as these data do not usually reach the Director of Mental Health routinely and certainly not in a timely manner".* MOH noted that steps are being taken to improve the process, but there is need for improvement in the human resources and training. Upon our request, MOH collated and provided mental health diagnosis data for the period 2010 to 2015. The data, revealed that of the 153,440 mental health case load, schizophrenia disorder accounted for 117,078 (76 per cent); while, mood disorders accounted for 16.5 per cent of the cases. However, we observed that MOH focused its attention mainly on promoting awareness on mood and anxiety related disorders. MOH indicated that *"although 72% of the patients in the mental health clinics are treated for Schizophrenia, we were aware that depression and anxiety are more common and often undiagnosed and untreated but contribute to increased morbidity and complications for other non-communicable diseases."*

## Recommendation

**Institutionalization of patients after they have been discharged is counterproductive to their rehabilitation and reintegration, and could be deemed as a violation of their rights. Deinstitutionalization and community-based mental health care promote better outcomes for patients and present cost efficiency.** MOH should immediately explore the benefits associated with the implementation of the mental health reform plan – including the relocation of patients from BVH to community-based living facilities – and move with some level of urgency to develop a strategy for full implementation in the short to medium term. During this period, MOH needs to work collaboratively with BVH and other interest groups to address the issue of institutionalization at BVH.

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# Part One

## Introduction

### Background

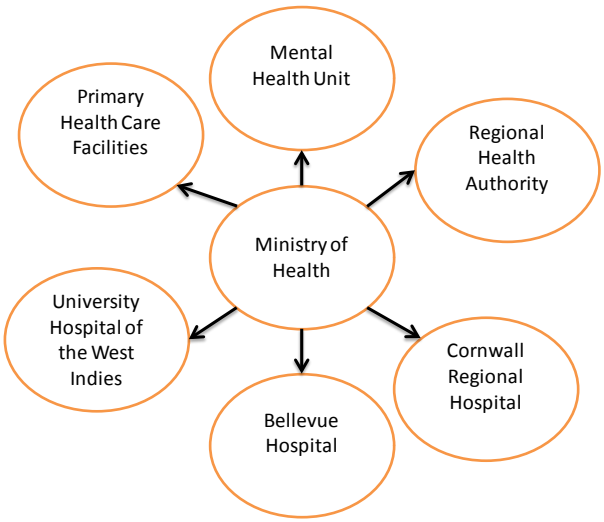
### What is mental Illness?

**1.1.** **Mental illness** "is a condition that impacts a person's thinking, feeling or mood and may affect his or her ability to relate to others and function on a daily basis. Each person will have different experiences, even people with the same diagnosis"[6].

### Why is mental health important?

**1.2.** **Mental health** is defined by the World Health Organization "as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. Therefore, if you don't have a healthy mental state it will be hard for you to live your life to the fullest extent[7]."

**Figure 1 Entities involved in the management and delivery of mental health services**




**Source:** AuGD compilation

[6] https://www.nami.org/Learn-More/Mental-Health-Conditions
[7] http://dpcedcenter.org/classroom/importance-mental-health

## MOH responsibility for mental health management

**1.3.** The mandate of the Ministry of Health (MOH) is "to ensure the provision of quality health services and to promote healthy lifestyles and environmental practices". The Mental Health Act of September 1997[8] guides the management of mental health services in Jamaica. MOH is tasked with the responsibility to ensure the realization of Vision 2030 actions, under the health sector, to introduce a policy to support primary health care in mental health, strengthen programmes to support mental health and facilitate community-based approach to mental health**.**

**1.4.** A Mental Health Review Board is established in each of the four Regional Health Authorities to investigate complaints from patients and monitor their treatment and care by conducting inspections of mental health facilities.

**1.5.** MOH established a Mental Health Unit, which is responsible to develop mental health policies and standards, review and monitor mental health programs and make recommendations for legislative amendments to ensure that Jamaica's mental health legislation is aligned with international best practices and standards.

## Obligation under WHO Convention on the Rights of Persons with Disabilities (CRPD)

**1.6.** Jamaica is a member country of the World Health Organisation (WHO). On March 30, 2007, GOJ ratified the United Nations Convention on the Rights of Persons with Disabilities (CRPD). Being a signatory to the Convention and its protocols, Jamaica is encouraged to adopt WHO Comprehensive Mental Health Action Plan 2013-2020. The Action Plan proposed four objectives, which member states should achieve in order to improve mental health services and to protect the rights of persons with mental illness . These are to strengthen effective leadership and governance; provide comprehensive, integrated and responsive mental health and social care services in community-based settings; implement strategies for promotion and prevention in mental health and strengthen information systems, evidence and research for mental health.

## Access to mental health services

**1.7.** Persons with mental conditions are mainly treated in community Out-patient primary health care facilities (health centres) and Type B classified general hospitals. In-patient care is provided at the psychiatric units at the University Hospital of the West Indies and the Cornwall Regional Hospital (CRH). However, comprehensive psychiatric services are predominantly offered at the Bellevue Hospital (BVH).

### Bellevue Hospital (BVH)

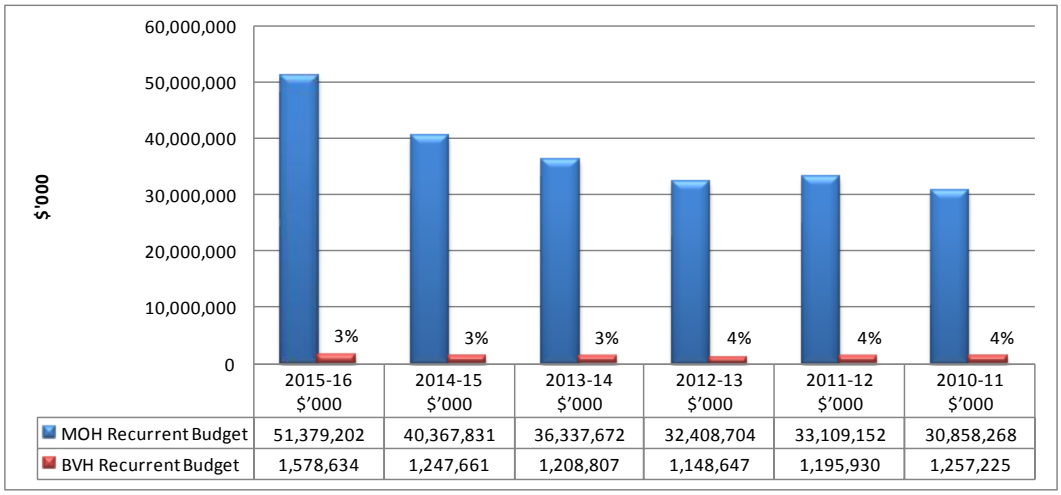
**1.8.** BVH, established in 1861 in Kingston, is the primary specialist mental health care institution in Jamaica and the largest psychiatric facility in the English speaking Caribbean. The hospital, first called the Jamaica Lunatic Asylum, was designated for the treatment of mental

[8]Revised 1999

illness. The name was changed to the Jamaica Mental Hospital in 1938 and then the Bellevue Hospital in 1946. The facility was initially constructed with a capacity of 1,500 beds, but was subsequently reduced to 800. In 2010, the Government of Jamaica (GOJ), through the Ministry of Health (MOH), granted BVH autonomous status. A Board of Management was introduced to provide oversight of BVH operations. BVH mission is *"to be responsible and committed to providing the highest quality psychiatric care, ensuring that medical treatment, nursing and rehabilitative care, is carried out in a clean and safe environment."* One of the main objectives of BVH is to *"return individuals to their highest functional levels in the communities in the shortest possible time."* The Kenneth Royes Rehabilitation Centre (KRRC), in Spanish Town, is operated by BVH.

