National Forum: Mental Health Promotion & Mental Disease Prevention

Organized by

The Ministry of Health of Trinidad and Tobago
in collaboration with
the Pan American Health Organization &
the World Health Organization

Held October 14-16, 2008
Kapok hotel, 16-18 Cotton Hill, St. Clair
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Draft Final Report

Prepared by
PAHO/WHO Trinidad and Tobago
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EXECUTIVE SUMMARY

With the phrase, “No health without mental health”, public health discourse now includes mental health, in its positive sense, as well as mental illness. Just as public health and the population health approach are established in other areas such as heart health and tobacco control, so it is becoming clearer that, “Mental health is everybody’s business”.

From October 14-16, 2008, the Ministry of Health in collaboration with the Pan American Health Organization/World Health Organization held the ***National Forum on Mental Health Promotion and Mental Disease Prevention***. Promoting mental health means enhancing the mental health of all in the community, of those with no experience of mental illness as well as those who live with or have a history of living with or one or more illnesses. Promoting mental health uses a range of actions that increase the chances of more people enjoying better mental health.

Traditionally, societies have looked to the health sector to deal with its concerns about health and disease. Certainly, maldistribution of health care – not delivering care to those who most need it – is one of the social determinants of health. But the high burden of illness responsible for premature loss of life arises in large part because of the conditions in which people are born, grow, live, work, and age – conditions that together provide the freedom people need to live lives they value. Daily living conditions together constitute the social determinants of health.

We do know much about the social determinants of health yet policy-making all too often appears to happen as if there were no such knowledge available. There is a pressing need to bring together different disciplines and areas of expertise, to work out how social determinants create health inequity, and how action on these determinants can produce better, fairer health.

Traditionally, society has looked to the health sector to deal with its concerns about health and disease. Action on the social determinants of health must involve the whole of government, civil society and local communities, business, global fora, and international agencies. Policies and programmes must embrace all the key sectors of society not just the health sector. That said, the Minister of Health and the Ministry of Health are critical to global change. They can

champion a social determinants of health approach at the highest level of society, they can demonstrate effectiveness through good practice, and they can support other ministries in creating policies that promote health equity.

Those invited to participate in the Forum demonstrated the recognition by the Government of Trinidad and Tobago that inter-sectoral collaboration is key to effective programs for mental health promotion. For some collaborative programs mental health outcomes are the primary objective. For the majority, however, these may be secondary to other social and economic outcomes but are valuable in their own right.

Approximately 60 attended the national forum with representation from: the Ministry of Health and Regional Health Authorities; the Tobago House of Assembly; the Ministry of Education; the Ministry of Labour, Small and Micro Enterprise Development; the Ministry of Social Development; the Ministry of the Attorney General; the University of the West Indies; the Chamber of Industry and Commerce; the National Parent Teachers Association and the private sector. Appreciation is extended to all those attending for their commitment to improving mental health services in the country.

RECOMMENDATIONS

DIRECTED TO THE MINISTRY OF HEALTH

It is recommended that the Ministry of Health:

1.1 Appoint a full-time National Mental Health Coordinator

1.2 Scale up investment in mental heath and promote allocative efficiency in the distribution of the budget towards mental health reflecting the continuum of care and placing emphasis on the promotion of mental health and prevention of mental heath disorders.

1.3 Seek enactment of the revised human rights driven mental health legislation.

1.4 Complete the assessment of the Mental Health System in Trinidad and Tobago using the WHO-AMIS instrument by the end of December 2008. This information should then be used to inform planning at the national and regional levels on an intra- and inter-governmental basis, and inter-sectoral (private sector, non-governmental organisations, community based organisations, civil society)

1.5 Finalize the national mental health policy committing the government to integrated mental health care and ensure that the national health policy reflects the same commitment.

1.6 Strengthen the delivery of community based mental health services and ensure that the integration of mental health services into primary care is accompanied by complementary services, particularly secondary care components to which primary care workers can turn for referrals, support, and supervision. Home care support is also important.

1.7 Strengthen the availability and accessibility of an adequate and qualified human resource base trained in mental health. Pre-service and/or in-service training of primary care workers on mental health issues is an essential prerequisite for mental health integration. Collaborative or shared care models, in which joint consultations and interventions are held between primary care workers and mental health specialists, should be considered as a way of providing ongoing training and support.

1.8 Liaise with the University of the West Indies and other training institutions to have rehabilitation, mental health issues and psycho-social responses included in the curriculum across multi-disciplines.

1.9 Strengthen programming for vulnerable groups especially those facing mental health challenges, the child and adolescent population, the elderly, etc.

1.10 Review and revise as necessary the terms of reference and membership of the National Mental Health Advisory Committee. Review and revise as necessary the terms of reference for mental health committees in regional health authorities and their operational status.

1.11 Implement an integrated, automated mental health information ensuring that is becomes an integral part of the more comprehensive national health information system and incorporating statistics based on the application of a determinants of health approach.

1.12 Educate the public by launching public awareness campaigns to overcome stigma and discrimination.

1.13 Collaborate with other government non-health sectors, non-governmental organizations, community-based organisations, faith-based organisations, communities, families and consumers in decision-making on policies and services.

DIRECTED TO THE MINISTRY OF EDUCATION WITH THE SUPPORT OF THE MINISTRY OF HEALTH

It is recommended that the Ministry of Education with the support of the Ministry of Health:

2.1 Promote the designation of schools as “Health-Promoting Schools” under the World Health Organization’s Global School Initiative reflecting that schools are a healthy setting for living, learning and working.

2.2 Strengthen the policy framework for mental health promotion and disease prevention in schools. This should include, but not be limited to:

- harmonisation of policies that address (or should address) mental health needs in children and adolescents, e.g. National School Health Policy, National Youth Policy, Health and Family Life Education, etc.

- development and dissemination of protocols for managing mental health issues in schools
- clarification of the roles of support services personnel (diagnostic specialists, social workers, guidance officers) in the school setting
- review legislation impacting on child health and protection and strengthen if necessary
- enforce legislation to prevent students from having easy access to purchase alcohol and tobacco

2.3 Re-orient child development services expanding screening to include psycho-social and cognitive aspects, developing/revising the referral protocols as well as ensuring follow-up on referrals and counter-referrals, and strengthening child/adolescent mental health services

2.4 Create a supportive environment for students to seek and receive counselling for substance abuse, mental health issues and other personal/social problems without fear of exposure and/or discrimination.

2.5 During teaching sessions, have emphasis placed on adopting healthy lifestyles, including eating balanced meals, conflict management, and substance abuse prevention. Ensure that mental health issues and other coping skills are part of the curriculum. Place Health and Family Life Education on the curriculum. Including these topics as part of the curriculum necessitates that it be accompanied by training as required of teachers.

2.6 Promote an inclusive approach to planning, developing and execution of mental health promotion and support initiatives in the school setting ensuring that the youth are involved at all stages

2.7 Actively involve and support parents/guardians to maintain students' healthy behaviours, through the strengthening of Parent Teachers Associations and other support groups.

2.8 Develop and implement training programmes on parenting with the support of non-governmental organizations, faith-based organizations and the National Parent Teachers Association of Trinidad and Tobago.

2.9 Train teachers, guidance counsellors, health care workers, and social service workers on the early detection of mental health concerns in children and adolescents.

2.10 Develop/establish joint teams to undertake early detection of mental health concerns in children and adolescents once agreement has been reached on the roles and responsibilities of each member of the joint team.

2.11 Use the mass media, both electronic and print, should be used to highlight health issues affecting students.

DIRECTED TO THE MINISTRY OF LABOUR
WITH THE SUPPORT OF THE MINISTRY OF HEALTH

It is recommended that the Ministry of Labour with the support of the Ministry of Health:

3.1 Strengthen the policy framework for mental health promotion and disease prevention in work places. This should include, but not be limited to:

- adequate employment opportunities for vulnerable populations including the mental health patients (employment policies, education and training)
- sustenance of those who do not have or have lost work (unemployment insurance, welfare assistance)
- avoidance of discrimination through legislation specific to employment for people with family care giving responsibilities and those with disabilities including mental health patients and regulation of the psychosocial work environment through psychosocial risk management and legislation on safety
- definition of job conditions including job security, hours of work, leave entitlements (including maternity and paternity leave) and minimum wages
- definition of the role of labour unions and international labour federations in improving job conditions

3.3 Ensure workplace health policies include mental health and wellness using the International Labour Organization model, i.e. flexible employment practices and hiring, ensuring safe place of work

3.2 Promote an inclusive approach to planning, developing and execution of mental health promotion and support initiatives in the work setting ensuring through collaboration with employees, employers, trade unions and other relevant stakeholders

3.4 Promote innovative means of promoting “healthy working relationships” in the work setting, e.g. incentive programmes e.g. tax breaks for employers; bonuses/time-off/leave for employees, employee reward and recognition program, and day care/homework centres, flexitime, gyms in the work setting, car-pooling, de-centralisation of workplaces, family days, sports days, social events, retreats and work-sponsored workshops focusing on topics such as team building, communication, conflict resolution, grievance, balancing personal and work lives, retirement, time management, fostering productive work relationships, managing anger and disappointment, and resolving conflicts effectively, etc.

3.5 Promote the establishment of employee assistance programmes in the work setting among employees, employers, trade unions and other relevant stakeholders

DIRECTED TO PAHO/WHO

It is recommended that PAHO Trinidad and Tobago convene two working group meetings:

- one of selected forum participants to prepare a short brief on the recommendations for the school setting that can be presented to the Ministries of Health and Education
- one of selected forum participants and representation from the International Labour Organization to prepare a short brief on the recommendations for the workplace setting that can be presented to the Ministries of Health and Labour

FINAL REPORT

TRINIDAD AND TOBAGO NATIONAL FORUM – MENTAL HEALTH PROMOTION AND MENTAL DISEASE PREVENTION

1. INTRODUCTION

With the phrase, “No health without mental health”, public health discourse now includes mental health, in its positive sense, as well as mental illness. Just as public health and the population health approach are established in other areas such as heart health and tobacco control, so it is becoming clearer that, “Mental health is everybody’s business”.

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Those invited to participate in the Forum demonstrated the recognition by the Government of Trinidad and Tobago that inter-sectoral collaboration is key to effective programs for mental health promotion. For some collaborative programs mental health outcomes are the primary objective. For the majority, however, these may be secondary to other social and economic outcomes but are valuable in their own right.

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2. OPENING CEREMONY

Dr. Rohit Doon, Advisor in Health Promotion, Communications and Public Health in the Ministry of Health acted as Chair of the Opening Ceremony. Ms. Sandra Jones, Permanent Secretary of the Ministry of Health welcomed participants to the national forum.

In her remarks, Dr. Carol Boyd Scobie, Pan American Health Organization/World Health Organization (PAHO/WHO) Representative in Trinidad and Tobago emphasized that mental health is a fundamental human right enabling people to experience life as meaningful and to be creative, active and productive. Improved mental health is linked to better health, productivity and safety and is key to development in every country. She went on to say that the World Health Organization is now calling on governments, donors and mental health stakeholders to rapidly increase funding and basic mental health services to close the huge treatment gap for a number of mental, neurological and substance use disorders.

Left to Right: Dr. Doon, Dr. Boyd Scobie,
Senator The Honourable Jerry Narace, Ms. Jones

The Minister of Health, Senator the Honourable Jerry Narace stated that a forum of this nature provided a unique opportunity to meet and exchange views and to look at practical ways of tackling the issue of mental health promotion in a country where mental health remains one of the main health challenges the country has been facing for several decades. He stated that addressing mental health is a major priority of the government, as it aims to ensure social inclusion where “everyone will be provided with an opportunity to make a contribution to national development”.

