HRED

THIRD SESSION OF THE TWELFTH PARLIAMENT (2022/2023)

THIRD REPORT OF THE

JOINT SELECT COMMITTEE ON

HUMAN RIGHTS, EQUALITY AND DIVERSITY

on

THE DISCRIMINATION FACED BY PERSONS WITH MENTAL ILLNESS AND THE ABILITY TO ACCESS QUALITY MENTAL HEALTH CARE

Committee Mandate

The Joint Select Committee on Human Rights, Equality and Diversity was established under House of Representatives Standing Order 106 and Senate Standing Order 96 and shall have the duty of considering, from time to time, and reporting whenever necessary, on all matters related to:

(a) compatibility of Acts of Parliament with human rights, and any matters relating to human rights in Trinidad and Tobago (but excluding consideration of individual cases);
(b) Government compliance with national and international human rights instruments to which Trinidad and Tobago is a party;
(c) the promotion of measures designed to enhance the equalization of opportunities and improvement in the quality of life and status of all peoples including marginalized groups on the basis of gender, age (elderly, youth, children) disability and the creation of an inclusive and more equitable society through greater social justice and sustainable human development within Trinidad and Tobago."

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Table of Contents

1. EXECUTIVE SUMMARY **6**

2. INTRODUCTION **10**

Background 10

Discrimination of Persons with Mental Illnesses *10*

Human Rights and Discrimination of Persons with Mental Illnesses *10*

Discrimination in Access to Health Care Services *11*

Ministry of Health (MOH) 12

Conduct of the Inquiry 13

3. EVIDENCE **14**

Objective 1: To Assess the State's Capacity to Provide Quality Mental Health Care to Persons With Mental Illnesses in Trinidad And Tobago. 14

Statistics on Persons with Mental Illnesses 14

Support Programmes and Services for Persons with Mental Illnesses 15

Adult Mental Health Services *15*

Child and Adolescent Mental Health Services *16*

World Health Organization Assessment Instrument for Mental Health Systems (WHO AIMS) Study 17

Quality Assurance Mechanisms 18

Standard Operating Procedures (SOPs) *18*

Resources Requirements and Challenges 18

Objective 2: To Examine the Discrimination Faced By Persons with Mental Illnesses In Trinidad and Tobago In Terms Of Access To Quality Healthcare. 20

Complaints of Discrimination in Access to Mental Health Treatment 20

Barriers to Accessing Mental Health Treatment 21

Methods to Remove Barriers to Accessing Mental Health Treatment 23

Mental Health Awareness Programmes 25

Legislation 27

4. FINDINGS AND RECOMMENDATIONS **29**

Objective 1: To Assess the State's Capacity to Provide Quality Mental Health Care to Persons With Mental Illnesses in Trinidad and Tobago. 29

Persons with Mental Health Illnesses 29
Provision of Quality Mental Health Care 29
Recommendations..30
Objective 2: To Examine the Discrimination Faced by Persons with Mental Illnesses in Trinidad and Tobago in Terms of Access to Quality Healthcare....................................31
Complaints of Discrimination 31
Barriers...32
Mitigation of Barriers 32
Mental Health Awareness 32
Legislation..33
Recommendations..33
APPENDIX I... 36
APPENDIX II 38
APPENDIX III... 45

ABBREVIATIONS

AGLA	Office of the Attorney General and Ministry of Legal Affairs
APTT	Association of Psychiatrists Trinidad and Tobago
EOC	Equal Opportunity Commission
EWMSC	Eric Williams Medical Sciences Complex
CSDP	Centre for Socially Displaced Persons
MoH	Ministry of Health
MSDFS	Ministry of Social Development and Family Services
NGO	Non- Governmental Organisation
NWRHA	North West Regional Health Authority
NCRHA	North Central Regional Health Authority
POS	Port of Spain
POSCC	Port of Spain City Corporation
RHA	Regional Health Authority
SDU	Social Displacement Unit
SWRHA	South West Regional Health Authority
TRHA	Tobago Regional Health Authority
TTAP	Trinidad and Tobago Association of Psychologists
TTPS	Trinidad and Tobago Police Service

TABLES

Table 1: Patients Diagnosed with Mental Illness at NWRHA from 2017-21 14
Table 2: Patients Assessed for Mental Illness at St. Ann's Hospital 2017-21 14
Table 3: Patients Assessed for Mental Illness at the TRHA 2017-21 15
Table 4: Persons Warded at SWRHA, TRHA and IPU-EWMSC 15
Table 5: Persons Admitted to St. Ann's Hospital for the period 2019 to 2021. 15
Table 6: SOPs of Mental Health Facilities 18
Table 7: Resource Requirements and Challenges 19
Table 8: EOC Complaints 2015 to 2021 21
Table 9: Measures from Stakeholders to Remove Barriers to Accessing Treatment 24
Table 10: Proposed Amendments to the Mental Health Act, 2000 27

1. EXECUTIVE SUMMARY

1.1. At its Seventh Meeting held on April 09, 2021, the Committee resolved to inquire into *'the discrimination faced by persons with mental illness and the ability to access quality mental health care.'* It was agreed that the following objectives would guide the inquiry:

- To assess the State's capacity to provide quality mental health care to persons with mental illnesses in Trinidad and Tobago; and
- To examine the discrimination faced by persons with mental illnesses in Trinidad and Tobago in terms of access to quality healthcare.

1.2. The Committee agreed to hold one virtual public hearing with officials from the Ministry of Health (MoH).

1.3. The Committee submitted its findings and recommendations with respect to the discrimination faced by persons with mental illness and the ability to access quality mental health care in **Chapter 4**.

1.4. A summary of the Committee's key findings and recommendations are:

5.1 The Quality Department of the RHAs are responsible for internal audits however there are no external audits conducted.

a. **The MoH should engage in an external audit of the mental health care quality of the services, procedures and policies at the RHAs.**

5.2 There is the need for additional mental health specialists for mental health services and increased interaction between; mental health services and departments/agencies responsible for HIV/AIDS, reproductive health, substance abuse, military and criminal justice, and traditional, religious and complementary healers that function as mental health providers.

a. **The MoH should:**

- ❖ **Conduct additional mental health public awareness programmes to promote good mental health and well-being practices and discourage negative stigma;**
- ❖ **Recruit additional mental health specialists for mental health services namely psychologists, occupational therapists, art and music therapists;**
- ❖ **Implement a multi-pronged and holistic approach to treating mental health and well-being of citizens by creating linkages between mental health services and departments/agencies responsible for HIV/AIDS, reproductive health, substance abuse, military and criminal justice and traditional, religious and complementary healers that function as mental health providers; and**
- ❖ **Create an official, publicly accessible national reporting system for mental health services and persons with mental health illnesses.**

5.3 There are several infrastructural, equipment and human resource upgrades awaiting realization across the mental health facilities in Trinidad and Tobago in order to facilitate the implementation of the community-based mental health service delivery as provided in the National Mental Health Policy.

a. **The MoH should review the infrastructure and resources required at the mental health facilities in Trinidad and Tobago to develop a three -year plan inclusive of long-term and short-term goals to commence reconciling the resources and infrastructures necessary at each mental health facility by January 2023.**

5.4 The MoH provides several programmes and services to persons with mental health illnesses however, according to the WHOAIMS study there are more NGOs associations in mental health focused on providing consumer-based mental health care services.