**1.9.** BVH is funded by the GOJ and received cash flows directly from the Ministry of Finance. **Figure 2** shows that over the last six years, 2010-11 to 2015-16, the budget provided to BVH averaged three per cent of MOH recurrent budget. Over that period, BVH budget increased from $1.3 billion in 2010-11 to $1.6 billion in 2015-16. MOH does not have a specific budget for the provision of mental health services.

## Figure 2 Analysis of MOH and BVH budget, 2010-11 to 2015-16




| | 2015-16 $'000 | 2014-15 $'000 | 2013-14 $'000 | 2012-13 $'000 | 2011-12 $'000 | 2010-11 $'000 |
|---|---|---|---|---|---|---|
| MOH Recurrent Budget | 51,379,202 | 40,367,831 | 36,337,672 | 32,408,704 | 33,109,152 | 30,858,268 |
| BVH Recurrent Budget | 1,578,634 | 1,247,661 | 1,208,807 | 1,148,647 | 1,195,930 | 1,257,225 |

**Source:** GOJ Estimates of Expenditure

### The audit scope and methodology

**1.10.** The audit focused on MOH strategies and programmes for the rehabilitation of the mentally ill to aid in their reintegration. Our assessment was limited to Bellevue Hospital (BVH). The audit also assessed if MOH is monitoring effectively the treatment and care of patients in mental health facilities. Our audit was planned and conducted in accordance with the Government Auditing Standards, which are applicable to Performance Audit and issued by the International Organization of Supreme Audit Institutions (INTOSAI).

**1.11.** Our assessment was based on the review of internal and external documents, interviews with senior management and staff at MOH and BVH, observations and analysis of information provided by MOH and BVH. We also obtained the views of stakeholders during a focus group discussion.

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# Part Two

## Rehabilitation and Reintegration

### Institutionalization of patients at BVH is counterproductive to their rehabilitation

**2.1** BVH is facing challenges in fulfilling its objective "to return patients to their highest functional levels, in the shortest possible time, in the communities[9]". Patients are institutionalized at BVH for periods up to 35 years. BVH informed us that patients remained at the Hospital after discharge due to family neglect and other social issues. Institutionalization of patients is counterproductive to their rehabilitation and reintegration[10]. The Hospital classified length of stay greater than seven months as chronic; however, BVH did not maintain comprehensive records on actual length of stay for each patient. Our review of a sample of the records for 107 patients showed that 13 have been institutionalized at BVH for periods between 21 and 35 years, 27 between 10 and 20 years, while 51 were at the mental hospital for periods between one and nine years . We were unable to determine the length of stay for 16 patients in our sample as the admission dates were not reflected on their records. We observed that 87 of these patients remained institutionalized although they were discharged from the Hospital.

**2.2** Ninety-four of the 107 patients (88 per cent) were diagnosed with schizophrenia, 12 (11 per cent) with bipolar disorders and one with depression. BVH informed us that persons with these mental disorders do not require long-term hospitalization. Patients requiring admission are often referred to BVH, as no beds are dedicated for mental ill patients at many hospitals, except for the psychiatric units at the CRH and UHWI, which have a combined bed capacity of 40. Our analysis of the 107 patient records showed that the registered address of 42 patients was in the parishes of Kingston and Saint Andrew (KSA), the area in which BVH is located; while 39 patients had addresses in other parishes. One other patient, who has been at BVH for 13 years, had an address outside of Jamaica. The address of the other 25 patients was not reflected on their records **(Figure 3)**.

[9] BVH website

[10] Various studies and stakeholders support the deinstitutionalization of persons with mental illness as it promotes a better quality of life and better aids in their rehabilitation. International conventions[10] also recommended that persons with mental illness have the right to be treated in the least restrictive settings and the right to integration into normal communities.

## Figure 3 Analysis of patients' length of stay at BVH

| Length of Stay | No. of Patients | | Diagnosis[11] | | | Location | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Years** | **Male** | **Female** | **Schiz.** | **Bipolar** | **Depre.** | **KSA** | **Other Parishes** | **U/N** | **F/A** |
| **21- 35** | 10 | 3 | 13 | 0 | 0 | 2 | 5 | 6 | 0 |
| **10 – 20** | 20 | 7 | 24 | 2 | 1 | 10 | 9 | 7 | 1 |
| **1-9** | 32 | 19 | 42 | 9 | 0 | 18 | 23 | 10 | 0 |
| **<1 years** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Unknown** | 14 | 2 | 15 | 1 | 0 | 12 | 2 | 2 | 0 |
| **Total** | **76** | **31** | **94** | **12** | **1** | **42** | **39** | **25** | **1** |

**Note:** *KSA - Kingston and Saint Andrew*
*U/N - Unknown*
*F/A - Foreign Address*

**Source:** AuGD review of patients records

**2.3** The treatment of patients closer to their homes is necessary to aid in their rehabilitation and to facilitate the ease for family members to visit their relatives. Although out-patient services are offered at community-based health care facilities, there is limited access to beds to provide admission closer to their homes. The limited access to beds at community-based health care facilities coupled with the institutionalization of patients at BVH prevented MOH from ensuring that GOJ fulfils its obligations under international convention. WHO convention recommends that persons with mental illness have the right to be treated in the least restrictive settings, and the right to housing and integration into normal communities.

> "The principle of the least restrictive alternative requires that persons are always offered treatment in settings that have the least possible effect on their personal freedom and their status and privileges in the community, including their ability to continue to work, move about and conduct their affairs. In practice, this means promoting community-based treatments and using institutional treatment settings only in rare circumstances. If institutional treatment is necessary, the legislation should encourage voluntary admission and treatment and allow involuntary admission and treatment only in exceptional circumstances. The development of community-based treatment facilities is a prerequisite for putting this principle into practice."
>
> **Source:** Mental Health Policy and Service Guidance Package: Mental Health Legislation and Human Rights - World Health Organization, 2003

**2.4** MOH noted that the proposed amendments to the Mental Health Act of 1997 will allow for the reform of mental health service in Jamaica and ensure conformity with international human rights and standards. The revision of the Act has been a major task in MOH strategic and operational plans since 2010. In January 2016, MOH forwarded the draft amendments to various stakeholders for consideration and comments. Further, MOH is in the process of developing a Mental Health Policy, which aims to, among other things, establish a framework to promote mental health and improve the provision of a comprehensive range of community-based mental health service.