Furthermore, the Minister announced that the Mental Health Bill has been finalized and will shortly be presented to the Legislative Review Committee. The proposed legislation is apparently aligned with the United Nations charter on Human Rights and seeks to shift the approach of organization and delivery of mental health services from the institution–centred model towards a primary health care based model. According to the Minister, this re-orientation demonstrates that Trinidad and Tobago sees mental health as a vital component of primary health care as advocated by Dr Margaret Chan, Director-General of the World Health Organization (WHO), when announcing the *Mental Health Gap Action Programme (mhGAP)* on October 9, 2008. WHO is appealing to its member countries to increase their support for mental health care services. The Minister stated that this comes at a time when the Vision in Trinidad and Tobago fully coincides with that directive. Vision 2020 envisages a "Caring Society" that identifies "the removal of the barriers that prevent many people from realizing their full potential, barriers that impede social mobility and social justice and which consign people to poverty and disadvantage".

The Minister emphasised that mental health must be viewed from a broad perspective since healthy public policy involves a multi-disciplinary, multi-sectoral approach. Supporting the WHO Report of the Commission on Social Determinants of Health, he emphasised that addressing health problems in a holistic manner means dealing with socio-economic, cultural and environmental determinants that are beyond the scope of responsibility of the health sector. Therefore, realizing the concept of mental health promotion involves multiple partners. The Minister underlined that as the reason for representatives from various agencies and sectors having been invited to the ***National Forum on Mental Health Promotion and Mental Disease Prevention***.

3. OBJECTIVES OF NATIONAL FORUM

Dr. Doon outlined the following objectives for the national forum:

- To create an awareness of: how to assess and strengthen mental health systems and the practice of promoting mental heath and psychosocial well-being.

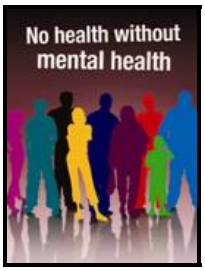
- To describe how mental health systems are being strengthened in the Americas and the Caribbean to provide a context for strengthening mental health systems in Trinidad and Tobago

- To identify priority areas for improving the mental health system in Trinidad and Tobago taking into account the preliminary results from the implementation of the WHO-AMIS instrument in Trinidad and Tobago

- To create an awareness of and develop action plans for promoting mental health promotion and mental disease prevention in schools and workplaces in Trinidad and Tobago

- To identify the next steps to be taken to promote mental health promotion and mental disease prevention in Trinidad and Tobago

4. MENTAL HEALTH SYSTEM: HOW TO STRENGTHEN IT?



On 9th October, 2008, WHO launched its action programme in Geneva, the mental health Gap Action Programme (mhGAP) which aims at scaling up services for mental, neurological and substance use disorders for countries especially with low- and middle-income.

The *mhGAP* focuses on the gap between what is needed to treat a range of priority disorders and what is actually available worldwide.

In the majority of countries, less than 2% of health funds are spent on mental health. In any one year, one-third of people living with schizophrenia, more than half of those suffering from depression, and three-quarters of those with alcohol use disorders are unable to access simple and affordable treatment or care. Worldwide, every 40 seconds, one person dies of suicide that is one of the leading causes of death among young adults. Suicide is a condition that is preventable. WHO is now calling on governments, donors and mental health stakeholders to rapidly increase funding and basic mental health services to close this huge treatment gap. The programme sets out a number of cost-effective strategies to tackle the treatment gap for mental, neurological and substance use disorders. These include: assessing countries needs and resources; developing sound mental health policy and legislation; and increasing human and financial resources. The programme relies on partnerships to scale up services with the objective of reducing the burden of mental, neurological and substance use disorders.

Dr. Shekhar Saxena, WHO Programme Manager in the Department of Mental Health and Substance Abuse, made a presentation on how to assess and strengthen mental health systems. Refer to Appendix 2 for a copy of his presentation. He indicated that mental health systems should have the following elements:

- policies, plans, legislation and financing
- mental health authorities (units in government)
- organization of services (e.g. catchment areas)
- facilities (outpatient, day treatment, hospital units, residences, etc)
- supply of psychotropic medicines
- human resources working for mental health and their training and supervision
- programmes for income and residence for people with disorders
- promotion and prevention programmes
- mental health components in general health care, schools, prisons, etc
- mental health information system

Throughout 2001, the World Health Organization carried out a global campaign to raise public awareness about mental health. The World Health Report 2001 -- "Mental Health: New Understanding, New Hope" -- looked at depression, schizophrenia, Alzheimer's disease and several other mental and brain disorders. It dealt with prevention, treatment and the provision of services. Most importantly, it made the following ten recommendations for action:

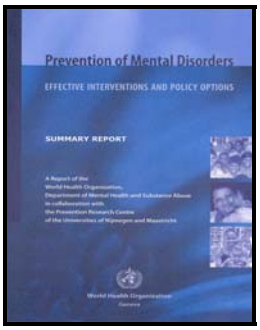
- provide treatment for mental disorders within primary care

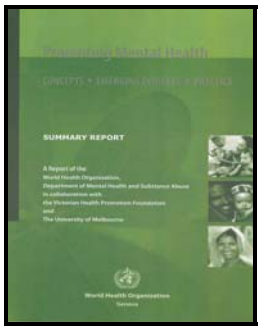
- make psychotropic medicines available
- give care in the community.(replace large custodial hospitals by community care facilities backed by general hospital psychiatric beds and home care support)
- educate the public (launch public awareness campaigns to overcome stigma and discrimination)
- involve communities, families and consumers in decision-making on policies and services
- establish national policies, programmes and legislation
- develop human resources. (train mental health professionals)
- link mental health with other social sectors
- monitor community mental health, and
- support more research

The WHO Atlas study reports that in 2005 more than 24% of countries do not have any system for collecting and reporting mental health information. Many other countries have information systems but these systems often are of limited scope and quality. This lack of good information impedes the development of mental health policies, plans and services. According to Dr. Saxena, a mental health system should be assessed both qualitatively (e.g. situational analysis through interviews with key stakeholders and the review of available reports, etc.) and quantitatively through a mental health system indicator scheme.

The World Health Organization (WHO) has an increasingly active and leading role in the area of mental health. A complete list of WHO documents on mental health can be viewed and downloaded from the WHO website (http://www.who.int/mental_health/en/). WHO recognises that, besides expanding services to those who at present receive none, prevention of mental disorders and promotion of mental health make critical contributions to population mental health in all parts of the world. WHO's recent efforts include international reviews of scientific evidence for these interventions, dissemination of the evidence in all countries, more particularly within the lower and middle income groups, and assisting governments and non-governmental organisations to use the evidence in developing programmes and activities.

WHO has recently published the following two reports "*Prevention of Mental Disorders: Effective Interventions and Policy Options"* and "*Promoting Mental Health: Concepts, Emerging Evidence, Practice"*. These Reports highlight the need for collaboration between health and non-health sectors in promoting mental health and psychosocial wellbeing. One of the serious limitations in developing this collaboration is the lack of clear and specific guidance on the practice of promoting mental health.





Another limitation is terminology. Those working outside health tend to speak of supporting psychosocial wellbeing while those in health tend to speak of public health and mental health. Exact definitions of the terms vary between and within the sectors, disciplines and across countries.

WHO has developed a guidance package to: (1) develop policies and comprehensive strategies for improving the mental health of populations; (2) use existing resources to achieve the greatest possible benefits; (3) provide effective services to those in need; and (4) assist the

reintegration of persons with mental disorders into all aspects of community life, thus improving their overall quality of life. The package consists of a series of fourteen (14) inter-related user-friendly modules that are designed to address the wide variety of needs and priorities in policy development and service planning. The modules can be accessed at;

http://www.who.int/mental_health/policy/essentialpackage1/en/index.html.

The topic of each module represents a core aspect of mental health. They can be used individually or as a package. They are cross-referenced with each other for ease of use. Countries may wish to go through each of the modules systematically or may use a specific module when the emphasis is on a particular area of mental health.

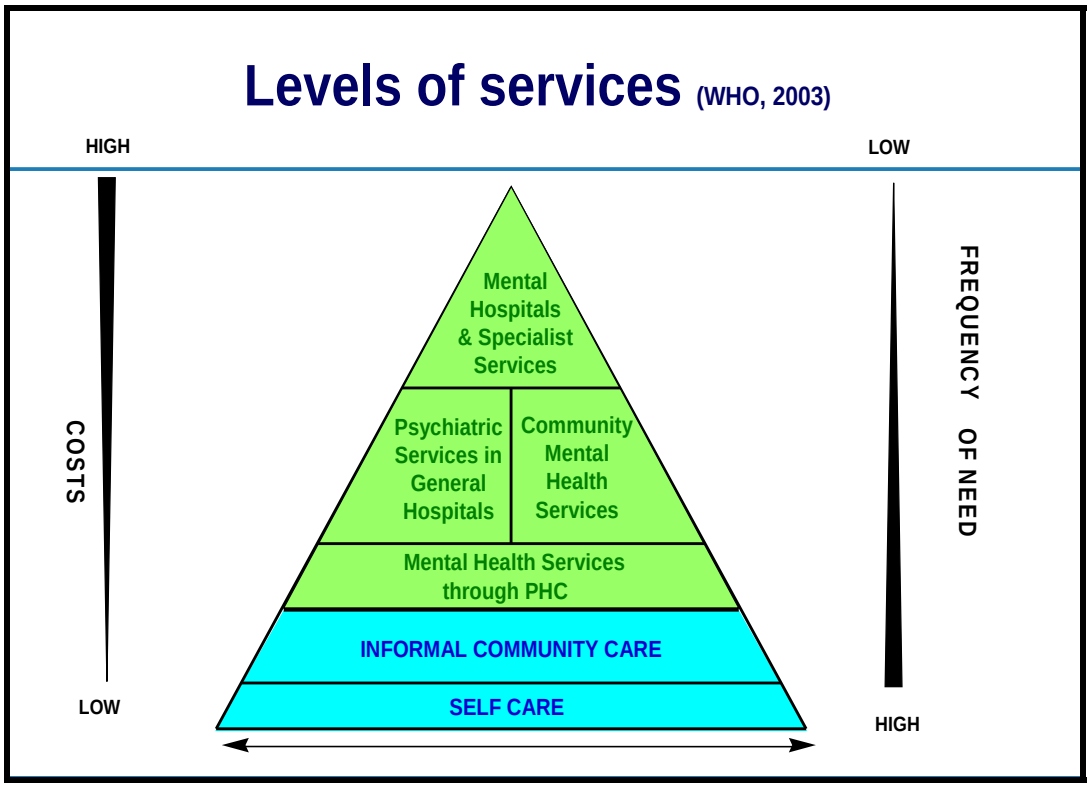
The modules can be used by the intended audience in a number of possible ways. Public health planners and mental health policymakers may use them to work on mental health promotion across the range of community sectors. Use of the modules by professionals or officials within these sectors directly and independently may also be beneficial. Mental health professionals will find the modules useful in their roles to assist with advocacy and leadership in sectors inside and outside health. The package also has separate modules for the separate sectors illustrating the ways mental health can be promoted in the course of that sector's work, and how this in turn can assist the sector with its own outcomes. In addition, the modules are cross-referenced when working on common themes such as violence reduction or substance abuse. A matrix is presented to guide those working in public health planning and in crosscutting issues, to emphasise the cross- referencing of topics and the common themes and methods.

Once a policy/draft policy and/or plan have been drawn up in a country, it is important to conduct an assessment of whether certain processes have been followed that are likely to lead to the success of the policy, and whether various content issues have been addressed and appropriate actions included in the policy and/or the plan. In order to assist with this evaluation, WHO has developed two checklists to assess the adequacy and the content of a mental health policy and/or plan as well as the process for developing them. The checklists can be accessed at http://www.who.int/mental_health/policy/essentialpackage1/en/index2.html .