a. **The MoH should engage in a review of the current mental health care services and implement the necessary changes in the system to adopt a more consumer-based approach to providing mental health care services.**

5.5 There were reported cases of discrimination against members of the LGBTQ+ community seeking mental health care services including:

- ❖ Denial of service;
- ❖ The persistence of mental health care providers to treat the sexual or gender orientation of the person rather than the presented mental health issue/s; and
- ❖ Provision of empirically unsupported and potentially harmful interventions and treatments, including conversion therapy.

a. **The MoH should provide for additional sensitivity training exercises to be administered for all medical professionals as well as educators to mitigate the discrimination faced by persons within the LGBTQ+ community in need of mental health care services and to ensure that patients are treated with dignity.**

5.6 The absence of State regulation of mental health services provided through NGOs and private practitioners also creates risks based on gender including the failure to address the mental health considerations of men and boys and women and girls.

a. **The MoH should implement greater regulation of mental health services provided through NGOs and private practitioners.**
b. **The MOH should conduct a formal scientific study on the provision of quality mental health care to and discrimination faced by persons with mental illnesses in Trinidad and Tobago, as they may have significant implications for the real availability of mental health care for citizens, and for public costs beyond the formal realm of mental health.**

5.7 There are barriers for persons with mental health illnesses to access to treatment for mental illnesses in Trinidad and Tobago in several areas including:

- The stigma and sociocultural and religious influences associated with persons with mental health illnesses;
- The financial strain and lack of economic Resources to access treatment;
- Inadequate professionals and inconsistent medication supply;
- Poor Infrastructure;
- Outdated and inadequate legislation;
- Discrimination of patients due to their sexual orientation;
- The absence of Gender-based treatment plans; and
- The Assumptions and Framework of the Mental Health Care System.

a. **The MoH should review and address the barriers for persons with mental health illnesses to access treatment in Trinidad and Tobago, to facilitate an effective roll-out of the model.**

5.8 The Mental Health Act, 2000 was inadequate to reflect the current needs and realities of the society and that the amendment of the Act is necessary to provide a more holistic, patient –rights based mental health system.

a. **The MoH should collaborate with the AGLA to amend the Mental Health Act, 2000 to include the amendments proposed by the stakeholders.**

2. INTRODUCTION

Background

Discrimination of Persons with Mental Illnesses

2.1. Mental illness or mental disorders are characterized by a combination of abnormal thoughts, perceptions, emotions, behaviour, and relationships with others (WHO 2017). Mental illness is a major health condition that affects individuals, families, and communities in both the developed and developing world. Statistics from the World Health Organization (2013) indicate that a quarter of the world's population will experience mental illness in their lifetime.

2.2. Mental illness affects people of different backgrounds and culture, irrespective of age, gender, race, education, religion, or socio-economic status (Regehr and Glancy 2014). According to research, individuals diagnosed with mental illness find themselves stigmatized by family, society, and the community at large. A majority of individuals with the illness find themselves discriminated against due to society's perception of mental illness (Regehr and Glancy 2014).

2.3. Discrimination may impact a person's access to adequate treatment and care as well as other areas of life, including employment, education and shelter. The inability to integrate properly into society as a consequence of these limitations can increase the isolation experienced by an individual, which can, in turn, aggravate the mental disorder. Policies that increase or ignore the stigma associated with mental disorder may exacerbate this discrimination.[i]

Human Rights and Discrimination of Persons with Mental Illnesses

2.4. Violations of basic human rights and freedoms and denial of civil, political, economic, social and cultural rights to those suffering from mental disorders are a common occurrence around the world, both within institutions and in the community. Physical, sexual and psychological abuse is an everyday experience for many with mental

illnesses. In addition, they face unfair denial of employment opportunities and discrimination in access to services, health insurance and housing policies. Much of this goes unreported and therefore this burden remains unquantified (Arboleda-Flórez, 2001).[ii]

Discrimination in Access to Health Care Services

2.5. The WHO Mental Health Survey Consortium (2004) previously reported that up to 85% of people with serious mental illnesses did not receive treatment in a one year period [iii]. Stigma surrounding poor mental health appears to be a major contributor to a lack of contact with services[iv]. In Europe, this is not really connected to the availability of clinical services (although social and community care remains limited in some countries). Instead there seems to be a reluctance to come into contact with services because of anticipated discrimination[v]. Individuals may be fearful of being discriminated against if they are labelled as having a mental health problem. As members of the general population, they are also exposed to common misconceptions surrounding mental illnesses – for instance that they cannot be cured or that drug treatments do not work.[vi]

2.6. By using available resources and appropriate support networks, victims of discrimination can find the support they need to exercise their rights and end the various forms of discrimination to which they may be vulnerable. Providing access to the following necessary resources and additional support for patients is critical:

- ***Education and awareness***: Despite progress in recent years, there is still a stigma associated with mental illness. Embarrassment can be reduced by helping people in at-risk communities understand that mental health is an essential part of well-being — just like a healthy diet, sleep and exercise.
- ***Policy changes***: Universal mental health care coverage would dramatically improve access for minorities. Quality improvement efforts include screening, cultural sensitivity training and language-appropriate treatment and educational materials.

- ***Advocacy and outreach:*** Public health advocates have proven effective in reducing barriers to care for at-risk communities.
- ***Integrating behavioral health with primary care:*** In minority communities where specialists are not plentiful, identifying a mental health practitioner can be a challenge. However, integrating mental health care with primary care could reduce disparities in access to care and could increase the odds of identifying a patient's mental illness.

2.7. Additionally, it is essential that health care professionals work to better recognize the effects of discrimination by taking Social Determinants of Mental Health (SDOH) into consideration as part of their approach to care, understanding which populations may be at greater risk for discrimination, screening for negative mental health outcomes that may be a direct result, and ensuring that discrimination is not occurring within their own practice settings. [vii]

Ministry of Health (MOH)

2.8. The National Mental Health Policy 2019-2029 is the overarching policy framework for mental health care in Trinidad and Tobago. This policy provides the strategic framework for achieving these goals as they relate specifically to human rights protection, promotion, prevention and mental health service delivery through a combination of inpatient, primary care and community-based services focusing on rehabilitation and recovery for persons with mental health and substance use conditions.

2.9. The Ministry of Health offers a range of free services for the prevention and treatment of mental illnesses to all citizens. As an inpatient (someone admitted to a hospital ward for a period of time) or an outpatient (someone accessing treatment while living at home or in the community) treatment can include:

- ❖ Medical care (management of pre-existing medical conditions);
- ❖ Medication (where appropriate);
- ❖ Psychological Interventions (individual psychotherapy, group therapy etc.);

- Social Work Interventions (liaison to social services, family counselling, treatment compliance support etc.); and
- Rehabilitative Interventions (occupational therapy, creative arts therapy, memory clinic services, speech and language therapy etc.)[viii]

Conduct of the Inquiry

2.10. The Committee conducted one public hearing held on February 11, 2022, with key stakeholders related to the discrimination faced by persons with mental illness and the ability to access quality mental health care. During this time, the Committee questioned the officials on matters based on the objective of the inquiry.

2.11. Prior and subsequent to the public hearing, the Committee sought responses from various stakeholders and the following written submissions were received:

- Ministry of Health (MoH);
- Equal Opportunity Commission (EOC);
- Trinidad and Tobago Association of Psychologists (TTAP); and
- Association of Psychiatrists Trinidad and Tobago (APTT).