[11] Schizophrenia, bipolar and depression mental disorders

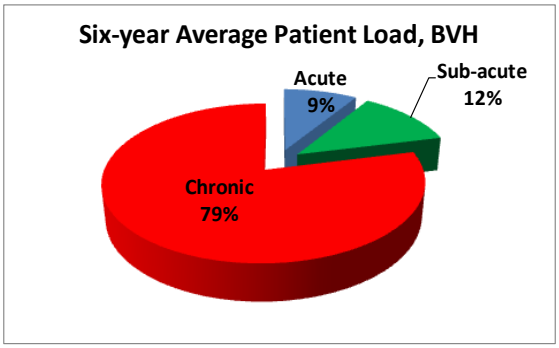
**2.5** The process to amend the Act and develop the Policy is a necessary first step towards ensuring that the governance framework is in place to support much needed improvements to mental health services in Jamaica. However, MOH did not provide a timeframe for the relevant submissions to be made to Cabinet for consideration.

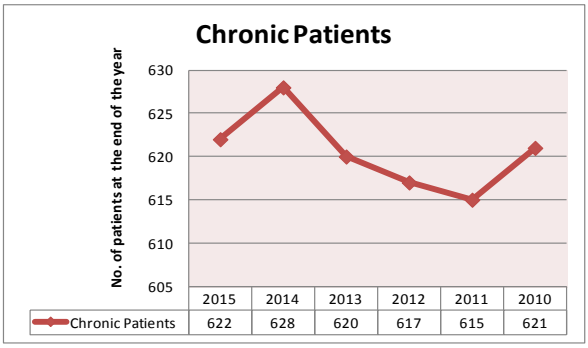
### Eighty-five per cent of patients at BVH should be at home with their families

**2.6** As at February 2016, there were 795 in-patients to BVH; this represents 99 per cent of the 800 bed capacity. Information provided by BVH revealed that 673 (85 per cent) of these patients were considered stable, based on their clinical assessments, and do not require hospitalization. These patients who are living at the institution in adult care facilities should be reintegrated at home with their families and in the normal community. Upon admission, patients are placed in acute wards for up to 28 days, and then transferred to sub-acute wards for further treatment and clinical assessment for up to five months. Once found to be stable, they are discharged after the stated maximum six-month period for hospitalization. Another 41 severely mentally retarded persons were also institutionalized at the Hospital.

**2.7** Institutionalization of patients has been a major issue at BVH. Our analysis of information provided by BVH showed that over the last six years, 2010 to 2015, occupancy rate at the Hospital each year averaged 93 per cent. Our analysis of data provided on BVH yearly statistical reports showed the average number of beds available at BVH over the six-year period was 845. We noted that chronic patients occupied on average 621 (73 per cent) of the average 845 available beds **(Appendix 1)**. Acute and sub-acute patients comprised on average nine and 12 per cent respectively of the average bed complement over the period (**Figure 4)**. We did not observe any reduction in the number of chronic patients at the Hospital, as the number moved from 621 in 2010 to 622 patients in 2015. The movement of patients at BVH is detailed in **(Appendix 2)**. MOH indicated that the mental hospital has implemented a paradigm shift in its operation in 2015. Patients are no longer offered long-stay care as the focus is to discharge them to their communities.

## Figure 4 Analysis of patient status, 2010 to 2015



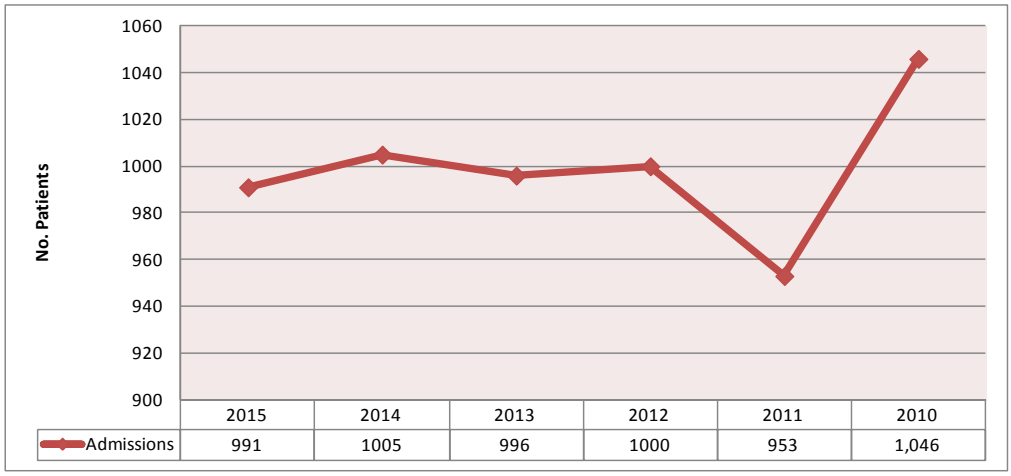




**Source:** AuGD analysis of information provided by BVH

**2.8** BVH social workers are mandated to, among other responsibilities, dialogue with relatives of those patients who are institutionalized, with a view to reintegrate them in their communities. There are six social workers assigned to BVH, representing a ratio of one social worker to 112 chronic patients as at February 2016. We observed from our review of the sample of records for the 107 patients that BVH social workers made contacts with relatives of 35 patients, but were not successful in reintegrating them in their communities.

**2.9** The institutionalization of patients has affected BVH ability to admit new patients, who required in-hospital treatment. Information provided by BVH showed that patients, who required admission, were denied the opportunity on 494 occasions[12] between June 2013 and January 2016, due to the unavailability of beds. BVH stated that the institution does not keep records of names patients who were denied admission. In instances where patients were denied admission, BVH indicated that efforts were made to contact KPH or UWI to seek admission of patients. If admission is not possible at these facilities, out-patient treatment is offered. BVH admitted on average 999 patients annually; the number of admissions moved from 1,046 in 2010 to 991 in 2015 **(Figure 5)**.

## Figure 5 Analysis of patient admissions at BVH 2010 – 2015




**Source:** AuGD compilation of information obtained from BVH records

### Kenneth Royes Rehabilitation Centre (KRRC)

**2.10** While minimal occupational therapy was conducted at BVH; we observed that patients at the Kenneth Royes Rehabilitation Centre (KRRC) in Spanish Town were more actively participating in this type of rehabilitation activity[13]. These include field crop and poultry production, laundry, house keeping and dietary services. We were informed that agricultural produce are utilized at the KRRC and BVH, while excess amounts are sold. For example, information provided by BVH showed between March 2012 and December 2015, KRRC produced 9,912 flats of eggs valuing $5 million. BVH received 9,133 flats, while 779 flats were

[12] BVH Nursing Administrative Monthly Reports

[13] **Occupational therapy** is the use of assessment and treatment to develop, recover, or maintain the daily living and work skills of people with a physical, mental, or cognitive disorder.

utilized at KRRC. BVH did not maintain information on the amount, value and utilization of field crops produced by KRRC over the period.