WHO Service Organization Pyramid for an Optimal Mix of Services for Mental Health

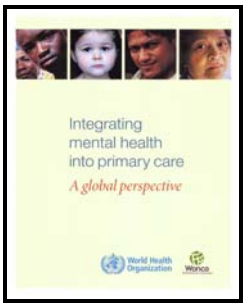
The *WHO Service Organization Pyramid for an Optimal Mix of Services for Mental Health* proposes the integration of mental health services with general health care. Integrated primary mental health care is a fundamental component of this model, and is supported by other levels of care including community-based and hospital services. The WHO model is based on the principle that no single service setting can meet all population mental health needs. It also promotes good use of resources, the involvement of individuals in their own mental health care, and a human rights and community-based orientation. The need for good linkages between primary care and other levels of care cannot be overstressed. A clear referral, back-referral and linkage system should be implemented in consultation with health managers and health workers at all service levels.

Regardless of resource level, all countries should aim to procure the best possible mix of services from all levels of the pyramid and regularly evaluate what is available, with the aim of gradually improving the range of available services.



The WHO model emphasizes the dimension of self-care that is required at each service level. Self-care is reflected at the bottom of the pyramid, and at this level refers to care without individual professional input. At all levels of the system, self-care is essential and occurs simultaneously with other services. This is reflected by the three dimensional nature of the pyramid. At each higher level of the pyramid, individuals become more engaged with professional assistance. However, self-care continues at all levels, which in turn promotes and encourages recovery and better mental health.

Integrating mental health into primary care requires leadership and long-term commitment. The 2008 report "Integrating Mental Health into Primary Care: A Global Perspective" was developed jointly by the World Health Organization (WHO) and the World Organization of Family Doctors (Wonca) provides advice on how to implement and scale-up primary care for mental health.



The following ten principles were identified in the report for integrating mental health into primary care.

- ***Policy and plans need to incorporate primary care for mental health.***

  Commitment from the government to integrated mental health care, and a formal policy and legislation that concretizes this commitment, are fundamental to success. Integration can be facilitated not only by mental health policy, but also by general health policy that emphasizes mental health services at primary care level. National directives can be fundamental in

encouraging and shaping improvements. Conversely, local identification of need can start a process that flourishes and prospers with subsequent government facilitation.

- ***Advocacy is required to shift attitudes and behaviour.***

  Advocacy is an important aspect of mental health integration. Information can be used in deliberate and strategic ways to influence others to create change. Time and effort are required to sensitize national and local political leadership, health authorities, management, and primary care workers about the importance of mental health integration. Estimates of the prevalence of mental disorders, the burden they impose if left untreated, the human rights violations that often occur in psychiatric hospitals, and the existence of effective primary care-based treatments are often important arguments.

- ***Adequate training of primary care workers is required.***

  Pre-service and/or in-service training of primary care workers on mental health issues is an essential prerequisite for mental health integration. However, health workers also must practise skills and receive specialist supervision over time. Collaborative or shared care models, in which joint consultations and interventions are held between primary care workers and mental health specialists, are an especially promising way of providing ongoing training and support.

- ***Primary care tasks must be limited and doable.***

  Typically, primary care workers function best when their mental health tasks are limited and doable. One fundamental question that must be addressed is whether primary care workers will treat people with severe mental disorders such as schizophrenia and bipolar disorder, and alternatively, whether they will manage common mental disorders such as depression and anxiety. Decisions must be taken after careful consideration of local circumstances. This requires consultation with policy-makers and health care workers, as well as users of mental health services and their families. Available human and financial resources and the strengths and weaknesses of the current health system for addressing mental health should be assessed. Functions of primary care workers may be expanded as practitioners gain skills and confidence.

- ***Specialist mental health professionals and facilities must be available to support primary care.***

  The integration of mental health services into primary care must be accompanied by complementary services, particularly secondary care components to which primary care workers can turn for referrals, support, and supervision. This support can come from community mental health centres, secondary-level hospitals, or skilled practitioners working specifically within the primary care system. Specialists may range from psychiatric nurses to psychiatrists.

- ***Patients must have access to essential psychotropic medications in primary care.***

  Access to essential psychotropic medications is essential for the successful integration of mental health into primary care. This requires countries to directly distribute psychotropic medicines to primary care facilities rather than through psychiatric hospitals. Countries also need to review and update legislation and regulations to allow primary care workers to

prescribe and dispense psychotropic medications, particularly where mental health specialists and physicians are scarce.

- ***Integration is a process, not an event.***

  Even where a policy exists, integration takes time and typically involves a series of developments. Meetings with a range of concerned parties are essential and in some cases, considerable scepticism or resistance must be overcome. After the idea of integration has gained general acceptance, there is still much work to be done. Health workers need training and additional staff might need to be employed. Before any of this can occur, budgets typically will require agreement and allocation.

- ***A mental health service coordinator is crucial.***

  Primary care for mental health is usually most effective where a coordinator is responsible for overseeing integration. Integration of mental health into primary care can be incremental and opportunistic, reversing or changing directions, and unexpected problems can sometimes threaten the programme's outcomes or even its survival. Mental health coordinators are crucial in steering programmes around these challenges and driving forward the integration process.

- ***Collaboration with other government non-health sectors, nongovernmental organizations, village and community health workers, and volunteers is required.***

  Government sectors outside health can work effectively with primary care to help patients with mental disorders access the educational, social and employment initiatives required for their recovery and full integration into the community. Collaboration with social, education, judicial, housing and employment services is crucial for helping vulnerable populations access the many psychosocial services that they required. Nongovernmental organizations, village and community health workers, and volunteers often play an important role in supporting primary care for mental health.

- ***Financial and human resources are needed*.**

  Although primary care for mental health is cost effective, financial resources are required to establish and maintain a service. Training is central to the successful integration of mental health into primary care. Therefore, training costs need to be covered, and additional primary and community health workers might be needed.

5. MENTAL HEALTH IN THE AMERICAS

Dr. Jorge Rodríguez, PAHO/WHO Mental Health Coordinator spoke about challenges and responses in mental health in Latin America and the Caribbean. Refer to Appendix 3 for a copy of his presentation. Since the 1960s and 1970s, Pan American Health Organization (PAHO) Member States have striven to improve their systems for delivering mental health services. Still, these initiatives, largely local and isolated, have often failed in attaining the level of reform agreed by regional consensus or addressing challenges in a structural, integrated manner.

In keeping with the Regional Conference on the Restructuring of Psychiatric Care in Latin America (1990) and especially, its most frequently mentioned document, the Caracas Declaration, PAHO has been using the human rights conventions of the Inter-American and United Nations systems as binding instruments for implementing mental health reform under the terms of the consensus reached that year in Caracas and buttressed with subsequent documents, declarations, and standards on health and human rights.

The 1990 Caracas Declaration was a major turning point because it formally established the Initiative for the Restructuring of Psychiatric Care in the Region of the Americas. The Caracas Declaration placed special emphasis on the need to integrate mental health services into the general operational framework of primary health care. In their final document, delegates and attendees said that psychiatric hospitals based on the model of the asylum for the insane constituted a clear obstacle to delivering a health service compatible with decentralized, participatory, comprehensive, continuing, and preventive community-based care. However, many countries in the Americas have not moved beyond the psychiatric hospital as close to the only option for care. Many have not yet introduced widespread, consistent processes for decentralizing mental health services as called for in international guidelines and standards and delivering such services in primary health centres and networks.

Two resolutions by PAHO Directing Council in 1997 and 2001, reiterated that commitment for compliance and technical cooperation in the ongoing reform of mental health services within PAHO Member States in Latin America and the Caribbean.

In 2006, a regional conference organized by PAHO and the Brazilian Ministry of Health was held in Brasilia. At the conference, new challenges were cited that were not brought up in Caracas – the most prominent of these were:

- Psychosocial vulnerability, including the problems of specific groups such as indigenous populations and those living in extreme poverty, and the adverse effects of the lack of urban planning in large metropolis;
- Increased morbidity and psychosocial problems among children and adolescents;
- Greater societal demand for services to facilitate the adoption of effective prevention measures and to address suicidal behaviour and drug and alcohol abuse at an early stage, and
- Violence, whose steady increase calls for a response from the health services, especially the mental health services, in order to treat victims.

The World Health Report 2001 reported that only a small minority of the 450 million people suffering from a mental or behavioural disorder is receiving treatment. The result of a special study on mental health in Latin America and the Caribbean published in the PAHO Pan American Journal of Public Health concluded that in the Americas, "over one-third of individuals with non-affective psychosis, over half of those with an anxiety disorder, and some three-fourths of those with alcohol use, abuse or dependence did not receive mental health care from either specialized or general health services." In that Journal, PAHO Director Dr. Mirta Roses Periago wrote that the number of people with mental disorders in the Region of the Americas is expected to rise from 114 million in 1990 to 176 million in 2010.

According to the Mental Health Atlas 2005, 76.5% of the countries in 2005 had national mental health plans. Dr. Rodríguez said that this is highly significant, given that only 15 years beforehand such plans were virtually nonexistent. The real challenge is to implement these

plans, since several assessments indicate that actually fewer than half of the countries of the Region have done so.

The Atlas also indicates that 75% of the Latin American and Caribbean countries have mental health legislation. However, Dr. Rodríguez again invites us to not take this at face value. "The question that we should ask is to what extent this legislation is part of a complete body of law and to what extent they have been brought into line with international standards, and if these laws are in fact being properly enforced in the different contexts."

WHO recommends that to meet the challenge of modernizing and restructuring mental health as proposed in the Caracas and Brasilia guidelines, nations should allocate a minimum of 5% of their general health budgets to mental health. Dr. Rodríguez indicated that we also need to see how much of all that money is earmarked or absorbed by centralized psychiatric hospitals.

Human resources data for mental health in the Region of the Americas in the 2005 Atlas point to an obvious conclusion: there is an enormous need for Latin American and Caribbean countries to invest heavily in training and to work on retaining health workers with specialized education or skills in mental health disciplines. It is paramount to involve actors other than the traditional ones – not just psychiatrists, nurses or psychologists. There is a need for the involvement of others such as general practitioners, general nurses, and social services personnel and the civil society as a whole also. Users/consumers themselves and their relatives are playing a key role in many countries not only in terms of advocacy but also in providing assistance, support and care to those who need it.

Dr. Rodríguez explained the importance of developing specific programs for vulnerable or at-risk groups. PAHO has taken up the challenge of assisting and cooperating with Member States to ensure that they have programs and the ability to properly meet the needs of indigenous populations, communities stricken by disasters, groups living in extreme poverty, and the victims of violence, whether political, social, or gender-based. PAHO is also promoting programs for children and adolescents as well as older adults.

6. MENTAL HEALTH: THE CARIBBEAN PERSPECTIVE

Dr. Wendel Abel from the Department of Community Health and Psychiatry at the Mona Campus of the University of the West Indies provided a regional perspective on mental health services in the Caribbean and spoke to similar challenges previously enunciated by Dr. Rodríguez, but specific to the Caribbean context. Refer to Appendix 4 for a copy of his presentation.

A sub-regional meeting of regional mental heath stakeholders organized PAHO/WHO was held in Barbados from 26-28 July 2007. Arising from this meeting, a Mental Health Policy Framework for the Region was prepared and subsequently was presented and accepted at the CARICOM Caucus Meeting of Health Ministers in September 2007.

Caribbean countries inherited a mental health system form the British that was centred on large mental hospitals and involved the warehousing of large numbers of persons whose treatment

was primarily the custodial. Worldwide the deinstitutionalization movement which began in the 1950's with the discovery of effective medication and the concomitant development of the community mental health services influenced practice in the Caribbean. Early efforts to modernise mental health services in the region included the introduction of community mental health services in Jamaica in the mid sixties with the construction of two acute psychiatric units in the early 70's and the deployment of mental health personnel in the community.