2.12. The **List of Officials** that appeared before the Committee is attached as **APPENDIX I.**

2.13. The **Minutes and Verbatim Notes** are attached as **APPENDIX II** and **APPENDIX III respectively**.

2.14. The Third Report was approved on .

3. EVIDENCE

Objective 1: To Assess the State's Capacity to Provide Quality Mental Health Care to Persons With Mental Illnesses in Trinidad And Tobago.

Statistics on Persons with Mental Illnesses

3.1. Data received from the MoH, indicated the number of individuals assessed and diagnosed with a mental health disorder at respective RHAs during the period January 2016 to September 2021 is as follows:

- At the South-West Regional Health Authority (SWRHA) totalled 7,425 of which there were 3,836 males and 3,589 females.

- The number of persons diagnosed with mental illness at NWRHA (St. Ann's Hospital and Community Cases) is shown in **Table 1** below:

Table 1: Patients Diagnosed with Mental Illness at NWRHA from 2017-21

Fiscal Year	SAH - Diagnosed Cases	Community- Diagnosed Cases	Community Female	Community Male
2017	501	N/A	N/A	N/A
2018	478	1,611	956	655
2019	548	1,734	994	740
2020	464	1,640	932	708
2021	492	1,725	1025	700

- The number of persons assessed for mental illness at the St. Ann's Hospital (SAH) and at the TRHA is shown in **Table 2** and **Table 3** below:

Table 2: Patients Assessed for Mental Illness at St. Ann's Hospital 2017-21

Fiscal Year	Number Assessed at SAH Assessment and Admissions
2017	2,642
2018	2,593
2019	2,534
2020	2,537
2021	2,488

Table 3: Patients Assessed for Mental Illness at the TRHA 2017-21

January 2017 – December 2021	
Male	Female
1348	1788

3.2. **Table 4** and **Table 5** below shows the persons with mental illnesses warded at mental health facilities for the period January 2018 to September 2021.

Table 4: Persons Warded at SWRHA, TRHA and IPU-EWMSC

Hospital	2018		2019		2020		2021		Total
	Male	Female	Male	Female	Male	Female	Male	Female	
SWRHA	537	289	539	294	539	309	8	11	2,507
TRHA	56	75	88	70	77	74	N/A	N/A	440
IPU – EWMSC	148	199	222	253	222	279	97	138	1,558
Total	741	563	849	617	888	662	105	149	4,505

Table 5: Persons Admitted to St. Ann's Hospital for the period 2019 to 2021.

Fiscal Year	Number of Admissions
2019	1,872
2020	1,630
2021	1,676

3.3. Data received from the MOH, highlighted the total number of persons who died by suicide for the period 2015-2020 is 580; of which 472 were males and 108 were females.

3.4. The intake statistics during the period January 2016 to September 2021, at the SWRHA, for the number of individuals assessed and diagnosed with dementia is 1,869 of which 776 were males and 1,093 were females.

Support Programmes and Services for Persons with Mental Illnesses

Adult Mental Health Services

3.5. The MoH utilises a multidisciplinary approach to provide adult mental health inpatient and outpatient services at all five (5) RHAs. Services provided include

psychiatric, psychological, social work services, support groups, home care and community outreach. Specialist adult services include alcohol and substance use services, forensic psychiatry, psycho-geriatric services.

Child and Adolescent Mental Health Services

3.6. Of the five (5) RHAs, mental health services are available for children and adolescents at the NWRHA, NCRHA, SWRHA, TRHA. There are three (3) Child Guidance Clinics located in Port of Spain, Pleasantville and Scarborough. Services provided by the Child Guidance Clinics include:

- Direct services including diagnostic examinations; treatment planning; individual, group and family psychotherapy;
- Indirect services;
  - maintaining community linkages for support of clients;
  - educating and sensitizing the community to the psychosocial, emotional and developmental needs of children;
  - facilitating community requests for services/crisis intervention if appropriate;
- liaison psychiatry; and
- consultation/collaboration.

3.7. The CALM Clinic was launched in September 2017 to ensure that there is early intervention and treatment for patients, counselling for parents, education for parents and schools. It provides linkages/referral to the Sexual Reproductive Clinic, Family Planning, OBGYN and Pediatric Clinic.

3.8. Children's Evaluation and Treatment Unit (CETU) is an eight (8) bed unit, at the St. Ann's Psychiatric Hospital, responsible for the assessment of children when ordered by the court.

World Health Organization Assessment Instrument for Mental Health Systems (WHO AIMS) Study

3.9. In 2018-2019, the MoH in collaboration with the Pan American Health Organization (PAHO), completed a study on mental health using the version 2.2 of the World Health Organization Assessment Instrument for Mental Health Systems (WHO AIMS) tool. This instrument is a tool for collecting essential information on the mental health system of a country and was first completed for Trinidad and Tobago in 2007.

3.10. The main findings taken from the executive summary of the WHO AIMS Report 2018-2019 were as follows:

- Two (2) new psychiatric wards were established in the Scarborough General Hospital and the Eric Williams Medical Sciences Complex and two (2) additional child and adolescent mental health clinics and eight (8) dedicated beds included in the public health system;
- More males than females were admitted to inpatient units, while more females than males attend outpatient services;
- Medications remain available in all classes for the entire population in the public mental health services;
- Additional psychologists, occupational therapists, art and music therapists need to be recruited for mental health services;
- Over 50% of primary care doctors have been trained in the Mental Health Gap Action Programme (mhGAP), but the practical integration of primary care and mental health services require more systemic adjustments;
- Limited formal interaction between mental health services and departments/agencies responsible for HIV/AIDS, reproductive health, substance abuse, military and criminal justice;
- There are more NGO consumer-focused associations in mental health;
- More traditional, religious and complementary healers that function as mental health providers need to be engaged; and
- Poor data collection especially with regard to diagnoses, use of restraints and the number of involuntary admissions. There is a need for official national reporting on mental health.

Quality Assurance Mechanisms

3.11. The quality department of the RHAs is responsible for monitoring services, inpatient services, outpatient services, auditing and evaluation of services. The Quality Department engages service user feedback but suggestion boxes are available at outpatient units, assessment department and admission wards, which are routinely checked, to allow for feedback from family members or patients. Furthermore, quality officers based at the hospital and clinics are available avenues for patients or family members to provide feedback on services.

Standard Operating Procedures (SOPs)

3.12. Standard Operating Procedures (SOPs) exist for admissions to facilities, tele-mental health[2], clinical handover and suicide prevention. **Table 6** below shows the SOPs used by mental health facilities.

Table 6: SOPs of Mental Health Facilities

NWRHA/SAH	SWRHA	TRHA
❖ Suicide Prevention Policy ❖ Use and Care of Resuscitation Carts ❖ Admission Policy ❖ Hospital Visitor Policy ❖ Procedure for Clinical Handover	❖ Restraint and Seclusion Policy ❖ SOP for the Management of Members of Staff who may be contemplating or threatening Suicide ❖ SOP Manual for Mental Health Officers ❖ SOP for the New Horizon Facility ❖ SOP for Child Guidance	❖ SOP for operation of Inpatient and Outpatient Services ❖ SOP for Tele-Mental Health Services

Resources Requirements and Challenges

3.13. In order to reflect international best practice in a Caribbean setting; the emphasis for mental health service delivery should be on access to community-based care that is timely, high-quality and effective. However, the lack of resources, equipment and inadequate infrastructure have posed various challenges for mental health facilities throughout Trinidad and Tobago.