**2.11** More patients could be involved in these occupational therapy programmes if KRRC was able to accommodate its full capacity. KRRC was constructed under a special programme in the 1980's to house patients discharged from BVH, but have no living accommodations. The facility was constructed to accommodate a capacity of 112 patients, 72 males and 40 females. However, the capacity at KRRC was reduced to 40 as the main building remained out-of-use since it was damaged by hurricanes **(Figure 6)**. Six houses provided by Food for the Poor were used to provide accommodation for another 12 patients, bringing the current capacity to 52. At March 17, 2016, 24 males and 8 females were housed at the facility.

## Figure 6 Kenneth Royes Rehabilitation Centre (KRRC)

**Picture 1**

**Picture 2**

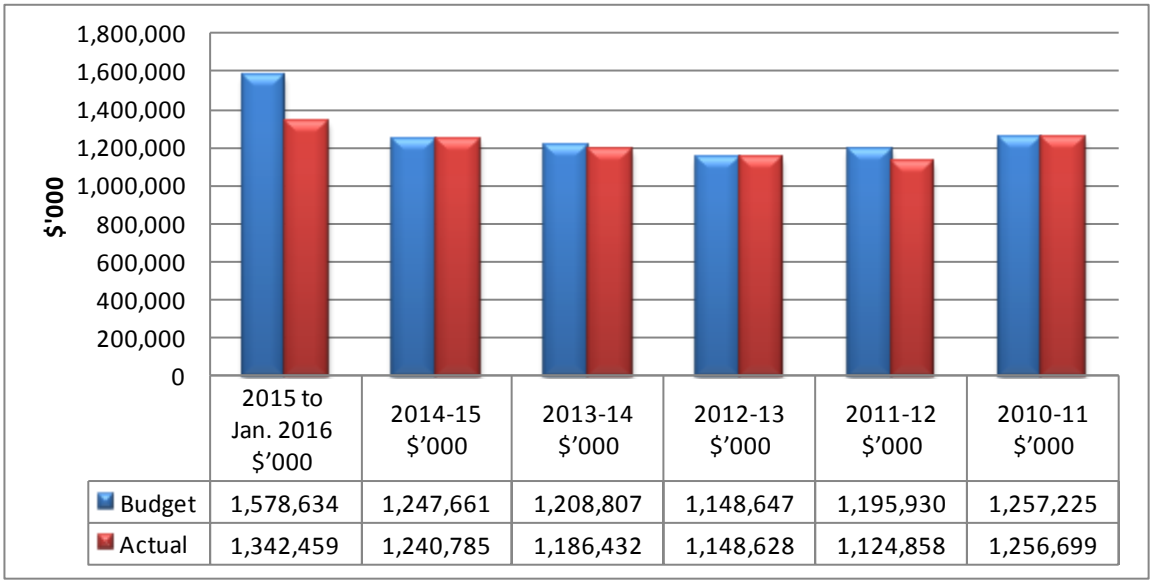
Note: **Picture 1** Section of main building remained out-of-use since it was damaged by hurricanes.
**Picture 2** Patient engaged in occupational therapy programme at KRRC

**Source:** AuGD file photos

### Institutionalization of patients at the mental hospital is costly

**2.12** The operation of BVH is funded directly through the Ministry of Finance and managed independently by its Board of Directors. Over the last six years, 2010-11 to 2015-16, the budget provided to BVH averaged three per cent of MOH recurrent budget. BVH budget increased from $1.3 billion in 2010-11 to $1.6 billion in 2015-16 **(Figure 7)**. BVH annual actual expenditure, inclusive of out-patient cost, averaged $1.2 billion between 2010-11 and 2014-15; while, the number of in-patient averaged 790. We were unable to determine the actual costs per in-patients as BVH did not provide detailed accounting records to facilitate our analysis. Not withstanding this, the average annual expenditure and number of in-patients suggested a per capita of $1.5 million. A costing conducted by BVH in 2000 to justify the transfer of patients from BVH to community-based residential facilities revealed that, at that time, it cost the GOJ $15.8 million to care for 44 patients per annum, representing $360,000 per patient each year. The transfer of the 44 patients would have cost $20 million in the first year and $6 million thereafter, resulting in a savings of approximately $10 million each year.

## Figure 7 BVH approved budget and actual expenditure




| | 2015 to Jan. 2016 $'000 | 2014-15 $'000 | 2013-14 $'000 | 2012-13 $'000 | 2011-12 $'000 | 2010-11 $'000 |
|---|---|---|---|---|---|---|
| Budget | 1,578,634 | 1,247,661 | 1,208,807 | 1,148,647 | 1,195,930 | 1,257,225 |
| Actual | 1,342,459 | 1,240,785 | 1,186,432 | 1,148,628 | 1,124,858 | 1,256,699 |

**Note**: Actual expenditure for 2015-16 presented as at January 2016

**Source:** AuGD compilation of BVH financial data

**Extracted from the Grant Request Form:**

"A workable example is what it costs BVH to provide care for one patient who should be living in a low level supervisory community-based residential facility. A research was conducted in 2000..... At that time it costs BVH J$9,000 to feed one (1) patient per month, in one year it costs them J$108,000. Overhead costs to BVH for providing care to this one patient was J$21,000 per month, for the year J$252,000. One outcome of this project is to reduce the cost to government through the transfer of forty-four (44) patients from BVH to three select existing NGO community-based residential facilities. The start-up cost will be this twenty million Jamaican dollars (J$20m) being requested, after which it will cost the government six million Jamaican dollars (J$6m) per year (actual cost) to assist in the maintenance of these patients in the facilities. In 2000 it costs the Government J$15,840,000 to care for these 44 patients per annum, (bear in mind that the cost would be much more in 2011 with inflation). The transfer of the 44 patients from BVH will cost the Government J$20m in the first year and $J6m thereafter. Within two years the Government will break-even, in the third year and thereafter the Government would have saved more than ten million Jamaican Dollars."

### Strategy for the relocation of patients from BVH did not materialize after 10 years

**2.13** The institutionalization of patients is exacerbated by lack of proper oversight and strategic direction by MOH to implement the reform of mental health services in Jamaica. MOH included the improvements in the quality and delivery of the community-based mental health services as outcome indicators in its strategic plans for the period 2012 to 2019. However, MOH did not ensure that a mental health reform plan, which included the relocation of patients from BVH to low cost community-based residential facilities, was implemented. MOH did not develop a complete strategy with specific targets for the implementation of the mental health reform plan in the medium to long-term, and the associated costs.

**2.14** MOH developed a Cabinet submission dated February 27, 2006, for the reform of Jamaica's mental health system and the relocation of patients from BVH. The Submission which entitled *"The Development of Community Mental Health Services and De-institutionalization"* recognised that "*one of the principles underlying mental health reform is to avoid unnecessary hospitalisation in a mental hospital, and treat persons with mental illnesses in the least restrictive situation possible."* The Submission further noted that the reform *"will allow patients to receive visits from family and friends when in the hospital and to keep connections with the community"* and that *"community care creates better outcomes and helps patients not to be displaced from their space in the family home."*

**Extracted from the Cabinet Submission 2006**

"The World Health Organisation Report (WHO) 2001: Mental Health New Understanding, New Hope outlined three essential components of deinstitutionalization, which the proposed reformation of mental health services hopes to develop:

- Prevention of inappropriate mental hospital admissions through the provision of community facilities
- Discharge to the community of long-term institutionalization of who have received adequate preparation
- Establishment and maintenance of community support systems for non-institutionalization of patients."