Mental health has been on the agenda of the Conference of Caribbean Health Ministers ever since the inception of the group. In 1973, at the 5th Conference in Roseau, Dominica, Professor Michael Beaubrun, then Professor of Psychiatry at the University of the West Mona urged governments to develop community mental health, integrate these services with general health, provide acute psychiatric units in general hospitals, revise existing mental health legislation and develop programmes to address alcoholism and drug dependence. In 1983, a conference on Mental Health Models held in Jamaica, further endorsed these policy directions. The Ninth Meeting of the Conference of Health Ministers held in 1984, adopted these recommendations and mandated that an Action Group be established to facilitate the implementation of these recommendations.

The Caracas Declaration (1990) included similar recommendations made by Beaubrun in 1975. In 1995, in a meeting of technical personnel from the English speaking Caribbean convened by PAHO in Barbados, a number of priority areas and strategies for action were identified. A regional mental health planning conference held in 1997 in Martinique further refined the mental health priorities, which were subsequently incorporated into the Caribbean Cooperation in Health (CCH II). In 2001, The Caucus of Health Ministers endorsed the importance of mental health and affirmed the recommendations from the World Health Report 2001. Between 2005 and 2006 CARICOM conducted a review of mental health services among member states to evaluate the extent to which Member States were implementing the WHO (2001) recommendations, to identify barriers to the development of mental health, identify best practices and make recommendations to guide future development of mental health. This was followed by a PAHO/ CARICOM consultation in 2007 resulting in the development of the mental health priorities under CCH III.

In general, the development of mental health policy plans and programmes in the Caribbean have lagged behind other health issues. Only a few countries have developed policies and where such policies exist, they are not coherent or comprehensive, Jamaica being the notable exception with a well formulated mental health policy and strategic plans. A lack of dedicated manpower and political will have been cited as critical barriers to the development of policy in the region.

Despite the fact that most countries in the region have ratified the Inter American Commission on Human Rights which safeguards the dignity of individuals and promotes human and civil rights; mental health legislation are outmoded and centred around mental hospitals. In general, these legislations are inconsistent with regional and international standards and current mental health standards. Most countries have started the process of reviewing, revising and enacting new legislation in order to make legislation compatible with regional and international standards and current mental health norms. There is clearly an urgent need to accelerate the review process of mental health legislation in the region, to revise archaic and anachronistic legislation and to enact more modern legislation that are consistent with regional and international standards.

With the exception of Belize, Jamaica and St. Lucia, most Caribbean countries do not have a mental health coordinator which has hampered the development of mental health services. The lack of a champion at the policy level has been highlighted as one of the major barriers in the development of mental health services in the Caribbean.

Most of the countries utilize the highest percentage of the available funds for the hospital care, leaving limited possibilities for the development of community-based services. Due to the fact that the greater part of the mental health limited budget is directed towards mental hospitals there has neither been a shift of resources and care to the community. Cost effective treatment exists but lack of priority, poor policy perspective, inadequate legislation, inadequate range of community services, and under-financing remain barriers to available effective treatment option.

In countries such as Barbados, the Bahamas, St. Lucia, Trinidad and Tobago mental health services are still largely centralized in monolithic, outdated mental hospitals which are predominantly custodial in there therapeutic orientation. Countries like Jamaica started a process of deinstitutionalization in the sixties, resulting in a decrease in the population of mental hospital; a large population of mentally ill still remain in this institution and prisons. Belize has achieved the lowest mental hospital bed per 10,000 in the region due to the development of a community mental health services.

The concept of community mental health services emerged in the 1950s; they include a comprehensive and accessible range of services enabling persons to be treated in their own communities. The services include treatment in general hospitals, acute psychiatric unit, outpatient services, crisis service and mobile care. Jamaica and Belize have successfully implemented a community mental health service and have achieved a concomitant reduction in mental hospital beds with the deployment of mental health services within the community. In Jamaica there has been major programmes established to train the majority of health workers to identify and treat common mental disorders.

The mentally ill are often marginalised and particularly so. Vulnerable groups include children, the elderly, the chronic and persistently mentally ill, and mentally ill offenders, the homeless mentally ill, deportees and pregnant females.

The participation of consumers and carers in service development, planning, delivery and evaluation is widely recognised and is considered good practice. In some countries a number of consumer/advocacy groups have emerged to provide care at the community level.

Access to safer and more effective drugs is an important part of policy which is directed towards providing quality care for the mentally ill. Most countries have created an essential drug list.

The ratio of psychiatrist per 10,000 population ranges from one per 77,000 and in Jamaica it is one per 100,000, contrasting with a ratio of one per 1000 in many European countries. There is also a shortage of mental health nurses, social workers, occupational therapists and psychologists. Develop human resources to facilitate the training of all health personnel in mental health, to enhance their performance and to optimise the use of limited human resources. Once more, the role of other sectors (education, social welfare, users and relatives groups) should contribute to increase those who can take care of different aspects of the persons suffering mental illness.

The Mental Health Policy Framework for the Region accepted at the CARICOM Caucus Meeting of Health Ministers in September 2007, made the following recommendations:

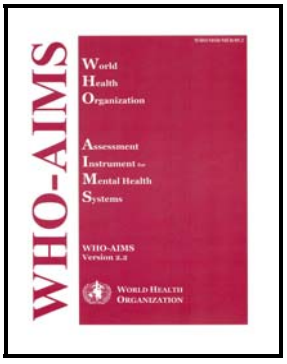
- Appoint national mental health coordinator
- Develop a comprehensive mental health policy
- Review, revise and enact legislation
- Develop mental health promotion programmes
- Establish a comprehensive range of community services
- Ensure adequate manpower
- Establish adequate mental health information system
- The development of alcohol and substance abuse policy
- Implement quality assurance
- Facilitate regional collaboration

7. MENTAL HEALTH SYSTEM: HOW TO ASSESS IT? ASSESSMENT IN TRINIDAD AND TOBAGO

The WHO Atlas study reports that in 2005 more than 24% of countries do not have any system for collecting and reporting mental health information. Many other countries have information systems but these systems often are of limited scope and quality. This lack of good information impedes the development of mental health policies, plans and services.

According to Dr. Saxena, a mental health system should be assessed both qualitatively (e.g. situational analysis through interviews with key stakeholders and the review of available reports, etc.) and quantitatively through a mental health system indicator scheme.

Mental health impact assessment, as a part of generic health impact assessment, aims to recommend changes to public policies, programmes, or projects in order to maximise health benefits arising, mitigate any negative effects, and prioritise areas of investment to promote mental health. To be successful and meaningful it relies on, among other things, the availability of good evaluative evidence on the nature, size, and likelihood of predicted mental health impacts. Longitudinal life-course studies examine the long-term health effects of exposures to poor living conditions and identify aspects of the social environment where interventions may be most appropriately targeted. Cross-sectional epidemiological studies give information that helps set priorities for proposed interventions based on the strength of observed associations, as for existing data on housing and poor mental health.



Dr. Shekhar Saxena, WHO Programme Manager in the Department of Mental Health and Substance Abuse made a presentation on how to assess mental health systems through the application of the WHO Assessment Instrument for Mental Health Systems (WHO-AMIS). This is a new WHO tool for collecting essential information on the mental health system of a country or region. Through WHO-AIMS it is possible to identify major weaknesses in mental health systems in order to have essential information for relevant public mental health action. The 10 recommendations of the *World Health Report 2001* serve as the foundation for WHO-AIMS.

Trinidad and Tobago is currently implementing this important tool and Dr Indar Ramtahal, Chair of the National Mental Health Committee, made a presentation on the preliminary results from its implementation. Refer to Appendix 5 for a copy of his presentation. The WHO-AMIS Workshop was conducted in Port of Spain, Trinidad and Tobago on 15 July 2008 and was facilitated by Ms. Devora Kestel, Mental Health Sub-Regional Advisor, PAHO/WHO Office of Caribbean Program Coordination. The identified WHO-AMIS focal points from the Ministry of Health and Regional Health Authorities comprised the participants at this workshop.

After the workshop, a survey questionnaire was prepared by the Ministry of Health focal point and distributed to the regional counterparts. Data collection started soon afterwards and submitted to the Ministry of Health focal point responsible for consolidating the database. The preliminary data was then submitted to the World Health Organization in October 2008. The final report of the assessment is to be completed by the end of 2008.

Dr Ramtahal reported that the preliminary recommendations included:

- Improve Service Delivery Systems – integrated community-based care plus establishment of crisis centres at the primary care level
- Increase public education and stakeholder improvement – attitude change towards mental illness and elimination of stigma; non-governmental organization/community-based organization involvement; promotion of self-help
- Advocacy – sensitisation of policy makers for appropriate legislation, policies and resource allocation, incorporation in school curricula
- Inter-sectoral and Inter-agency Collaboration – sustained and active collaboration among partners in various sectors
- Creating a supportive and enabling environment
- Monitoring and Research – refining the lists of parameters for data collection, maintaining and improving the established centralised repository or database for mental health supported by rigorous data collection at the primary or institution level, implementation of a routine programme of data entry and analysis of mental health data

After Dr. Ramtahal's presentation, participants were divided into working groups. Participants identified the following as strengths of the current mental health system:

- political support for mental health promotion and mental disease prevention at the highest level
- existing legislation/ policy/ plan and draft revised legislation (human rights driven)
- decentralised system (existing) – primary, secondary, tertiary; infrastructure of a central mental hospital, general hospitals, and health centres; sufficient numbers of treatment facilities; adequate home visits by Mental Health Officers (Community Programmes); existing rehabilitation programme
- human resources: Psychiatrists, Psychologists, Social Workers, Nurses, mental health officers; relatively high ratio of mental health professionals to patients; high ratio of trained nurses available for community care
- availability of medications
- available data

Conversely, participants identified the following as weaknesses of the current mental health system:

- absence of national mental health coordinator operating full-time, Lack of “bus driver”, No dedicated leadership at MOH
- need for implementation of new legislation
- weakness/confusion in the transition from Ministry of Health to Regional Health Authorities, overlap of boundaries for the delivery of mental health services, mental health committees are not constituted in all regional health authorities
- need to create “Mental Health – Health linkages”, absent functional linkages between Ministries of Health and Education, lack of stakeholder participation (employer and employees)
- insufficient funding for mental health, low budget, disorganized services and mismatch of resources to need, under-funding of community mental health
- care concentrated at mental hospital; lack of community facilities; need to adopt a primary, preventative approach to mental health; services not generally geared towards health promotion/ maintenance/ rehabilitation but towards “ medication management”; deficiency in mental health promotion in public educational awareness programmes; no 24-hour service

- absence of primary health practitioners, lack of human resources and training, inequitable distribution of competent health care professionals, lack of knowledge of available resources
- lack of research, lack of health information system, absence of benchmarks
- not enough services for specific vulnerable groups; limited access to vulnerable populations, e.g. children, adolescents; limited programmes for children and adolescents; weakness of child and adolescent services within the Ministry of Health

Participants identified the following priority areas for the improvement of the mental health system in Trinidad and Tobago:

- appoint a full-time National Mental Health Coordinator in the Ministry of Health
- establish community mental health facilities, integrate mental health with primary health care, address deficiency in mental health promotion/ education/ stigma reduction programmes
- increase number of staff and upgrade training, train primary health care personnel in mental health
- strengthen programming for child and adolescent mental health
- consult with stakeholders (ongoing), obtain stakeholder buy-in (private and public)
- strengthen mental health information system

In addition, participants identified the following resources as being required to realise an improvement of the mental health system in Trinidad and Tobago:

- financial implications for implementation of priority areas noting that there also needs to be improved allocative efficiency
- strengthening of the IS/IT system to facilitate mental health data collection
- human resources – appointment of a national mental health coordinator, staff for community-based facilities, additional trained personnel as required (counsellors, teachers, general practitioners, psychiatrists, programme managers and implementers)
- public-private partnerships: public-private, media
- coordinated training programmes for persons living with mental disorders
- sensitization campaign targeted at employers on removing “blinders”

Participants felt that the following stakeholders needed to be engaged to realise improvements in the mental health system in Trinidad and Tobago: non-governmental organizations, community-based organizations, persons living with mental disorders, consumers, families, the general public, government, the private sector and media.