[2] Telemental health is the use of telecommunications or videoconferencing technology to provide mental health services. Source: https://www.nimh.nih.gov/sites/default/files/documents/21-MH-8155-Telemental-Health.pdf

3.14. **Table 7** highlights the resources and infrastructural upgrades needed by mental health facilities and the challenges faced by facilities to cope with the lack of resources.

Table 7: Resource Requirements and Challenges

Medical Facility	Resource Requirements	Challenges Resulting From Lack of Resources
NWRHA- St. Ann's Psychiatric Hospital	❖ Repairs to the roofs of the buildings throughout the institution and some of the wellness centres. Some of the wards have major leaks which affect patients when it rains; ❖ Replace/repair bridge that connects the Hospital Attendants Office, Psychology, Sewing Room and Social Workers Office to the rest of the institution; ❖ Upgrade of the electrical supply to the compound and the various wards; and ❖ Replacement of the grease trap from the kitchen. ❖ New equipment for the Laundry Department; and ❖ Replacement of aged and obsolete equipment in the kitchen.	❖ Adverse impact on staff morale; and ❖ The compromised quality of patient experience.
Eric Williams Medical Sciences Complex - Psychiatric Unit	❖ Reorganisation of the ward to allow for additional space for interaction, activities, occupational therapy type projects, psychosocial interventions and creative therapy. ❖ The inability to adequately separate male and female patients. ❖ The need for a spatial organisation that ensures privacy to interview patients. ❖ The absence of the human resources i.e. psychologists, occupational therapists, creative arts therapists and community psychiatric nurses.	❖ Increased levels of stress and negative impact on staff morale and motivation. ❖ The compromised quality of patient experience. ❖ An impediment in the delivery of adult and child and adolescent mental health care.
SWRHA	❖ Inadequate Human Resources; ❖ Inadequate outpatient facilities; ❖ Inadequate Infrastructure; and ❖ The development and implementation of Behavioural Health and Wellness Centres, which will include a weekly Psychiatric Outpatient Clinic, a Depot Clinic, a Substance Abuse Prevention and Treatment Clinic, a Memory Clinic and a space allocated solely for the purpose of delivering child and adolescent mental health services.	❖ An impediment in the delivery of adult and child and adolescent mental health care. ❖ Space, which was previously assigned to Community Mental Health teams, are now being utilized by Primary Health Care for COVID-19 services; which affects the clinical operations and service delivery.
TRHA	❖ Increased number of beds and supporting human resources.	❖ Adverse impact on staff morale.

	❖ A continuous supply of psychotropic medications. ❖ A second seclusion room needed, as there are times when more than one patient is in need of this type of isolation.	❖ Impediment in the delivery of adult and child and adolescent mental health care.
Child Guidance Clinic (CGC)	❖ The area of the Child Guidance Clinic is shared with Community Paediatric service, Primary Health care for COVID-19 services and the present vaccination rollout, and the spaces are unavailable for CGC use on these days. ❖ The Child Guidance Clinic operates at the Pleasantville Health Centre, which is not child friendly area, nor a therapeutic setting. ❖ The lack of post-discharge follow-up for psychiatric inpatients, which results in patients defaulting clinic, medication non-concordance and increased risk of re-admission, the increasing need for mental health services and the increasing complexity in presenting issues.	❖ Longer waiting periods while attending and in between clinic appointments, since the space is shared; ❖ The children with parents attending appointments exposed to adults in the shared waiting space. ❖ It is challenging for staff to monitor and ensure smooth operations during clinics and to adhere to the HSE guidelines; ❖ Increased levels of stress and the negative impact on staff morale and motivation.

Objective 2: To Examine the Discrimination Faced By Persons with Mental Illnesses In Trinidad and Tobago In Terms Of Access To Quality Healthcare.

Complaints of Discrimination in Access to Mental Health Treatment

3.15. The Equal Opportunity Commission (EOC) allows for persons who have faced discrimination due to mental health issues to lodge complaints under the status ground of disability.

3.16. The discrimination need not be limited to accessing goods and services, as the Commission can receive complaints of discrimination in the areas of employment, education and the provision of accommodation.

3.17. The Commission is empowered to investigate these complaints, and where possible to bring the parties to the table for conciliation. If it cannot be resolved voluntarily between the parties, the matter may be referred to the Equal Opportunity Tribunal for hearing and determination.

3.18. For the period 2015 to 2021, the Commission received 16 complaints from persons with mental health illnesses who experienced discrimination in the areas of employment, education, the provision of accommodation and access to goods and services.

Table 8: EOC Complaints 2015 to 2021

Year	Number of complaints that alleged discrimination on the ground of disability (either by itself or in conjunction with other grounds)	Number of complaints where the disability was mental health (including sex of complainant and nature of disability)	
		Female	Male
2015	12 complaints	1 manic-depressive;	3
2016	20 complaints	None	10
2017	10 complaints	None	None
2018	11 complaints	None	None
2019	11 complaints	None	None
2020	07 complaints	None	None
2021	14 complaints	1 - major depressive disorder	1-post-traumatic neurological disorder.

3.19. According to the EOC, while there are few complaints from persons alleging discrimination on the ground of mental illness many of the persons who alleged discrimination based on a physical condition or an intellectual condition exhibited symptoms of anxiety, irritability, mood disorder or depression, likely coming out of the attitudinal and architectural barriers that they faced. For example, a number of complaints received (See **Table 8**) were from persons with Attention Deficit Disorder (ADD). In other words, what these persons experienced affected their mental health and well-being, which likely was undiagnosed or untreated.

3.20. Thirteen (13) complaints about access to goods and services lodged by the male in 2015 and 2016 (See **Table 8**) was as a result of the inability of his disability to be diagnosed or treated; despite, interventions locally and at the Mayo Clinic abroad.

Barriers to Accessing Mental Health Treatment

3.21. Based on the information provided by the APTT and the TTAP the following barriers exist for persons with mental health illnesses to access mental health treatment in Trinidad and Tobago:

- ***Stigma*** - The stigma against medical illness within the Trinbagonian society especially among the more mature citizens and among medical practitioners can result in the following:
    - The non-acknowledgement of mental health care needs until conditions advance to the point of crisis;
    - The prevention or limiting of mental health care-seeking behaviour;
    - The limiting of social support for those who struggle with psychological distress or mental disorders;
    - The embarrassment and ostracism of those experiencing psychological distress or mental disorders; and
    - The instigation of discrimination against those experiencing psychological distress or mental disorders such as wrongful termination or unwarranted eviction.