**2.15** The Submission outlined various strategies for the reform of the mental health system to fully integrate mental health services with general health care. The mental health reform strategies included the development of a legal framework and infrastructure to support mental health reform[14]. In relation to the infrastructure development, the strategies included the upgrade of health centres to accommodate the increase in clinical sessions, the construction of discrete wards at four hospitals to accommodate a total of 100 beds and refurbishing of two hospitals to facilitate optimum care. A strategy for the re-location of long-staying patients from BVH to supervise and supportive living facilities was also part of the reform plan. The strategy included the provision of 24 living facilities to manage patients requiring extended and various levels of supervised and supportive care **(Appendix 3)**.

**2.16** The Submission recognised that deinstitutionalization was in keeping with international standards for efficient and cost effective mental health care, and will be implemented in a phased manner to ensure that all the required services are fully developed and strengthened in all regions before full deinstitutionalization. Cabinet approved the Submission in March 2006; however, MOH is yet to achieve any of the mental health reform strategies.

**2.17** In May 2011, MOH requested a grant of $20 million from the National Health Fund (NHF) for the renovation of three model community-based supervised living facilities, to house 44 patients from BVH and provide institutional strengthening for the operation of the facilities **(Appendix 5)**. These are Ebenezer Home in Mandeville to house 10 patients, the Clarendon Association for Street People (CLASP) and the Westmoreland Association for Street People

[14] Italy and Paraguay implemented similar strategies in the reform of their mental health system. Both country reported significant reduction of long-staying patients at psychiatric hospitals **(Appendix 4)**.

(WASP) residential facilities to house 20 and 14 patients respectively. In December 2011, MOH and NHF signed the project grant agreement for $18.6 million. MOH used $10.7 million to purchase four buses, $1.4 million to construct a chain-linked perimeter fence at WASP and $1.24 million to pay for works at KRRC. MOH also used $3.1 million and US$23,700 (JA$2 million[15]) to procure furniture, computer equipment and various services for institutional strengthening. To date, 44 patients are yet to be transferred from BVH. In addition, MOH included the construction of a 20-bed psychiatric ward at the Spanish Town Hospital as a major output in the Strategic Plan 2014-17. MOH is yet to estimate the costs and indicate a timeframe for the construction of this facility.

[15] BOJ Weighted Average rate January 17, 2012 (Invoice date)

# Part Three

# Monitoring

### Review boards established to monitor treatment of the mentally ill are non-functional

**3.1** We observed that the mechanism, established under the Mental Health Act, to allow for independent monitoring of patients in mental health care facilities and the investigation of complaints from patients and their relatives was not functioning as intended. Section 26(1) of the Act requires the Portfolio Minister to establish a mental health review board for each health region to investigate complaints from patients and monitor their treatment and care by conducting inspections of mental health facilities. International Conventions require that persons with mental illness should be protected against any form of inhumane treatment and discrimination. The functions of the review boards are outlined in **Figure 8**.

## Figure 8 Functions of a Mental Health Review Board

**Mental Health Act**

**Section 27(1)**

a. *To receive and investigate complaints from patients, relatives or next friends of patients on any matter connected with their care or treatment or their discharge from, or detention in, a psychiatric facility within the health region;*
b. *To undertake a periodic review at least once in every six months of all patients who have been undergoing treatment in a psychiatric facility within the health region."*

**Section 27(4)**

*Where a Review Board undertakes a periodic review under subsection (1) (b), the Review Board shall, within sixty days thereafter, forward a written report of its findings to the Senior Medical Officer of the psychiatric facility and a copy to the patient and, if the patient is not able to understand the report, to the nearest relative or next friend of the patient.*

**Section 27(5)**

*The Review Board shall cause to be made and transmit to the Minister a yearly report dealing generally with the activities of the Review Board during the preceding year.*

**3.2** We reviewed the appointments of the regional review boards since April 2010 and observed that MOH was consistent in establishing the review boards, except for the period August 10, 2012 to December 16, 2014. Despite the establishment of the review boards, we found no documented evidence that the review boards were carrying out their functions to ensure the protection of patients' rights. For example, during our review of patient records at BVH, we found allegations, made by five patients, about issues relating to poor service delivery and inappropriate conduct of staff towards patients. Four of the complaints were made to BVH and one to MOH between August 2014 and December 2015. However, these complaints were not investigated by the South East Regional Health Authority (SERHA) Review Board which is responsible for BVH. Further, we found no evidence of an established procedure that the regional boards were expected to follow, for the receipt and processing of complaints from patients and reporting of findings.

**3.3** Our assessment of the performance of the boards is shown in **Figure 9**. We found no documentary evidence that the review boards conducted the required periodic reviews at least once in every six months of patients undergoing treatment in mental health facilities and submit a written report of the findings to the Senior Medical Officer (SMO). MOH only provided a report of an assessment of a private mental health rehabilitation facility in Montego Bay. The assessment was undertaken by the Western Regional Health Authority (WRHA) Review Board. Information provided by MOH shows that mental health patients are treated at 133 state-operated out-patient primary health care facilities and 59 private rehabilitation facilities. In-patient care is provided at the psychiatric units at the UHWI, CRH and BVH. We found no evidence of any reviews conducted at BVH, the premier mental health facility in Jamaica. In addition, we found no evidence that the review boards submitted, to the portfolio Minister, the required yearly reports dealing generally with their activities. Despite requests, MOH did not present the reports for the last six fiscal years, 2009-10 to 2014-15.

**3.4** The inactivity of the review boards was demonstrated by the failure to hold regular meetings to develop strategies to effectively execute and evaluate their functions. We observed that over the period April 2010 to March 2016, the WRHA Review Board held four meetings. We found no evidence that the review boards for NERHA, SRHA and SERHA held any meetings during the six-year period. The breakdown of this mechanism which was established by the Act would prevent MOH from effectively monitoring the delivery of mental health treatment and care in mental health facilities, in order to identify issues which require corrective actions.

## Figure 9 Mental health review boards performance 2010 - 2016

| Details | NERHA | WRHA | SRHA | SERHA |
|---|---|---|---|---|
| No. of complaints received from patients and investigated | N/P | N/P | N/P | N/P |
| No. of meetings | 0 | 4 | 0 | 0 |
| No. of periodic reviews of psychiatric facilities (required at least every six months). | 0 | 1 | 0 | 0 |
| No. of reports of periodic review findings forwarded to SMO of the psychiatric facility and patient. | 0 | 1 | 0 | 0 |
| No. of yearly reports transmitted to the Minister dealing generally with the activities of the Review Board during the preceding year. | 0 | 0 | 0 | 0 |

**Notes:** NP - Not provided
*Our performance analysis was based on documentary evidence provided by MOH and the Regional Heath Authorities (RHAs).*

NERHA - North East Regional Health Authority
WRHA - Western Regional Health Authority
SRHA - Southern Regional Health Authority
SERHA - South East Regional Health Authority

**Source:** AuGD analysis of Mental Health Review Board performance

**3.5** In addition, the establishment of a Mental Health Tribunal is required by Section 31(1) of the Act for the purpose of hearing appeals from the decisions of the review boards. The Tribunal was only established for the period October 2, 2006 to August 10, 2012.