Furthermore, reflective of a planning cycle, participants recommended the following as the critical steps needed to realize improvements in the mental health system in Trinidad and Tobago: conduct of a needs assessment, development of plans at the national and regional levels, and development of an implementation strategy.

8. THE PRACTICE OF PROMOTING MENTAL HEALTH AND PSYCHOSOCIAL WELL-BEING & SECTORAL PRIORITIES FOR MENTAL HEALTH PROMOTION AND MENTAL DISEASE PREVENTION

Dr. Shekhar Saxena, WHO Programme Manager in the Department of Mental Health and Substance Abuse made a presentation on the practice of promoting mental health and psychosocial well-being and sectoral priorities for mental health promotion and mental disease prevention. Refer to Appendix 6 for a copy of his presentation.

What leads to mental health? Social, economic, cultural, political, psychological, and biological factors interact with each other, just like health and illness in general. Poor mental health is linked with poverty and social disadvantage. In all countries, whether low or high income, poverty, discrimination and violence have a powerful adverse influence on mental health and the risks of mental illness.

The term mental health is commonly and inaccurately understood as referring to mental illnesses and their prevention and treatment. Mental health is a set of positive attributes. It is defined by the World Health Organization as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community”.

Within a public health framework, the activities that can improve mental health include the promotion of health, the prevention of illness and disability, and the treatment and rehabilitation of those affected. These are different from one another, even though the actions and outcomes overlap. They are all required, are complementary, and no one is a substitute for the other.

Improving mental health requires population-based policies and programmes alongside specific health service activities for the prevention and treatment of ill-health. The public health or population health approach is established in other areas such as heart health and tobacco control. This approach is just as applicable to mental health, and it is becoming clearer that ‘Mental health is everybody’s business’.

Mental health promotion refers to the mental health of everybody in the community, including those with no experience of mental illness as well as those who live with illness and disability.

Like health promotion, mental health promotion involves actions that:

- support people to adopt and maintain healthy ways of life; and
- create living conditions and environments that allow or foster health.

Health promotion is an approach to improving public health that requires broad participation working with all sectors of community life in promoting mental health and wellbeing and joint public health planning. Mental health promotion actions are often social and political. Making changes in schools, influencing housing and working conditions, working to reduce stigma and discrimination of various types, and developing policy initiatives to reduce violence are examples. The changes are made and decisions are taken by politicians, educators and others with community influence. Health practitioners are important as advocates and as aids to introducing the policies and programs.

The definition of mental health can have a wide and varied interpretation across cultures. Although the attributes defining mental health are universal, their expression differs culturally and in different contexts. Sensitivity to the factors valued by each culture and in various political, economic, and social settings increases the relevance and success of interventions. Understanding the effects of discrimination on the lives of women or indigenous communities in certain societies, or people living with epilepsy, for instance, makes a big contribution to intervention programmes. The definition needs to be adapted for children.

Evidence is available on the effectiveness of public health and social interventions for promoting the mental health of populations in locally devised and culturally appropriate ways. Promoting mental health will usually have additional benefits for health. The potential contribution of mental health promotion to the prevention of health-damaging and anti-social behaviours is probably greater than its potential to prevent mental disorders. Some interventions have the primary goal of promoting mental health and other interventions are intended mainly to achieve something else but improve mental health as an additional benefit. Activities designed to promote other aspects of health, to reduce risk behaviours such as tobacco, alcohol and drug misuse and unsafe sex, to improve the relationships between teachers and students in schools, or to alleviate social and economic problems such as crime and intimate partner violence, will often promote mental health.

Every country in the world is now party to at least one human rights treaty that recognises health-related human rights. Governments and policy-makers need to:

- recognize the key linkages between human rights and health, including mental health; understand the legal framework for mental health;
- analyse and assess public health policies and programs from a human rights perspective; and
- apply a rights-based approach to their own work (ensuring fairness, dignity and local participation).

Certain people and groups within society, such as women and children are particularly vulnerable to human rights violations. Countries need to pay particular attention to the situation of such people, and adopt specific measures to safeguard and realize their rights, including their right to mental health. Tackling important social and health concerns such as HIV prevention, maternal and child health, violence at home and in the streets, substance abuse, and gender equity requires interventions that focus on self-efficacy and appropriate participation, which are in turn components of mental health.

9. THE CONTEXT OF HEALTH PROMOTION: THE TRINIDAD AND TOBAGO PERSPECTIVE

Ms. Yvonne Lewis, Deputy Director of Health Promotion in the Trinidad and Tobago Ministry of Health, made a presentation on health promotion in Trinidad and Tobago. Refer to Appendix 7 for a copy of her presentation.

She outlined the evolution of the health promotion approach and in particular, highlighted the 1994 Caribbean Charter for Health Promotion and its strategies. Ms. Lewis stated that health promotion is a cross cutting strategy and not just the responsibility of the Ministry of Health. All sectors, including the private sector and civil society have a role to play in promoting the health of the population. Health promotion facilitates strategic allegiances dealing with the social dimension of health as well as promoting advocacy and empowerment for the individual and community.

In 2002, a mental health promotion plan was developed for Trinidad and Tobago. Mental health promotion covers a variety of strategies, all aimed at having a positive impact on mental health. Like all health promotion, mental health promotion involves actions that create living conditions and environments to support mental health and allow people to adopt and maintain healthy lifestyles. The key strategies of the mental health promotion plan developed for Trinidad and Tobago plan included: research and Information gathering on mental health and risk behaviours for mental ill health; sensitisation programmes on mental health issues using varied methodology; curriculum intervention in schools and training of health professions; development of health promotion indicators for all health institutions and services provided; and development of health promotion indicators for workplaces.

Ms. Lewis spoke about the “settings approach” in health promotion which focuses on the “setting” or place where people live, learn, work or play. The settings of the mental health promotion plan developed for Trinidad and Tobago plan focuses on four main settings, namely: healthy schools, healthy workplaces, healthy communities, and health promoting health facilities (health promoting health centres, health promoting hospitals etc). Taken together, these will contribute to and foster a healthy island.

For the National Forum, the Ministry of Health of Trinidad and Tobago decided to focus on two important settings for mental health promotion and mental disease prevention – schools and workplaces.

10. MENTAL HEALTH PROMOTION FOR SCHOOLS AND THE EDUCATION SECTOR

WHO's Global School Health Initiative, launched in 1995, seeks to improve the health of students, school personnel, families and other members of the community through schools. The Global School-based Student Health Survey (GSHS) was first conducted in Trinidad and Tobago by the Ministry of Health and Ministry of Education from 19-30, April 2007 sampling students in schools containing Forms 1-4. The school response rate was 100 %, with an overall response rate of 78% and a total of 2,969 students participated in the survey from, (32 schools in Trinidad and Tobago 25 school in Trinidad and 7 from Tobago). Of the sample, 69.1% were in the age group 13-15 years and 24.9% were from Form One and 27.2% of the sample from Form Four. Males constituted 49.8% of the sample and females 50.2%.

The survey showed that:

- 11.6% of students most of the time or always felt lonely during the past 12 months. Female students (15.1%) are significantly more likely than male students (8.2%) to feel lonely most of the time or always. Overall, 10.5% of students most of the time or always felt so worried about something that they could not sleep at night during the past 12 months. Female students (14.4%) are significantly more likely than male students (6.4%) to most of the time or always feel so worried about something they can not sleep at night. Overall, 21.5% of students felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing their usual activities during the past 12 months. Female students (27.3%) are significantly more likely than male students (15.5%) to feel so sad or hopeless almost every day for two weeks or more in a row.

- 17.9% of students seriously considered attempting suicide during the past 12 months. Female students (21.5%) are significantly more likely than male students (14.1%) to seriously consider attempting suicide. Overall, 17.4% of students made a plan about how they would attempt suicide during the past 12 months. Overall, 17.4% of student made a plan about how they would attempt suicide. Overall, 9.0% of students have no close friends.

- 23.3% of students missed classes or school without permission on one or more of the past 30 days. Male students (29.1%) are significantly more likely than female students (17.3%) to miss classes or school without permission.

- 42.0% of students reported that most of the students in their school were kind and helpful never or rarely during the past 30 days. Overall, 42.9% of students reported their parents or guardians never or rarely checked to see if their homework was done during the past 30 days. Overall, 46.8% of students reported their parents or guardians never or rarely understood their problems and worries during the past 30 days. Overall, 33.9% of students reported their parents or guardians really know what they were doing with their free time never or rarely during the past 30 days. Overall, among the students who rode in a motor vehicle driven by some one else, 48.2% never used a seat belt during the past 30 days.

- 39.8% of students were physically attacked one or more times during the past 12 months. Male students (49.2 %) are significantly more likely than female students (30.0%) to have been physically attacked one or more times during the past 12 months. Overall 42.0% of students were in a physical fight one or more times during the past 12 months. Male

students (55.9 %) are significantly more likely than female students (27.9 %) to have been in a physical fight. Overall, 47.9% of students were seriously injured one or more times during the past 12 months. Male students (53.6 %) are significantly more likely than female students (42.0 %) to have been seriously injured.

- among students who were seriously injured during the past 12 months, 28.9% were playing or training for a sport when their most serious injury happened to them, 25.6% had their most serious injury caused by a fall, 43.6% had their most serious injury occur as a result of hurting themselves by accident, and 17.0% experienced a broken bone or dislocated joint as their most serious injury.

- 20.8% of students were bullied on one or more days during the past 30 days. Among students who were bullied during the past 30 days, 17.4% were bullied most often by being hit, kicked, pushed, shoved around, or locked indoors. Male students (26.6%) are significantly more likely than female students (7.3%) to be bullied most often by being hit, kicked, pushed, shoved around, or locked indoors.

- 16.5% of students belong to a violent group. Male students (22.2%) are significantly more likely than female students (10.9%) to belong to a violent group.

- the prevalence of current alcohol use among students overall is 42.5% . Male students (47.9%) are significantly more likely than female students (36.3%) to have had two or more drinks on the days they drank alcohol during the past 30 days. In addition, 17.3% of the students usually get the alcohol they drank by buying it in a store, shop, or from a street vendor. Male students (27.1%) are significantly more likely than female students (7.4%) to usually get the alcohol they drink by buying it from a store, shop, or from a street vendor. The prevalence of lifetime drug use (using drugs such as marijuana, hemp, or cocaine one or more time during their life) was 13.6%. Male students (17.5%) are significantly more likely than female students (9.6%) to report lifetime drug use.

In addition, during his opening remarks the Minister of Health reported that research conducted at the child guidance clinic located at the Eric Williams Medical Sciences Centre, showed that attendance diagnostic rates among 10-19 year-olds range from 30% for depression to 5% for psychosis.

As well, the Minister announced that the Ministry of Education was piloting the School Violence Prevention Academy in 25 schools, aimed at the development and implementation of school-specific action plans to deal with school violence.

Mental Health Promotion for Schools and Education Sector

Ms. Devora Kestel, Mental Health Sub-Regional Advisor in the PAHO/WHO Office of Caribbean Program Coordination, made a presentation on mental health promotion in the school setting and education sector. Refer to Appendix 8 for a copy of her presentation. Schools are a gateway for mental health promotion.