- ***Sociocultural and religious influences*** – There view of symptoms of mental illnesses, as signs of the supernatural rather than a medical issue, encourage persons to seek the help of their religious leaders or spiritual workers rather than mental health professionals;

- ***Financial strain:*** many patients with mental illnesses do not have long-term employment and consequently live in a state of financial insecurity;

- ***Inadequate professionals –*** There is a shortage of mental health professionals in the public sector– registered mental health nurses, community psychiatric nurses, psychologists;

- ***Inconsistent medication supply*** - shortages of psychiatric medications frequently occur and disrupt the treatment of clients with mental illnesses;

- ***Poor Infrastructure -*** Mental health facilities throughout the country are in need of repair and updating;

- ***Outdated and inadequate legislation*** – The Mental Health Act needs to be updated to account for the advancements in mental health care;

- ***LGBTQ+*** - there have been numerous reports of discrimination against members of the LGBTQ+ community seeking mental health care services, usually on the grounds of the religious objections of mental health care providers;

- ***Economic Resources*** - the State has not sufficiently invested in the development of preventive mental health care in Trinidad and Tobago, most mental health care is often through private providers;

- ***Gender-based*** - the State has not adequately invested in the development of diverse and well-informed systems and personnel for the provision of gender-based mental health services, as such the population are largely reliant upon non-State support systems.

- ***The Assumptions of the Mental Health Care System*** – The public mental health system is built upon a set of assumptions about mental health and the delivery of mental health care. These assumptions inherently restricts the provision of mental health care to only:
    - those who present with symptoms sufficiently severe to meet criteria for a psychiatric diagnosis, and
    - who are amenable to seeking care at a mental health facility, and
    - who are amenable to receiving psychiatric care, most often in the form of hospitalisation and/or medication.

- ***The Framework of the Mental Health Care System –*** The framework adopts the same assumptions of mental health care system and is a barrier to:
    - the planning or implementation of systems, policies, or programmes aimed at improving the mental health of the overall population;
    - efforts at prevention of mental disorders, subclinical mental distress, or preconditions to mental distress and mental disorders;
    - the address of social, economic, and environmental conditions that may underlie the development of mental disorders and subclinical mental distress;

Methods to Remove Barriers to Accessing Mental Health Treatment

3.22. The **Table 9** below provides the proposed methods for removing the barriers and increasing access to treatment for persons with mental health illnesses, according to APTT and the TTAP.

Table 9: Measures from Stakeholders to Remove Barriers to Accessing Treatment

<table>
<tr><th>Measure</th><th>Implementation of Measures to Remove Barriers to Accessing Mental Health Treatment</th></tr>
<tr><td colspan="2">APTT</td></tr>
<tr><td>Education</td><td>❖ Medical workers themselves should undergo sensitization sessions to educate them about mental illnesses and how to deal with persons living with mental illnesses, especially as it relates to the low violence risk posed by, the majority of those who are living with mental illnesses.
❖ Public education exercises continued and expanded where feasible.</td></tr>
<tr><td>Legislation</td><td>❖ Review of the Mental Health Act requires to make it more effective and more representative of the challenges faced by patients living with mental health issues.
❖ Enforcement of the legislation to prevent persons from infringing on the rights of the mentally ill.</td></tr>
<tr><td>Investment</td><td>❖ Attracting qualified personnel to remedy shortages, infrastructure upgrades, ensuring reliable supplies of pharmaceuticals all require increased investment from the MoH through the RHAs.</td></tr>
<tr><td>Staff Development</td><td>❖ The Mental Health Unit identify those areas that require additional expertise and resources and put a framework in place for staff to receive training in these areas to better allow them to meet the needs of the clientele.</td></tr>
<tr><td>Data Collection and Research</td><td>❖ Consistent and accurate data collection and investing in research regarding the epidemiology of mental illness within Trinidad and Tobago and the impact of mental illness on the national community are very important to plan services that would truly benefit our populace.</td></tr>
<tr><td colspan="2">TTAP</td></tr>
<tr><td>Adopt a Culturally-Valid, Holistic Framework for Mental Health Care</td><td>❖ The development of a more holistic, culturally-valid approach to mental health, by taking some of the following steps:
• collaborating with other stakeholder governmental entities;
• collaborating with non-governmental organisations and community groups, including religious and cultural organisations, and especially leaders of such organisations;
• creating a multidisciplinary team of mental health and allied professionals, including psychologists, psychiatrists, counsellors, social workers, occupational therapists, speech therapists, environmental design engineers, and others;
• conducting a needs assessment among diverse communities and segments of society;
• conducting research on the efficacy of indigenous practices for mental health care;
• focusing on prevention of psychological distress and other antecedents to the development of diagnosable mental disorders; and
• focusing on capacity-building and maintenance of psychologically healthy environments, systems, policies, and behaviours.</td></tr>
<tr><td>Increase Resources for Mental Health Care</td><td>❖ The increase in resources for mental health care by:
• procuring material resources for mental health care;
• developing policy favouring the use of evidence-based, non-medical mental health interventions;
• advocating for the hiring of mental health professionals competent to conduct non-medical interventions;
• establishing and enforcing standards of mental health care within the State's systems;</td></tr>
</table>

	• facilitating the education of non-governmental organisations and their individual providers regarding standards of care, especially with respect to issues of gender and sexual diversity, and gender-based oppression and violence; • conducting ongoing assessment and research regarding mental health care needs, provision, and outcomes in Trinidad and Tobago; • facilitating the training of new mental health care professionals and the continuing education of current professionals; • facilitating the education and training of mental health professionals for competent Spanish-language care provision.
Normalise Mental Health and Its Care	❖ The reduction of the stigma associated with mental health and mental health care by: • implementing a culturally-valid programme of public education; • facilitating the development of community resources for mental health care; • collaborating with some of the aforementioned governmental entities and incorporating mental health care-affirming messaging into multiple areas of governmental service • collaborating with culturally-accepted non-governmental organisations and communities to promote mental health care within and through culturally-valid means

Mental Health Awareness Programmes

3.23. The MoH, in collaboration with PAHO and the Regional Health Authorities, Create Better Minds, non-government organisations and private and public stakeholders, on October 10, 2018, launched a national inaugural mental health awareness campaign 'Paint De Town Green'© Create Better Minds on World Mental Health Day to engage in public sensitization initiatives aimed at mitigating the discrimination against mental illness.

3.24. The MoH has generated an online Mental Health and Psychosocial Support Services (MHPSS) National Emergency and Crisis Mental Health Services Directory. Further mental health promotion is integrated into the Ministry's annual health promotion programmes. The public education activities include:

- ❖ Mental Health Awareness
- ❖ Stress Management;
- ❖ Mental Health in the Workplace;
- ❖ Employee health and wellness;
- ❖ Psychological First Aid;
- ❖ Suicide Awareness;
- ❖ Healthy Lifestyle/Healthy Me Healthy You;

- ❖ Post Disaster Mental Health Public Education; and
- ❖ Management of Loss and Bereavement.

3.25. According to the MOH, training programmes conducted were for specialist and non-specialists in mental health awareness Trinidad and Tobago. The programmes aimed to assist in reducing the stigma associated with persons with mental health illness amongst health care workers as well as ensure the provision of efficient and effective treatment and care to persons with mental illnesses when accessing medical care.

3.26. The MoH implemented the Mental Health GAP Action Programme (mhGAP) in 2015 to scale up awareness of mental, neurological and substance use disorders in services in non-specialized health settings. The mhGAP training sessions occurred in all Regional Health Authorities (RHAs) in Trinidad and trained over 50% of primary care doctors in mhGAP.

3.27. The MoH assisted in the Training of Police in Mental Health Awareness in 2019 and in the development of a pilot programme in collaboration with the Police Training Academy to provide mental health training for police officers. This programme currently in the process of being accredited and expected to improve the knowledge and skills of police officers in engaging persons with mental illness.