### MOH did not demonstrate that mental health data is being utilized effectively

**3.6** MOH Community Mental Health Reporting (CMHR) Procedures Manual requires regional mental health officers to collect preliminary data on case load and diagnosis[16] among other things. This data is collected from patients at 133 health centres. The data is captured on a Daily Work Record. At the end of each week, the data is recorded on a Weekly Tally Sheet and compiled monthly. A monthly mental health reporting form is completed, for each parish, and forwarded to MOH, RHA and the director of Mental Health Service. However, MOH could not demonstrate that data collected on mental health diagnosis was collated and analysed in a timely manner and used to manage effectively mental health services and the promotion of awareness.

**3.7** We expected MOH to collate the data on mental health diagnosis and analyze the information to inform its strategic and operational decisions. MOH would be able to use this information to focus research activities on those mental disorders to monitor trends, determine cause, develop strategic and operational plans and, better promote awareness of mental health issues in Jamaica. This would enable MOH to better manage mental health in Jamaica. Information on the number of patients diagnosed with various mental health disorders would, for example, help MOH to be aware of the types of mental disorder that are more prevalent in the Jamaican society, based on statistical evidence.

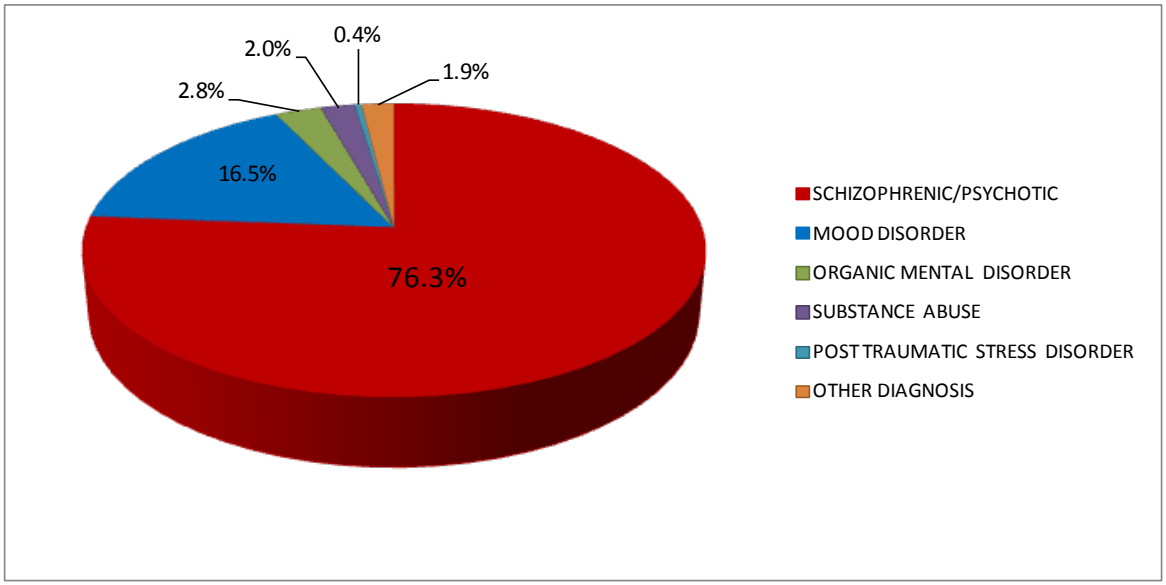
**3.8** We reviewed MOH website, annual reports and strategic plan to assess the extent to which the information on mental health diagnosis was used to inform the public of the prevalence of the various types of mental disorders. However, the information was not available. In addition, we were unable to determine the extent to which MOH used historical data to inform the management of mental health services. MOH indicated that *"the process of collection and submission of the mental health data has many challenges as these data do not usually reach the Director of Mental Health routinely and certainly not in a timely manner".* MOH noted that steps are being taken to improve the process, but there is need for improvement in the human resources and training.

**3.9** MOH collated and provided mental health diagnosis data for period 2010 to 2015, upon our request. The data revealed that of the 153,440 mental health case load, schizophrenia disorder accounted for 117,078 (76 per cent); while, mood disorders accounted for 16.5 per cent of the cases **(Figure 10).** As shown in **Figure 11**, schizophrenia was the leading mental health disorder, accounting for on average 73 per cent of the cases, while mood disorders accounted for 19 per cent each year. However, we observed that MOH focused its attention

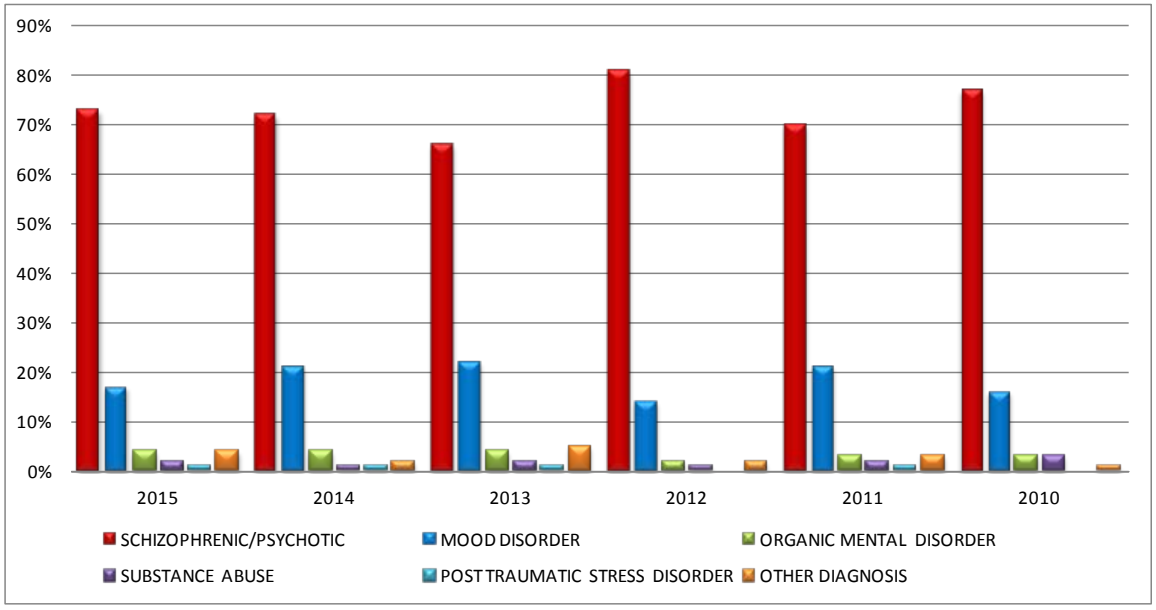
[16] **Diagnosis**
**Psychotic** (Schizophrenia, Brief Psychotic, Schizoaffective, Substance-included Psychotic Disorders);
**Mood** (Depressive Disorder, Bipolar Disorder);
**Anxiety** (Post Traumatic Stress Disorder );
**Cognitive** (Dementia)
**Substance Abuse** (Alcohol Dependence, Cannabis Dependence, Polysubstance Dependence; Alcohol Abuse , *Cannabis Abuse Cocaine Abuse)

mainly on promoting awareness on mood and anxiety related disorders**.** MOH indicated that *"although 72% of the patients in the mental health clinics are treated for Schizophrenia, we were aware that depression and anxiety are more common and often undiagnosed and untreated but contribute to increased morbidity and complications for other non-communicable diseases."* We also observed that MOH did not consider mental health research as a priority, as this activity was not included in MOH strategic and operational plans for the period 2010 to 2019.