Mental health promotion is integral to the educational work of schools and involves all school professionals. An effective school strives to help children to be healthy and successful learners to the best of their abilities. Children who become withdrawn due to depression or poor social skills are less likely to engage in classroom learning activities. Children concentrate poorly if

they are emotionally upset by conflict at home or in school. Promoting the healthy development of children prevents school failure and dropout.

Mental health promotion is for all children. *Universal* interventions affect children across the whole school population, e.g. measures to reduce the tolerance of violence, whether between students or between teachers and students. *Selected* interventions target subgroups of children particularly vulnerable to risk factors or demonstrating problem or risky behaviours. *Indicated* interventions are directed to children with high risk or early signs of mental illness.

In some countries, primary care centres may screen every child or adolescent who presents at their facility, but this practice has several drawbacks. Printing, scoring, administering, interpreting, and storing numerous tests is expensive. False negatives and false positives will inevitably occur, and may result in services being denied to those who need them, and offered to those who do not, especially when questionnaires are used in populations different from those for whom they were developed. Increased detection rates will likely lead to increased demand for treatment services, and primary care centres might find it difficult to immediately meet these demands. Selective screening of children and adolescents – informed by clinical judgement – is a useful alternative to population-wide screening. For example, if a child presents with hyperactivity, it is sensible to screen for behaviour problems, scholastic difficulties, and intellectual disability, as well as risk behaviour such as tobacco use.

Mental health is affected by the interpersonal relationships or school climate. A child-friendly school encourages tolerance and equality between boys and girls and different ethnic, religious and social groups. It promotes active engagement and cooperation, avoids the use of physical punishment, and does not tolerate bullying. It is a well-structured learning environment in which expectations are high, fair and clearly communicated. It encourages creativity as well as academic abilities, promotes the self-confidence of children, and establishes links between the school and the family.

Universal school mental health promotion and long-term interventions promoting the positive mental health of all pupils and involving changes to school climate can be effective and are likely to be more successful than brief class-based mental illness prevention programmes.

Specific interventions can increase social and emotional competence and positive behaviours, to reduce risk and increase resilience. Social and emotional competence enables people to make informed decisions, solve problems, think critically and creatively, communicate effectively, empathise with others, build healthy relationships, refuse unhealthy peer pressure and manage their lives in a healthy and productive manner. This increases the chances for positive development and coping with adversity. Children with high levels of social and emotional competence do better than others in school, at work and in their personal life in adolescence and adulthood. Teaching life skills to young people can improve health and education. Evidence from high-income and some low-income countries indicates that life skills education is effective in the prevention of substance abuse, adolescent pregnancy and bullying and in improving academic performance and school attendance as well as the promotion of mental wellbeing and healthy behaviours.

To become well-rounded individuals, effective citizens and healthy adults, children need to develop social and emotional competencies. They also need the confidence and opportunities

to use these skills constructively to help develop a sense of identity. Several types of interventions can improve competence and self-worth, as well as lessen emotional and behavioural problems and the chances of school dropout for students – and burnout, absenteeism and abusive behaviours among teachers. Some interventions target the school as a whole, others target one part of the school system (e.g. children in a given grade) or a specific group of students identified to be at special risk for emotional or behavioural problems (targeted interventions). Programmes that focus simultaneously on different levels, such as changing the school environment as well as improving individual skills, are generally more effective than those that intervene on one level.

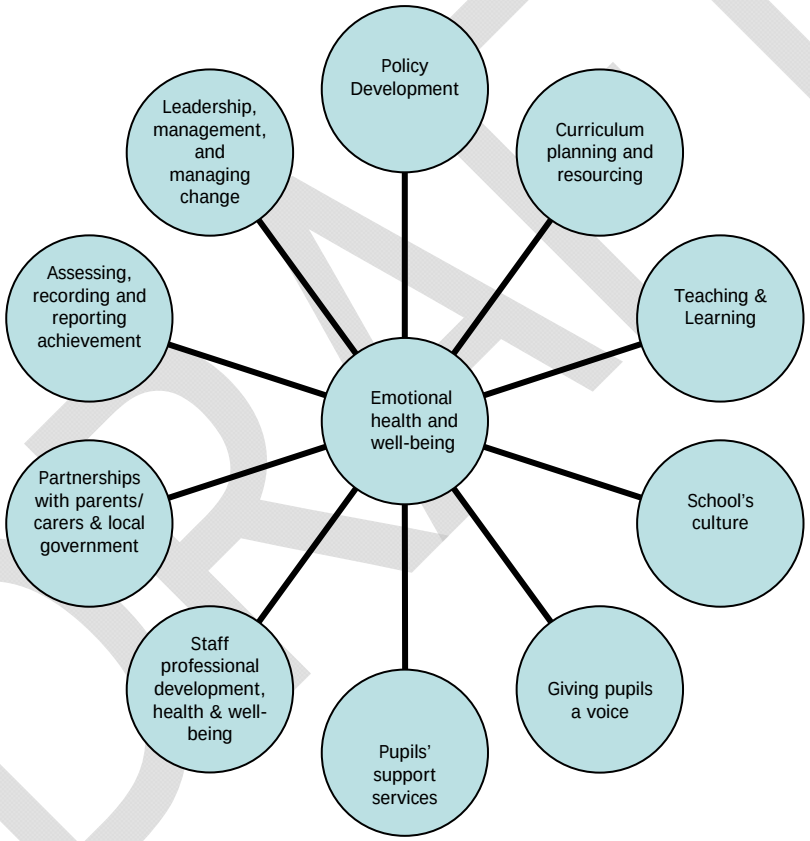
Early identification and effective treatment of mental illness is critical to preventing mental disorders. Early identification of the signs of mental illness and severe behavioural difficulties, and efficient connections to psychosocial supports and treatment where necessary can help to stop the illness developing, persisting or becoming more severe, and prevent co-occurring illnesses, substance use and disabilities. The age of the child may influence the presentation of certain symptoms such as anxiety and depression. Mental health problems may first become apparent during adolescence. A young person experiencing depression or another mental health problem has no frame of reference for his or her condition and may not recognise this as an illness or seek treatment. Depression is common, especially for young people who have low self-esteem. They may feel that they have no future or are 'useless'. Depression reduces the quality of a young person's life at a time when he or she should be full of optimism and hope. A young person who sees no future is more likely to take risks with his or her health.

Mental health promotion involves not only the school day but also out-of-school-time. Risky behaviours such as tobacco smoking, drug use, unsafe sexual activity, and shoplifting, and violent crime committed by and against youth occur mostly during unsupervised after school hours. Schools and community partners can provide or facilitate access to supervised activities that are in themselves interesting and also promote health and social-emotional competences. School professionals can work with families to encourage effective parenting techniques, homework support, and appropriate levels of supervision.

Inter-sectoral linkages between schools, public health and other community services are a key component of effective mental health promotion. A range of social and civic sectors including family stabilisation, psychosocial services, housing, criminal justice, health and welfare, have a stake in the healthy development of children and youth and can contribute to health promotion. Schools are well placed to initiate work on developing partnerships across these sectors. Schools can also advocate on behalf of children and families to obtain access to needed community resources. Explicit partnerships (with memoranda of agreement for instance) can give access to youth development and enrichment programmes and individual supports like mentoring, family assistance, and psychosocial services. Partners include civic and faith-based organizations, criminal justice system, and other health, family, and social services. Good linkages to local primary care providers are essential. A system of routine health services in schools is an effective way to link children and young people into needed health services.

The school is also as a workplace. Burn out and absenteeism among teachers have a significant adverse effect on teachers, students and the school climate in many countries, especially in poorly resourced schools. Health promoting interventions are important; and where teachers are abusive or absent this needs to be detected and the situation managed actively. Teacher training programmes can include educational psychology, the practice of learning and teaching and how to discipline students in socially acceptable ways.

The domains of the 'whole school approach' include emphasis on: distributed leadership (or delegation), inclusive policies and practices, engagement and connection, continuum of care, supportive school structures, and targeted and indicated activities within supportive whole school policy and practice. England's SEAL (Social and Emotional Aspects of Learning) programme reflects a 'whole school approach'. England's National Healthy Schools programme was launched in October 1999 to support schools from all phases of education (aged 4-19) to develop policy and practice as they work towards and gain Healthy Schools status. Primary SEAL provides an early intervention approach to improving the mental health of adolescents while Secondary SEAL addresses their current needs and helps to create a social and emotional climate that is inclusive, reduces bullying, promotes feelings of belonging and encourages emotional health and well-being. Adults have an important role to play in setting the school climate, but the social climate is largely determined by the students themselves. England's "whole-school approach" is set out in diagrammatic form below:



WHO Tool for the Rapid Assessment for Improving the Capacity of School Health Programs

The Rapid Assessment and Action Planning Process (RAAPP) is a country-driven and evidence-based method. It equips ministries of education and health and other national organizations to assess and improve their capacity to promote health through schools. Given the link between health and education, RAAPP is based on two concepts put forth by the World Health Organization and its partners: Health-Promoting Schools (HPS) and Focusing Resources on Effective School Health (FRESH).

The RAAPP provides:

- a framework to unite key leaders and staff across ministries to improve school health programs
- an opportunity for a wide range of participants to offer opinions and insights to describe current conditions and capacities of national infrastructure
- a method for a country to collect and own its own data to improve school health
- a means to transform the insights and suggestions of stakeholders into a strategic action plan

For further information on this tool, visit the WHO website at:

http://www.who.int/school_youth_health/assessment/raapp/en/index.html

Recommendations from the School-based Student Health Survey in Trinidad and Tobago

Recommendations from the report of the implementation of the Global School-based Student Health Survey in Trinidad and Tobago included, but were not limited to the following:

- implement the School Health Policy and establish a Comprehensive School Health Service and Adolescent Health for students.
- teach mental health issues and other coping skills as of part of the curriculum
- actively involve and support parents/guardians to maintain students' healthy behaviours, through the strengthening of Parent Teachers Associations and other support groups.
- use the mass media, both electronic and print, should be used to highlight health issues affecting students and provide interventions and or possible solutions to same.
- create a supportive environment for student to seek and receive counselling for substance abuse, mental health issues and other personal / social problems with out fear of exposure and or discrimination.
- enforce legislation so as to prevent students from having easy access to purchase alcohol and tobacco.
- place Health and Family Life Education on the curriculum and taught in all schools.
- place emphasis on adopting healthy lifestyles, including eating balanced meals, conflict management, and avoidance of alcohol, drugs, and other illicit substances must be stressed during teaching sessions.

11. WORKING GROUP ACTION PLANS FOR THE SCHOOLS: A SETTING FOR MENTAL HEALTH PROMOTION AND MENTAL DISEASE PREVENTION

The following pages present the action plans from the working groups.

The following is the action plan from one working group.

Goal: Improved mental health and well-being of students in one (1) secondary school for each of eight (8) education districts									
#	**Strategic Objective**	**#**	**Action(s)**	**Timeframe for Implementation**		**Champion (Lead Responsibility)**	**Identification of Key Stakeholders Involved**	**Resources Required**	**Monitoring and Evaluation Mechanisms**
				Commence	**Completed**				
1	Capacity building for teachers in substance abuse prevention	1.1	Develop a project proposal	Immediately (October 2008)	1 month (November 2008)	Ministry of Education (Student Support Services)	Ministry of Health (Health Promotion) Ministry of Social Development (NADAP) UWI (School of Education) School Boards NPTA Student Organisations	Budget Trainer Training Materials	1.1. Proposal Developed
		1.2	Outsource specialist to conduct training	January 2009	February 2009				1.2. Specialist outsourced
		1.3	Identify focal person on staff	January 2009	February 2009				1.3. Focal person on staff identified
		1.4	Develop a work plan for teachers (HFLE curriculum)	March 2009	April 2009				1.4. Work plan developed
		1.5	Conduct training	May 2009	July 2009				1.5.1. Training commenced 1.5.2. Resources committed 1.5.3. Commitment of the National Parent Teachers Association, School Boards assured

The following is an action plan that has been combined from two working groups.