3.28. Further training programmes conducted by the MOH include:

1) Violence Risk Assessment Training - Training in the Historical Clinical Risk - 20 (HCR-20) in 2009.
2) The Prevention and Management of Aggression and Violence Programme- a continuous training programme implemented in 2014;
3) Psychological First Aid - From 2012 to 2019, there have been 11 training sessions and trained 269 persons from the RHAs as well as other organizations.
4) Stigma reduction Training for healthcare providers in August 2021 – A Virtual Course in "Understanding Stigma and strengthening Cognitive Behavioural Interpersonal Skills".
5) Introduction to Monitoring and Evaluation for application to MHPSS programmes

Legislation

The Mental Health Act, 2000

3.29. The Mental Health Act, 2000, governs the mental health facilities within Trinidad and Tobago. However, the current Act is unable to represent the current needs and realities of the society.

3.30. According to the TTAP and the MOH, the proposed amendments in **Table 10** below are necessary to promote a comprehensive patient-rights based approach to mental health treatment in Trinidad and Tobago.

Table 10: Proposed Amendments to the Mental Health Act, 2000

Stakeholder	Proposed Amendments	Impact of Proposed Amendment
TTAP	❖ The Act, by defining mental health care as the provision of psychiatric services in response to diagnosed mental disorders, disallows the State's engagement in prevention of mental disorders and their precursors. ❖ The framing of mental health facilitates and reinforces the false dichotomy of mad/not-mad which contributes to the culturally-embedded stigma associated with mental health care, and necessarily reduces the likelihood that members of the population will seek care. ❖ A new Act of Parliament be developed including: i. should rest upon a more holistic model of mental health and its care, such as a bio-psycho-social model or an ecological model; ii. should include prevention and intervention of psychological distress and mental disorders as mutually essential components of mental health care; iii. should be informed by scientific evidence and best practices; iv. should include consideration of cultural validity for implementation; v. should include a broad mandate for public education; vi. should include requirements for standards of care and practice and their enforcement;	❖ Widen the range of the population afforded access to mental health care; ❖ Reduce stigma associated with mental health care; ❖ Increase the rate of acceptance of mental health and its care within the population; ❖ Facilitate earlier intervention regarding mental health; ❖ Reduce the likelihood of development of mental disorders; ❖ Lower the population risk of self-harm, harm to others, criminal behaviour, and other negative social, health, or economic effects of mental disorders; ❖ Lower the overall demand for crisis mental health care; ❖ Increase the range of professional knowledge, skills, and experience brought to bear in the provision of mental health care; ❖ Improve the quality of care provided, both by the state and by non-state providers of care; ❖ Holistic mental health care systems, inclusive of intentional prevention approaches, significantly reduce overall system costs, not only for mental health care, but for such downstream and/or related areas of health care, criminal justice, education, and private industry.

	vii. should consider issues of vulnerability, marginalisation, diversity, inclusion, and equity; viii. and should include explicit provision of significantly increased material resources in support of the policies and practices included in it;	
MOH	❖ Should address the issue of a patient's right to consent to treatment and the specific conditions which must apply for treatment to be given without the patient's consent; ❖ Should state that, "A Regional Health Authority shall, in relation to a Community Health Care Centre for which it is responsible, provide primary care and treatment to mentally ill persons in a community"; ❖ Should provide for a patient upon discharge being subject to a supervision direction in circumstances where that patient exhibited dangerous behaviour prior to admission or during treatment at a public in-patient facility and where there is a likelihood of that patient becoming dangerous to himself or others upon being discharged; ❖ Should provide for the establishment of a Civil Mental Health Tribunal and a Forensic Mental Health Tribunal, whereas under the current legislation one (1) Psychiatric Hospital exists and a Mental Health Review tribunal, which was never operationalized, is no longer relevant; ❖ Should provide for Guardianship whereas the current legislation does not. This allows for the next-of-kin of a mentally ill person or a social worker to apply to a Judge for a guardianship in respect of such a person on the grounds that (a) he is suffering from a mental illness and his mental illness is of a nature or degree which warrants his reception into guardianship; and (b) it is necessary in the interests of the welfare of the patient that guardianship be given; and ❖ Should declare Community Residences, Reception Centres and Homes for Older Persons to be Approved Homes that are permitted to receive children or older persons, as applicable, who are suffering from mental illness. The current legislation does not address residential care of children who suffer with mental illnesses.	❖ Ensure that hospitals and health facilities that provide mental health care and treatment are environments where patients' views are heard and their rights are respected in all decision-making processes. In this regard, the preamble to the Bill clearly outlines the rights of every mentally ill person, and lists more specifically, the rights of every patient in a mental health facility; ❖ Ensure that mental health care and treatment are provided by all RHAs in the communities where they provide other primary health care services. This is essential for the successful implementation of the Cabinet approved National Mental Health Policy (2019 to 2029); ❖ Enhance the management of violence risk through supervised community care for mentally ill persons who pose such a risk, thus reducing the need for unduly prolonged hospitalization of such persons; ❖ Ensure that no one is detained at a psychiatric hospital or facility for longer than medically required by specifying a clear process whereby a patient, his next of kin or his personal representative may appeal his detention, for both civil and forensic admissions; ❖ Provide for the care and protection of mentally ill persons who by virtue of their symptoms are unable to care for themselves by conferring the powers required to ensure the patient's care upon the person named in the application; and ❖ Bring mental health legislation into alignment with other relevant pieces of legislation; such as the Children's Authority Act and the Children's Community Residences, Foster Care and Nurseries Act.

4. FINDINGS AND RECOMMENDATIONS

Objective 1: To Assess the State's Capacity to Provide Quality Mental Health Care to Persons With Mental Illnesses in Trinidad and Tobago.

Persons with Mental Health Illnesses

4.1. Based on the Statistical information provided by the MOH in **Tables 1 to 5,** the Committee found that, more males than females were admitted for inpatient care at mental facilities. Additionally, for the period 2015-2020 more males than females committed suicide.

Provision of Quality Mental Health Care

4.2. According to international best practice, external auditors can be contacted to conduct an audit of the procedures, policies and quality of the services of the RHAs. The Committee found that while the Quality Department of the RHAs are responsible for internal audits, there are no external audits conducted.

4.3. The Committee noted the following:

- ❖ Additional mental health specialists needed for mental health services; and
- ❖ Increased interaction needed between mental health services and departments/agencies responsible for HIV/AIDS, reproductive health, substance abuse, military and criminal justice and traditional, religious and complementary healers that function as mental health providers.

4.4. The Committee found that there was a need for official national reporting on mental health.

4.5. The Committee found that there are several infrastructural, equipment and human resource upgrades to be executed across the mental health facilities in Trinidad and Tobago in order to facilitate the implementation of the community-based mental health service delivery as provided in the National Mental Health Policy (**See Table 7**).

4.6. The Committee found that while the MoH provides several programmes and services to persons with mental health illnesses; according to the WHOAIMS study there are more NGOs associations in mental health focused on providing consumer-based mental health care services.