## Figure 10 Analysis of mental health diagnosis 2010 – 2015




## Figure 11 Analysis of annual mental health diagnosis 2010 – 2015



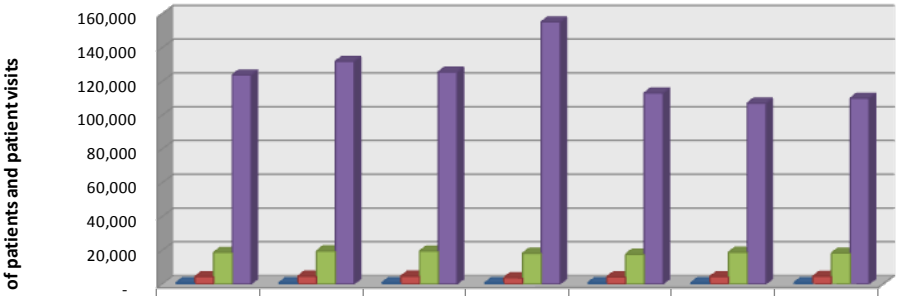

**Source:** AuGD analysis of data provided by MOH

### Mental health services are mainly offered at primary health facilities

**3.10** Our analysis showed that over the last six years, 2010 to 2015, on average 78 per cent of mental health patients received treatment at primary health facilities, while only 22 per cent received treatment at BVH. Given that MOH neither makes specific budgetary allocation to mental health nor maintains actual expenditure for this activity, we were unable to determine whether allocations, between BVH and primary health care facilities, were consistent with MOH intention to encourage mental health reform. MOH only provided information on the total expenditure for community-based mental health services for fiscal year 2014-15. The information revealed that only five per cent of the mental health expenditure of $1.3 billion, for that year, was spent on community-based mental health care, which treated on average 78 per cent of mental health patients each year between 2010 and 2015. BVH expenditure was 95 per cent of the total mental health expenditure, although the number of patients who received treatment at BVH over the period averaged only 22 per cent.

**3.11** There is an increasing trend for mental health services at primary health care facilities. **Figure 12** shows that the number of patients obtaining mental health service or visiting primary health care facilities for the first time in a given calendar year increased from 18,332 in 2010 to 19,610 in 2015. Meanwhile, total patient visits have increase by 20 per cent over six years, moving from 110,040 in 2010 to 131,836 in 2015. However, the number of out-patients visiting BVH remained relatively constant moving from 4,522 in 2010 to 4,601 in 2015. The number of in-patients also remained fairly constant over the period.

## Figure 12 Mental health patient visits, 2010 to 2015




| | Six-year Average | 2015 | 2014 | 2013 | 2012 | 2011 | 2010 |
|---|---|---|---|---|---|---|---|
| Total No. of In-patients - BVH | 790 | 786 | 802 | 788 | 793 | 779 | 790 |
| Total No. of Outpatients - BVH | 4,336 | 4,601 | 4,617 | 3,707 | 4,245 | 4,324 | 4,522 |
| No. of patients (Case Load) - Primary Health Care | 18,685 | 19,610 | 19,512 | 18,203 | 17,645 | 18,809 | 18,332 |
| Total Patient Visits (Primary Health Care) | 123,825 | 131,836 | 125,551 | 155,252 | 113,139 | 107,129 | 110,040 |

**Note:**
**Case Load:** Patients obtaining community mental health service for the very first time, and patients visiting for the first time within a given calendar year
**Total Patient Visits:** Case load + re-visits
**Source:** AuGD analysis of Mental Health data

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# Appendices

## Appendix 1 BVH bed capacity and patient load, 2010 to 2015

| Details | Average 6-years | | 2015 | 2014 | 2013 | 2012 | 2011 | 2010 |
|---|---|---|---|---|---|---|---|---|
| **No. of Patients** | **No.** | **Percentage** | | | | | | |
| **Acute** | 72 | 9% | 74 | 75 | 73 | 75 | 66 | 70 |
| **Sub-acute** | 97 | 12% | 90 | 99 | 95 | 101 | 98 | 99 |
| **Chronic** | 621 | 79% | 622 | 628 | 620 | 617 | 615 | 621 |
| **Total No. of Patients** | **790** | **100%** | **786** | **802** | **788** | **793** | **779** | **790** |
| **Bed Complement** | | | | | | | | |
| **Acute** | 76 | 9% | 76 | 76 | 76 | 76 | 75 | 79 |
| **Sub-acute** | 101 | 12% | 102 | 102 | 102 | 102 | 102 | 97 |
| **Chronic** | 668 | 79% | 618 | 618 | 618 | 618 | 769 | 769 |
| **Total Bed Complement** | **845** | **100%** | **796** | **796** | **796** | **796** | **946** | **945** |
| **% of beds occupied** | **93%** | **-** | **99%** | **101%** | **99%** | **100%** | **82%** | **84%** |

**Source:** AuGD analysis of information provided by BVH

## Appendix 2 Movement of Patients at BVH 2010 to 2015

| Details | 2010 | | | | 2011 | | | | 2012 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Acute | Sub-Acute | Chronic | Total | Acute | Sub-Acute | Chronic | Total | Acute | Sub-Acute | Chronic | Total |
| No. of Patients from previous year | 67 | 86 | 641 | 794 | 70 | 99 | 621 | 790 | 66 | 98 | 615 | 779 |
| No. of Patients admitted during the year | 1046 | 5 | 0 | 1051 | 953 | 2 | 0 | 955 | 1000 | 2 | 0 | 1002 |
| No. of Patients transferred from acute care | 0 | 471 | 0 | 471 | 0 | 352 | 0 | 352 | 0 | 361 | 0 | 361 |
| No. of Patients transferred from sub-acute care | 0 | 0 | 188 | 188 | 0 | 0 | 129 | 129 | 0 | 0 | 166 | 166 |
| **Total in hospital for the year** | **1113** | **562** | **829** | **2504** | **1023** | **453** | **750** | **2226** | **1066** | **461** | **781** | **2308** |
| No. Of Patients Discharged | 568 | 275 | 193 | 1036 | 595 | 203 | 129 | 927 | 618 | 176 | 149 | 943 |
| No. of Patients Transferred to Sub-Acute | 471 | 0 | 0 | 471 | 352 | 0 | 0 | 352 | 361 | 0 | 0 | 361 |
| No. of patients leaving  without permission | 4 | 4 | 15 | 23 | 10 | 23 | 6 | 39 | 12 | 22 | 15 | 49 |
| No. of Patients Transferred to Chronic | **0** | **184** | 0 | 184 | 0 | **129** | 0 | 129 | 0 | 162 | 0 | 162 |
| **No of patients remaining at end of year** | **70** | **99** | **621** | **790** | **66** | **98** | **615** | **779** | **75** | **101** | **617** | **793** |