According to the groups, one guidance officer would serve over 500 students and there would be one guidance officer for an average of three schools. The officers would be trained in guidance and counselling and there would be three types of guidance officers – academia, social, and personal. The levels would be preventive and remedial.

Goal: Happy, healthy, productive children maximizing their fullest potential in a conducive environment

#	Strategic Objective	#	Action(s)	Timeframe for Implementation		Champion (Lead Responsibility)	Identification of Key Stakeholders Involved	Resources Required	Monitoring and Evaluation Mechanisms
				Commence	Completed				
1	Systematic working together of all stakeholders - Ministry of Health - Ministry of Education	1.1	Create a committee to determine clearly defined roles	First 3 months	3rd month	Ministry of Education Ministry of Health	Students Parents Teachers School supervisors School staff Community staff Community police Probation officers Social welfare School boards PTA	Human Resources - Recruit, retain, train and retrain Financial Materials	Evaluation tools Evaluator (independent)
		1.2	Joint teams to assess early identification of training needs	First 3 months	3rd month				
		1.3	Develop referrals protocol	4th month	6th month				

The following is the action plan developed by the last group. This group identified the goal, strategic objectives and actions.

Goal: To develop health-promoting educational institutions			
#	**Strategic Objective**	**#**	**Action(s)**
1	Strengthening the Policy Framework for mental health in schools	1.1	Harmonize all policies addressing mental health, e.g. National Policy, Health and Family Life Education, Youth
		1.2	Develop protocols for managing mental health issues in schools (need to be shared)
		1.3	Clarify roles of support services personnel (diagnostic specialists, social workers, guidance officers)
		1.4	Promote health and mental well-being of teachers, students and parents
		1.5	Obtain and review repository of all policies affecting the youth
		1.6	Disseminate policies to all institutions of learning
		1.7	Review and strengthen legislation impacting on child health and protection
2	Training of staff in education, health and other social services regarding "signals" of kids in need of help	2.1	Develop and implement training programme on parenting with the support of NGOs and faith-based organizations
		2.2	Evaluate training programmes
		2.3	Expand mental health training for general practitioners beyond 2 months
3	Re-orienting Child Development services	3.1	Expand screening to include psycho-social and cognitive aspects and ensure referrals and counter-referrals are followed through
		3.2	Strengthen and expand child mental health services
4	Creating supportive environments that optimize learning opportunities, positive interactions, mutual trust & respect, & general health and mental well-being among all stakeholders		

12. MENTAL HEALTH PROMOTION IN EMPLOYMENT, LABOUR AND WORK SECTORS

Ms. Devora Kestel, Mental Health Sub-Regional Advisor in the PAHO/WHO Office of Caribbean Program Coordination, made a presentation on mental health promotion in the work setting. Refer to Appendix 9 for a copy of her presentation.

As well, Professor Gerald Hutchinson from the Faculty of Medical Sciences at the St. Augustine Campus of the University of the West Indies provided an employer perspective on mental health promotion in Trinidad and Tobago. Refer to Appendix 10 for a copy of his presentation.

Work affects a person's mental health and in turn an employee's mental health affects the workplace. Access to meaningful employment substantially contributes to a person's identity; it provides income for an individual and his or her family and can make a person feel that he or she is playing a useful role in society. Work is an important source of social support. Participation in work also contributes to the economic and social development of communities.

The workplace can contribute positively to a person's mental health, may exacerbate an existing problem, or may contribute to the development of a mental health problem. It depends on the psychosocial working conditions, the match with worker abilities and aspirations, and a culture of worker participation in decisions about organisational structure and processes. Workers commonly experience brief periods of stress and anxiety at work without ill-effect, but prolonged exposure to stress is likely to harm workers' health and expose them to risk of illness. Stress is a pattern of emotional (e.g. anxiety, depression), cognitive (e.g. poor concentration), behavioural (e.g. increased alcohol use) and physical (e.g. increased blood pressure, headaches) reactions to adverse conditions and may be characterized by high levels of arousal, distress and feelings of not coping. Stress is not usually classified as a mental disorder, although it can precipitate both physical and emotional problems.

For individuals, mental health problems can lead to a reduced quality of life, as well as having significant economic and social effects. Absence from work is likely to affect the person's income. In combination with the costs of health care, this may cause significant financial hardship for employees with mental health problems. Many workers, particularly those in low-paid employment or small workplaces, do not have insurance that covers the cost of ill-health or absence from work. These employees are often not able to access the health services they need to treat their mental health problem, and may not be able to afford the time off work required for recovery. Families also experience the impact of mental health problems. They may have economic difficulties related to the reduced income and increased health care costs, the stress of coping with altered behaviour, disruption to the household routine, and restricted social activities.

Organisation-wide or systems approaches to job stress are more effective than other alternatives, with benefits both to individuals (for example, better health) and to organisations (for example, lower absenteeism). Interventions to reduce work stress can be directed either at the coping capacity of employees or at the working environment.

Programmes on mental health at work often focus on the individual employee. Those directed at employees may be aimed at improving health and coping for all or alternatively for early detection and management of mental health problems including harmful alcohol or drug use. Certain work factors are associated with mental ill health and sickness absence among workers in a wide range of employment: long hours worked, work overload and pressure, and the effects of these on personal lives. One major source of stress for employees is exposure to critical incidents, such as assaults, sexual or psychological harassment, and accidents. Acute stress disorders and post-traumatic stress disorder are potential consequences of critical incidents that need to be managed. Post-traumatic stress disorder, in particular, can lead to personal distress, significant disability and reduced work performance.

A policy of mental health at work includes, however, consideration of the mental health of the organization itself. The social environment at work is particularly relevant: good team work, management support with clear roles and responsibilities, opportunities for job development, and a culture that involves people in making decisions. Effective interventions include support for workers, more job control, increased staff involvement in decisions, workload assessment, better effort/reward balance, role clarity, attention to work-life balance and appropriate leave entitlements, and policies to tackle bullying and harassment.

Work health and safety laws and regulations need to refer to mental health. Governments have a crucial role in promoting mental health, including the mental health of workers, and in ensuring that mental health problems are recognized early and treated effectively. Work is important for mental health and indeed the right to work in just and favourable conditions and with protection from unemployment is enshrined in the United Nations Universal Declaration of Human Rights (Article 23). Governments are also usually employers themselves, often employing thousands of people. Macro-level or national policies are needed:

- to provide adequate employment opportunities for the population including minority and displaced groups (employment policies, education and training)
- to ensure the sustenance of those who do not have or have lost work (unemployment insurance, welfare assistance)
- to avoid discrimination through legislation specific to employment for people with disabilities and family care giving responsibilities
- to regulate the psychosocial work environment through psychosocial risk management and legislation on safety
- to define job conditions including job security, hours of work, leave entitlements (including maternity and paternity leave) and minimum wages
- to define the role of labour unions and international labour federations in improving job conditions

Other legislative and policy provisions have focused on the obligations of the employer to provide a safe working environment. A range of international standards and guidelines commit countries to develop safe workplaces. Employers also need to understand how these laws affect their work and planning. Regulatory policies for the workplace can relate to a range of interventions in the workplace to improve mental health and lower the risk of mental disorders, including:

- task and technical interventions e.g. job enrichment with variation or incentives, job control as processes

- providing staff support in case of work or personal difficulties. Here employee assistance programs are worthwhile. Such a program is offered by an employer and provides psychological services to help employees (and their families) deal with personal problems that might adversely impact their work performance, health, and well-being. Referral may be from the supervisor or self-referral.
- encouraging health and fitness among employees e.g. physical exercise, social opportunities
- promoting mental health through workplace sponsored workshops on topics such as: managing stress in a busy world, reducing noise, balancing the job demand, appropriate reward for efforts, flexible working conditions as much as possible
- improving role clarity and social relationships e.g. communication, conflict resolution, grievance, balancing personal and work lives, retirement, time management, fostering productive work relationships, managing anger and disappointment, and resolving conflicts effectively.

Investment in healthy working practices and the health and wellbeing of workers improves productivity and is cost effective for business and wider society. The failure to prevent, recognize and treat mental health problems in the workplace has an impact on employers, employees and their families, and the community generally. Mental health problems have an impact on employers and businesses directly through increased absenteeism, reduced production, increased costs, and reduced profits. They also affect employers indirectly through factors such as reduced morale of staff.

Lack of work is associated with poor mental health and mental illness especially in vulnerable populations. This also has adverse effects on the children and families. People with disabilities, including mental disabilities, are often denied opportunities for meaningful employment, and so remain trapped in a cycle of marginalization, social exclusion and poverty. Unemployment among people who are disabled is far higher than among other individuals of working age, and many disabled people who want to work are unable to do so. They are frequently discouraged because of limited opportunities to obtain work, insufficient incentives for employers to employ people with mental disabilities, financial penalties of employment, stigma and discrimination, such as beliefs that people with mental health problems are not productive.

Activities of the United Nations have emphasized the right of disabled people to have the same opportunities as other citizens, including participation in economic activities such as work. The introduction of antidiscrimination legislation in some countries has been one of the most important legislative approaches to improving mental health in the workplace. While some countries have legislation that protects the rights of people with mental retardation, individuals may experience difficulties in asserting these rights because of their limited cognitive abilities.

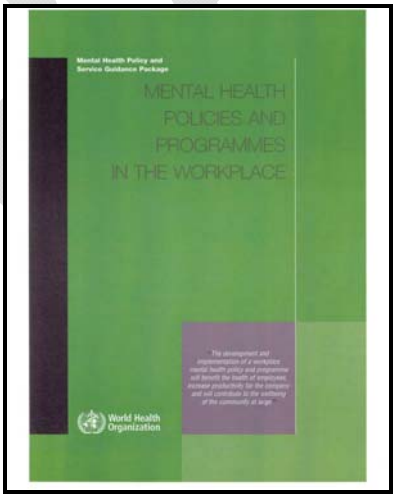
In 1993, the United Nations General Assembly adopted the Standard Rules on the Equalization of Opportunities for Persons with Disabilities (United Nations, 1993). The resolution identified a number of issues that need to be addressed to attain equal opportunities for disabled people, including: awareness-raising; medical care; rehabilitation; support services; employment; income maintenance and social security; family life and personal integrity; culture; recreation and sports; and religion. The International Labour Organization's Declaration on Fundamental Principles and Rights at Work, adopted in 1998, commits governments, employers and workers' organizations to uphold principles and rights in four areas, including the elimination of discrimination in the workplace. Many countries have legislation that prohibits discrimination against people with mental health problems. The effectiveness of these laws depends on (1) the underlying model of disability and whether it is inclusive of mental health problems; (2) the

concept of equality, for example whether the law relates only to employment or also promotes access to education and training; and (3) the location of the legal provisions (i.e. whether provisions appear in criminal, constitutional, civil, labour or social welfare law). National laws can use a variety of mechanisms to promote the employment of people with disabilities, including the following:

- quota schemes, which require businesses of a certain size to employ a specified proportion of people with a disability;
- equity or non-discrimination laws, which make it unlawful for people to discriminate on the basis of mental health problems;
- job retention laws, which require employers to retain people who become disabled while employed.

Training and vocational support avoids poor mental health and mental illnesses associated with lack of work and lack of suitable work. This may entail provision of a living wage, job training, and liaison with education authorities about appropriate secondary and post-secondary education. Counselling or job search training for unemployed people can help them cope with unemployment and reduce the negative effects on mental health.