Recommendations

4.7. **The Committee recommends that the MoH engage in an external audit of the mental health care quality of the services, procedures and policies at the RHAs.**

4.8. **Given the shortcomings highlighted in findings of the WHO AIMS study Committee recommends that the MoH:**

- ❖ **Conduct additional mental health awareness programmes with the public to promote good mental health and well-being practices and discourage negative stigma associated with mental illnesses;**
- ❖ **Engage in recruitment exercise for additional mental health specialists needed for mental health services namely psychologists, occupational therapists, art and music therapists;**
- ❖ **Implement a multi-pronged and holistic approach to treating mental health and well-being of citizens by creating linkages between mental health services and departments/agencies responsible for HIV/AIDS, reproductive health, substance abuse, military and criminal justice and traditional, religious and complementary healers that function as mental health providers; and**
- ❖ **Create an official national reporting system for mental health services and persons with mental health illnesses that is accessible to the public.**

4.9. **The Committee recommends that the MoH review the infrastructure and resources required at the mental health facilities in Trinidad and Tobago to develop a three -year plan inclusive of long-term and short-term goals to**

commence reconciling the resources and infrastructures necessary at each mental health facility by January 2023.

4.10. **The Committee recommends that the MoH engage in a review of the current mental health care services and implement the necessary changes in the system to adopt a more consumer-based approach to providing mental health care services.**

Objective 2: To Examine the Discrimination Faced by Persons with Mental Illnesses in Trinidad and Tobago in Terms of Access to Quality Healthcare.

Complaints of Discrimination

4.11. The Committee found that while the EOC has received complaints from 16 persons with mental illnesses for the period 2015 to 2021, two of the complaints were in relation to access to employment rather than access to mental health services. Additionally 13 of the complaints were filed by the same person whose illness was unable to be treated.

4.12. The Committee found that according to the MoH for the period 2015 to September 2021, the Ministry of Health and the RHAs has not received any formal complaints of discrimination from guardians/persons with mental illness when trying to access health services.

4.13. The Committee found that the TTAP reported cases of discrimination against members of the LGBTQ+ community seeking mental health care services including:

- Denial of service;
- The persistence of mental health care providers to treat the sexual or gender orientation of the person rather than the presented mental health issue/s; and
- Provision of empirically unsupported and potentially harmful interventions and treatments, including conversion therapy.

4.14. The Committee noted that either the persons with mental illness or their family can submit a report to the Quality Departments of the RHAs and to the Mental Health Unit, Ministry of Health for review and assessment.

Barriers

4.15. The Committee found that the absence of State regulation of mental health services provided through NGOs and private practitioners also creates risks based on gender. There is a failure to address the mental health considerations of men and boys and women and girls.

4.16. The Committee found the barriers highlighted at 3.21 for persons with mental health illnesses to access to treatment for mental illnesses in Trinidad and Tobago.

Mitigation of Barriers

4.17. The Committee was informed of the methods proposed by stakeholders at **Table 9** for removing the barriers and increasing access to treatment for persons with mental health illnesses.

Mental Health Awareness

4.18. The Committee noted that the MOH has endeavoured to promote mental health awareness through the mhGAP programme, the Training of police officers in mental health awareness and the online MHPSS National Emergency and Crisis Mental Health Services Directory.

4.19. The Committee was informed that in December 2021 that although there was a National Policy Framework for Mental Health, a draft of the National Mental Health Communication Strategy was completed and is expected to be finalised in the first quarter of 2022.

Legislation

4.20. The Committee found that the Mental Health Act, 2000 was inadequate to reflect the current needs and realities of the society and that the Act be amended to provide a more holistic, patient –rights based mental health system.

Recommendations

4.21. **The Committee recommends that the MOH conduct a formal scientific study on the provision of quality mental health care to and discrimination faced by persons with mental illnesses in Trinidad and Tobago, as they may have significant implications for the real availability of mental health care for citizens, and for public costs beyond the formal realm of mental health.**

4.22. **The Committee recommends that MoH collaborate with the AGLA to amend the Mental Health Act, 2000 to include the amendments proposed by the stakeholders in Table 10.**

4.23. **The Committee acknowledges the current efforts of the MoH in providing mental health awareness but recommends that additional sensitivity training exercises be administered for all medical professionals as well as educators to mitigate the discrimination faced by persons within the LGBTQ+ community in need of mental health care services and to ensure that patients are treated with dignity. .**

4.24. **The Committee recommends that the MoH implement greater regulation of mental health services provided through NGOs and private practitioners.**

4.25. **The Committee acknowledges the role of the decentralised model of care in providing a more consumer-based approach to mental health care delivery; as such, the Committee recommends that the MoH, review and address the barriers at 3.21 for persons with mental health illnesses to access treatment in Trinidad and Tobago, to facilitate an effective roll-out of the model.**

4.26. **The Committee recommends that the MoH note and implement the recommendations to removing barriers and increasing access to treatment for persons with mental health illnesses proposed by stakeholders in Table 9.**

4.27. **The Committee recommends that the MOH provide the Committee with an update on the implementation of the stakeholder recommendations in Table 9 by January 2023.**

4.28. **The Committee recommends that the MOH in collaboration with the MOE develop specific outreach projects to target young persons (12-25 years) who experience mental health issues. These outreach projects may take the form of mass education campaigns at schools and at regional health care centres.**

Your Committee respectfully submits this Report for the consideration of Parliament.

Dr. Muhammad Yunus Ibrahim
Chairman

Ms. Shamfa Cudjoe, MP
Vice - Chairman

Mr. Esmond Forde, MP
Member

Ms. Anita Haynes, MP
Member

Mr. Keith Scotland, MP
Member

Mr. Kazim Hosein
Member

Ms. Jearlean John
Member

Mrs. Hazel Thompson-Ahye
Member

<u>October 25, 2022</u>

APPENDIX I
Officials Attendance List

NAME	POSITION	MINISTRY/ORGANISATION
Public Hearing November 05, 2021		
Dr. Hazel Othello **Ms. Marsha Connell** **Ms. Keisha Lewis**	Director, Mental Health Services State Counsel II (Ag.) GM, Mental Health Services, NWRHA	Ministry of Health (MOH)

APPENDIX II
Minutes

EXCERPT OF THE MINUTES OF THE EIGHTH MEETING OF THE JOINT SELECT COMMITTEE ON HUMAN RIGHTS, EQUALITY AND DIVERSITY, HELD ON FRIDAY FEBRUARY 11, 2022 AT 9:34 A.M.

Present

Dr. Nyan Gadsby-Dolly, MP	Chairman
Mrs. Lisa Morris-Julian, MP	Vice – Chairman
Mr. Kazim Hosein	Member
Ms. Anita Haynes, MP	Member
Mrs. Hazel Thompson-Ahye	Member
Ms. Jearlean John	Member
Mr. Esmond Forde, MP	Member
Ms. Donna Cox	Member

Secretariat

Ms. Khisha Peterkin	Secretary
Mr. Brian Lucio	Assistant Secretary
Ms. Aaneesa Baksh	Graduate Research Assistant
Ms. Ria Rampersad	Graduate Research Assistant

Excused/Absent

The meeting was held virtually via Zoom

Call to Order and Welcome

1.1 The Chairman called the meeting to order at 9:34 a.m. and welcomed those present.

Public Hearing: The Public Hearing on an inquiry into the Discrimination Faced by persons with Mental Illnesses and the Ability to Access Quality Mental Health Care

8.1 The meeting resumed in public at 10:20 a.m.

8.2 The following persons joined the meeting:

Ministry of Health (MOH)