| Details | 2013 | | | | 2014 | | | | 2015 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Acute | Sub-Acute | Chronic | Total | Acute | Sub-Acute | Chronic | Total | Acute | Sub-Acute | Chronic | Total |
| No. of Patients from previous year | 75 | 101 | 617 | 793 | 73 | 95 | 620 | 788 | 75 | 99 | 628 | 802 |
| No. of Patients admitted during the year | 996 | 5 | 0 | 1001 | 1005 | 3 | 0 | 1008 | 991 | 2 | 0 | 993 |
| No. of Patients transferred from acute care | 0 | 372 | 0 | 372 | 0 | 398 | 0 | 398 | 0 | 414 | 0 | 414 |
| No. of Patients transferred from sub-acute care | 0 | 0 | 168 | 168 | 0 | 0 | 168 | 168 | 0 | 0 | 144 | 144 |
| **Total in hospital for the year** | **1071** | **478** | **785** | **2334** | **1078** | **496** | **788** | **2362** | **1066** | **515** | **772** | **2353** |
| No. Of Patients Discharged | 612 | 189 | 153 | 954 | 596 | 223 | 150 | 969 | 564 | 262 | 137 | 963 |
| No. of Patients Transferred to Sub-Acute | 372 | 0 | 0 | 372 | 398 | 0 | 0 | 398 | 414 | 0 | 0 | 414 |
| No. of patients leaving  without permission | 14 | 26 | 12 | 52 | 9 | 9 | 10 | 28 | 14 | 26 | 13 | 53 |
| No. of Patients Transferred to Chronic | 0 | 168 | 0 | 168 | 0 | 165 | 0 | 165 | 0 | 137 | 0 | 137 |
| **No of patients remaining at end of year** | **73** | **95** | **620** | **788** | **75** | **99** | **628** | **802** | **74** | **90** | **622** | **786** |

**Source**: BVH yearly Statistical Reports 2010 to 2015

## Appendix 3 Analysis of 2006 action plan for Mental Health Reform

| Infrastructure: | | Outcome |
|---|---|---|
| **Upgrade health centres to accommodate the increase in clinical sessions for both adult and child psychiatry services:** | | |
| ALL RHAs | Types 3-5 and appropriate type 2 health centres | **Not yet achieved** |
| **Construction of discrete wards in regional hospitals:** | | |
| SRHA | Mandeville Hospital - 20 beds | **Not yet achieved** |
| NERHA | St. Ann's Bay Hospital - 20 beds | **Not yet achieved** |
| SERHA | Spanish Town Hospital - 20 beds | **Not yet achieved** |
| SERHA | Kingston Public Hospital - 40 beds | **Not yet achieved** |
| **Refurbishing of hospitals to and to facilitate optimum care** | | |
| SERHA | Linstead Hospital | **Not yet achieved** |
| WRHA | Cornwall Regional Hospital | **Not yet achieved** |
| Various levels of supervised and supportive living facilities in each region: | | |
| NERHA | One highly supervised living facility | **Not yet achieved** |
| | Three supportive living facilities (1 per parish) | **Not yet achieved** |
| WRHA | One highly supervised living facility | **Not yet achieved** |
| | Four supportive living facilities - 1 per parish (Include the expansion WASP[17] facility) | **Not yet achieved** |
| SRHA | One highly supervised living facility | **Not yet achieved** |
| | Three supportive living facilities -1 per parish (Include the expansion CLASP[18] facility) | **Not yet achieved** |
| SERHA | Four highly supervised living facility: (2 each in KSA and St. Catherine) | **Not yet achieved** |
| | Seven supportive living arrangements: (6 in KSA and 1 in St. Catherine) (including KRRC and Open Arms) | **Not yet achieved** |
| **Out-patient vocational income generating programme will be developed in various regions especially in the urban areas.** | | |
| SERHA | One such facility is to be developed at the WRHC[19] | **Not yet achieved** |
| **Establishment of a special unit for Forensic Psychiatric patients and for patients being treated against their will to be developed jointly by the Ministry of Justice and Health** | | |
| N/S | N/S | **Not yet achieved** |

**Note:** N/S Not Specified

**Source:** Cabinet Submission dated February 27, 2006

[17] Westmoreland Association for Street People
[18] Clarendon Association for Street People
[19] Windward Road Health Complex

## Appendix 4 Best practices in implementing mental health reform

| Italy |
| --- |
| In 1978 Italy introduced Law No. 180 gradually phasing out psychiatric hospitals and introducing a community-based system of psychiatric care. Treatment for acute problems is delivered in general hospital psychiatric units, each with a maximum of 15 beds. A network of community mental health and rehabilitation centres support mentally ill people, based on a holistic perspective. As a result of the law, no new patients were admitted to psychiatric hospitals, and a *process of deinstitutionalization of psychiatric In-patients was actively promoted. The In-patient population dropped by 53% between 1978 and 1987, and the final dismantling of psychiatric hospitals was completed by 2000. |
| **Paraguay** |
| In 2008, the Paraguayan government formally committed itself to reform its public health system in accordance with regional human rights treaties and the recommendations of regional human rights bodies. Since the 2008, the Paraguayan government has taken positive steps towards mental health reform. The hospital's in-patient population has been reduced by almost half since 2003, and the government is expanding community-based services and support. Today 28 long-term hospital residents in group homes in the community, and a handful of "chronic patients" live independently, having joined the workforce. Another nine group homes are scheduled to open in the next two years. |

**Source:** WHO-AIMS World Report on Disabilities 2011

## Appendix 5 MOH grant request for pilot project

| ACTIVITY | $ |
|---|---|
| Upgrade 3 existing facilities to accommodate 45 suitable patients from BVH.<br>Refurbishing of CLASP: J$2,351,930.00<br>Refurbish Ebenezer Home: J$2,952,293.20<br>Partitioning of WASP from the Infirmary: J$1,521,120.00 | 6,825,343.20 |
| Purchase of two 15 seater busses to support community mental health services at a cost of $ 2.7m each. | 5,400,000.00 |
| Equipment and Furniture:<br>Ebenezer Home : J$155,666.70<br>CLASP : J$431,333.40<br>WASP : J$820,040.00 | 1,407,040.00 |
| Ministry of Health to convene a series of stakeholders' forum | 500,000.00 |
| Develop and implement training programme for chronic patients and staff in community living | 90,000.00 |
| Procurement of restraints for facilities and mental health teams island-wide | $2,790,000.00 |
| Training of staff in the use of appropriate restraints (island-wide ) | 100,000.00 |
| Update AIMs database | 0 |
| Professional and Project Management Fees (10%) | 1,500,000.00 |
| Contingency (5%) | 1,000,000.00 |
| Purchase 2 laptops, 2 printers and 1 desktop computer to support the mental health education and promotion programme | 387,616.80 |
| | **$20,000,000.00** |

**Source:** MOH grant request form