International labour federations can assist national governments and labour unions to define the role of unions in improving conditions of work and security of work. Employer, employee and nongovernmental organizations, also have an important role in working with governments to improve the mental health of employees. These partners should advocate for the development of policies and strategies that promote the mental health of employees and prevent and treat mental health problems.



Additional information on mental policies and programmes in the workplace is available in the World Health Organization publication on the subject. This above publication can be downloaded at:

http://www.who.int/mental_health/policy/services/13_policies%20programs%20in%20workplace_WEB_07.pdf

13. WORKING GROUP ACTION PLANS FOR THE WORKPLACE: A SETTING FOR MENTAL HEALTH PROMOTION AND MENTAL DISEASE PREVENTION

The following is an action plan that has been combined from two working groups.

Goal:	**A decent job in a safe and healthy workplace conducive to productivity.**								
#	**Strategic Objectives**	**#**	**Action(s)**	**Timeframe for Implementation**		**Champion (Lead Responsibility)**	**Identification of Key Stakeholders Involved**	**Resources Required**	**Monitoring and Evaluation Mechanisms**
				Commence	**Completed**				
1 2 3	Non-discriminatory rights-based policies for employment To foster a psychosocial environment that promotes and sustains good mental and physical health Collaboration among employees, employers, trade unions and other interested parties in promoting wellness	1	Ensure access to services (e.g. EAP) without repercussions	(No time frame indicated)	(No time frame indicated)	Various Ministries (e.g. Labour, Works, etc)	Employees Employers Community	Money Manpower Materials	Quarterly, using specific tools
		2	Develop a system to review and revise policies, including monitoring policies						
		3	Develop incentive programmes (e.g. tax breaks for employers; bonuses/time-off/leave for employees)						
		4	Ensure safe place of work						
		5	Establish day care/ homework centres						
		6	Establish gyms						
		7	Adopt flexitime						
		8	Encourage car-pooling						
		9	Promote decent work for decent pay						
		10	De-centralise workplaces						

The following is an action plan from one working group.

Goal: Promoting and maintaining wellness in the workplace									
#	**Strategic Objective**	**#**	**Action(s)**	**Timeframe for Implementation**		**Champion (Lead Responsibility)**	**Identification of Key Stakeholders Involved**	**Resources Required**	**Monitoring and Evaluation Mechanisms**
				Commence	**Completed**				
1	Promoting healthy working relationships	1.1	Develop TEAM-BUILDING EXERCISES, linked with opportunities for EXERCISE (i.e. gym, aerobics, etc.) • Pre-requisite: sensitisation/ buy-in			(Global perspective) In-house committee/s – LEAD	Health and Safety Officer/s Management Human Resource Division/s Trade union/s and other collective bargaining units Corporate Communications	Finances Staffing (human resources) Materials, equipment (Technology)	Client satisfaction survey to determine the following items (with opportunities to make suggestions for improvement of services rendered) - Client satisfaction and buy-in - How well-utilized the facilities that are made available - Employee retention - Happiness and wellness index DESIRED OUTCOMES: - Improved productivity - Better working relationships - More cohesive team work
		1.1.1	Create/identify in-house committees to serve as champion	1st month	End of 1st month				
		1.1.2	Prepare budget proposal for activities and equipment	2nd month	End of 2nd month				
		1.1.3	Plan and conduct team-building workshops	3rd month	End of 5th month				
		1.1.4	Plan and conduct retreat	6th month	End 8th month				
		1.1.5	Identify suitable location, purchase equipment and hire fitness instructor/s for gym and aerobics	9th month	11th -12th month				
		1.1.6	Plan and conduct family day, sports day and other social events	6 weeks	End of 6th week				
		1.2	Establish Employee Assistance Programmes (EAP)	(None identified)	(None identified)				
		1.3	Establish and implement a fair rewards and recognition programme	(None identified)	(None identified)				
		1.4	Introduce child-care facilities and in-house homework centres	(None identified)	(None identified)				
		1.6	Introduce discretionary leave provisions for special circumstances	(None identified)	(None identified)				

The following is an action plan from the last working group. This group identified the strategic objectives and identified the champion and key stakeholders to be involved.

Goal: None identified			
#	**Strategic Objective**	**Champion (Lead Responsibility)**	**Identification of Key Stakeholders Involved**
1	Ensure that workplace health policies include mental health and wellness policy, using the International Labour Organization model	Ministry of Labour	Supported by Ministry of Health
2	Develop policies as to employment of disabled (to include mental health patients) • Incentives • Rehabilitation Act	Ministry of Labour	Ministry of the Attorney General Ministry of Health Ministry of Social Development
3	Expand the University of the West Indies and other training institutions' teachings to cover rehabilitation, mental health issues and psychosocial responses, and to include all categories of staff		
4	Create/train to fulfil needs • Flexible employment practices and hiring • Expand working force to meet needs		
5	Review establishment (recruitment) and terms of employment of para-medical staff that are essential to good mental health		

14. RECOMMENDATIONS

DIRECTED TO THE MINISTRY OF HEALTH

It is recommended that the Ministry of Health:

1.1 Appoint a full-time National Mental Health Coordinator

1.2 Scale up investment in mental heath and promote allocative efficiency in the distribution of the budget towards mental health reflecting the continuum of care and placing emphasis on the promotion of mental health and prevention of mental heath disorders.

1.14 Seek enactment of the revised human rights driven mental health legislation.

1.15 Complete the assessment of the Mental Health System in Trinidad and Tobago using the WHO-AMIS instrument by the end of December 2008. This information should then be used to inform planning at the national and regional levels on an intra- and inter-governmental basis, and inter-sectoral (private sector, non-governmental organisations, community based organisations, civil society)

1.16 Finalize the national mental health policy committing the government to integrated mental health care and ensure that the national health policy reflects the same commitment.

1.17 Strengthen the delivery of community based mental health services and ensure that the integration of mental health services into primary care is accompanied by complementary services, particularly secondary care components to which primary care workers can turn for referrals, support, and supervision. Home care support is also important.

1.18 Strengthen the availability and accessibility of an adequate and qualified human resource base trained in mental health. Pre-service and/or in-service training of primary care workers on mental health issues is an essential prerequisite for mental health integration. Collaborative or shared care models, in which joint consultations and interventions are held between primary care workers and mental health specialists, should be considered as a way of providing ongoing training and support.

1.19 Liaise with the University of the West Indies and other training institutions to have rehabilitation, mental health issues and psycho-social responses included in the curriculum across multi-disciplines.

1.20 Strengthen programming for vulnerable groups especially those facing mental health challenges, the child and adolescent population, the elderly, etc.

1.21 Review and revise as necessary the terms of reference and membership of the National Mental Health Advisory Committee. Review and revise as necessary the terms of reference for mental health committees in regional health authorities and their operational status.

1.22 Implement an integrated, automated mental health information ensuring that is becomes an integral part of the more comprehensive national health information system and incorporating statistics based on the application of a determinants of health approach.

1.23 Educate the public by launching public awareness campaigns to overcome stigma and discrimination.

1.24 Collaborate with other government non-health sectors, non-governmental organizations, community-based organisations, faith-based organisations, communities, families and consumers in decision-making on policies and services.

DIRECTED TO THE MINISTRY OF EDUCATION WITH THE SUPPORT OF THE MINISTRY OF HEALTH

It is recommended that the Ministry of Education with the support of the Ministry of Health:

2.12 Promote the designation of schools as "Health-Promoting Schools" under the World Health Organization's Global School Initiative reflecting that schools are a healthy setting for living, learning and working.

2.13 Strengthen the policy framework for mental health promotion and disease prevention in schools. This should include, but not be limited to:

- harmonisation of policies that address (or should address) mental health needs in children and adolescents, e.g. National School Health Policy, National Youth Policy, Health and Family Life Education, etc.
- development and dissemination of protocols for managing mental health issues in schools
- clarification of the roles of support services personnel (diagnostic specialists, social workers, guidance officers) in the school setting
- review legislation impacting on child health and protection and strengthen if necessary
- enforce legislation to prevent students from having easy access to purchase alcohol and tobacco

2.14 Re-orient child development services expanding screening to include psycho-social and cognitive aspects, developing/revising the referral protocols as well as ensuring follow-up on referrals and counter-referrals, and strengthening child/adolescent mental health services

2.15 Create a supportive environment for students to seek and receive counselling for substance abuse, mental health issues and other personal/social problems without fear of exposure and/or discrimination.

2.16 During teaching sessions, have emphasis placed on adopting healthy lifestyles, including eating balanced meals, conflict management, and substance abuse prevention. Ensure that mental health issues and other coping skills are part of the curriculum. Place Health and Family Life Education on the curriculum. Including these topics as part of the curriculum necessitates that it be accompanied by training as required of teachers.

2.17 Promote an inclusive approach to planning, developing and execution of mental health promotion and support initiatives in the school setting ensuring that the youth are involved at all stages

2.18 Actively involve and support parents/guardians to maintain students' healthy behaviours, through the strengthening of Parent Teachers Associations and other support groups.

2.19 Develop and implement training programmes on parenting with the support of non-governmental organizations, faith-based organizations and the National Parent Teachers Association of Trinidad and Tobago.

2.20 Train teachers, guidance counsellors, health care workers, and social service workers on the early detection of mental health concerns in children and adolescents.

2.21 Develop/establish joint teams to undertake early detection of mental health concerns in children and adolescents once agreement has been reached on the roles and responsibilities of each member of the joint team.

2.22 Use the mass media, both electronic and print, should be used to highlight health issues affecting students.

DIRECTED TO THE MINISTRY OF LABOUR
WITH THE SUPPORT OF THE MINISTRY OF HEALTH

It is recommended that the Ministry of Labour with the support of the Ministry of Health:

3.1 Strengthen the policy framework for mental health promotion and disease prevention in work places. This should include, but not be limited to:

- adequate employment opportunities for vulnerable populations including the mental health patients (employment policies, education and training)
- sustenance of those who do not have or have lost work (unemployment insurance, welfare assistance)
- avoidance of discrimination through legislation specific to employment for people with family care giving responsibilities and those with disabilities

including mental health patients and regulation of the psychosocial work environment through psychosocial risk management and legislation on safety
- definition of job conditions including job security, hours of work, leave entitlements (including maternity and paternity leave) and minimum wages
- definition of the role of labour unions and international labour federations in improving job conditions

3.6 Ensure workplace health policies include mental health and wellness using the International Labour Organization model, i.e. flexible employment practices and hiring, ensuring safe place of work

3.2 Promote an inclusive approach to planning, developing and execution of mental health promotion and support initiatives in the work setting ensuring through collaboration with employees, employers, trade unions and other relevant stakeholders

3.7 Promote innovative means of promoting “healthy working relationships” in the work setting, e.g. incentive programmes e.g. tax breaks for employers; bonuses/time-off/leave for employees, employee reward and recognition program, and day care/homework centres, flexitime, gyms in the work setting, car-pooling, de-centralisation of workplaces, family days, sports days, social events, retreats and work-sponsored workshops focusing on topics such as team building, communication, conflict resolution, grievance, balancing personal and work lives, retirement, time management, fostering productive work relationships, managing anger and disappointment, and resolving conflicts effectively, etc.

3.8 Promote the establishment of employee assistance programmes in the work setting among employees, employers, trade unions and other relevant stakeholders

DIRECTED TO PAHO/WHO

It is recommended that PAHO/WHO Trinidad and Tobago convene two working group meetings:

- one of selected forum participants to prepare a short brief on the recommendations for the school setting that can be presented to the Ministries of Health and Education
- one of selected forum participants and representation from the International Labour Organization to prepare a short brief on the recommendations for the workplace setting that can be presented to the Ministries of Health and Labour

APPENDICES