Ms. Melanie Noel	Deputy Permanent Secretary (Ag,)
Dr. Hazel Othello	Director, Mental Health Services
Ms. Keisha Lewis	GM, Mental Health Services, NWRHA
Dr. Venkata Ramana Vedula	Primary Care Physician II, ERHA
Dr. Pravinde Ramoutar	Director of Health, SWRHA

Professor Gerard Hutchinson	Regional Coordinator/Head Psychiatry Services, NCRHA
Dr. Samuel Shafe	Medical Director, St. Ann's Hospital

Opening Statements

8.3 The following official of the Ministry of Health gave brief opening remarks:

1. Ms. Melanie Noel	Deputy Permanent Secretary (Ag)

Key Issues Discussed

8.4 The following are the key subject areas/issues discussed during the hearing:

Ministry of Health's Approach to Mental Health Care

i. The Ministry of Health is guided by all of the conventions to which the Government of Trinidad and Tobago has agreed, principal among these is the Universal Declaration of Human Rights, and the mandates of these conventions are further reflected in national mental health policies. The Ministry is also advised on their approach to mental health care services by the Pan-American Regional Health Organisation (PAHO).
ii. International Benchmarks were used as a guideline for the *National Mental Health Policy 2019-2029*. It is currently in the implementation phase which focuses on the decentralisation of mental health services.
iii. The Ministry was in the process of developing a National Mental Health Information System that would allow mental health service providers across the country to record their information directly into a shared system. A completion date had not yet been determined.
iv. The major categories of mental health illnesses fall in either one of four disorders: depressive, anxiety, psychotic or substance abuse.
v. It was the aim of the National Mental Health Policy to be able to provide psychiatric care in communities, via an expansion and diversification of the services that were offered in various clinics across the country.
vi. The Ministry stated that the Mental Health Act is currently under review, however, the officials could not provide a date for its completion. It was noted that the amendments did not impact on the human rights of patients but was meant to provide a legal basis for the Ministry to improve its role and function. One of the changes that

the Ministry hoped to accomplish was to make supervision mandatory for clients leaving inpatient care.

Measuring the Quality of Mental Health Care Services

vii. Internal audits to measure the quality of inpatient and outpatient service delivery are carried out periodically by the resident Quality Departments within the Regional Health Authorities. No external audits are commissioned, although this practice is common in other countries.

viii. Feedback on the customer experience of mental health services provided could also be submitted through the Customer Service Representatives of the various Quality Departments of the Regional Health Authorities (RHAs), as well as through feedback forms and suggestion boxes available at these facilities.

ix. The officials of the North West Regional Health Authority disclosed that one of the main indicators of success was the ability of a patient with mental a health illness to re-gain functionality within the society.

x. In terms of the extent to which this was achieved depended on the type of disorder and severity of symptoms. Family support was also a key contributor to the creation of a successful outcome but depressive and anxiety disorders were often easier to treat than more severe illnesses such as schizophrenia.

xi. The COVID-19 pandemic was reported by the Ministry not to have had a negative impact on the supply of drugs to treat mental illnesses. It was further observed that mental health drugs were either available through the Chronic Disease Assistance Programme (CDAP) or the various hospital pharmacies via prescription.

xii. Statistics used by the Ministry of Health on key measures such as suicide were not generated internally but were obtained by the Trinidad and Tobago Police Service.

xiii. The Ministry of Health also cited their strict adherence to principles of patient confidentiality through its Confidentiality Policy which required persons seeking information on patients to formally submit their requests in writing to the Ministry's Legal Department. The Ministry also facilitated requests from the Court to provide patient information.

Inpatient and Outpatient Services

xiv. A decision on whether a patient is admitted for inpatient or outpatient treatment is based on the assessment of the attending clinician, in which case if a patient is unable to consent; written approval is obtained from a relative.

xv. Inpatient care is usually advised if the severity of the patient's symptoms cannot be sufficiently addressed within the community setting. The majority of patients in receipt of mental health services receive outpatient care.

xvi. Patients usually attend clinics based on their geographic catchment area.

xvii. The Ministry noted that psychiatric nurses were instrumental in conducting home visits in various communities to encourage outpatients to adhere to their treatment.

xviii. There is a higher proportion of male patients in inpatient care primarily because they are less willing to access outpatient services and face relapses as a result. A greater prevalence of relapse in turn increases the chance for repeat admissions.

Training of Mental Health Care Personnel

xix. COVID-19 had stymied the Ministry of Health's facilitation of Continuing Medical Education sessions for mental health staff. However, doctors are trained in best practice guidelines during their postgraduate studies in Psychiatry.

xx. Training has also been provided to the staff of the Port of Spain City Corporation and was scheduled to be extended to the Municipal Police. Though the curriculum was still awaiting accreditation, the training would cover restraint, prevention and management. However, it was highlighted that officers in the various arms of the protective services needed more sensitisation specifically in the area of de-escalation and safely treating persons with mental health illnesses within communities.

xxi. No specific training has been carried out for medical staff relevant to the various international conventions to which the country is a signatory.

Role of the Ministry of Health in the Regulation of Mental Health Care

xxii. In relation to the use of restraints on children, it was noted that many Children's Homes sought the advice of the Ministry of Health on this matter, however, it was the general policy of the Ministry not to use restraints.

xxiii. The Ministry of Health also collaborated with the Student Support Services of the Ministry of Education to provide training and sensitisation for parents whose children were identified as having a mental health issue.

xxiv. The Ministry also performed evaluation and assessment exercises on children to determine the status of their mental health based on requests by the Judiciary, Children Court and to a lesser extent, families, at the Children's Evaluation and Treatment Unit, St. Ann's Hospital.

xxv. Regulations to guide the treatment of persons with mental health illnesses in private care facilities were forthcoming but would make provisions for periodic reviews. In

the interim, the completed guidelines were being used to promote conformity among service providers.

Public Education and Sensitisation

xxvi. Various efforts of the Ministry to raise awareness on mental health issues were exemplified including outreach sessions on World Mental Health Day, facilitation of tailored programmes for various workplaces in addition to the individual initiatives of mental health professionals. It was further highlighted that the request for tailored sensitisation programmes had increased during the COVID-19 pandemic.

xxvii. Overall there was a need to augment public education and sensitisation on mental illnesses, specifically in de-stigmatising the dialogue around mental health and its identification and treatment in children.

xxviii. It was also observed that persons with certain types of mental illnesses were unable to comprehend the nature of their illnesses and may neglect their medication or treatment. It was therefore important that patients work with healthcare providers to find a suitable or alternative treatment in order to prevent the perpetuation of harm.

Infrastructural Capacity Constraints

xxix. The demands of treating COVID-19 patients had a negative impact on the use of physical space dedicated to mental health services at the North West Regional, Eastern Regional and South West Regional Health Authorities.

xxx. Due to the age of the St Ann's Hospital it has been constantly undergoing upgrade and renovation works and whilst this has not impacted bed capacity, the overall aim of the administration was to decentralise services and focus on quality of care.

xxxi. Behavioural Health and Wellness Centres were envisioned to provide daily access to mental health care with an emergency response team on call 24/7. In some regional districts, outreach clinics providing mental health care was only available on specific days and the community access approach was proposed to improve the accessibility of such services, specifically in rural areas.

Adjournment

9.1 The Chairman thanked Members and the listening public for their attendance and adjourned the meeting.

9.2 The adjournment was taken at 12:25 p.m.

I certify that the Minutes are true and correct.

Chairman

Secretary

February 28, 2022

APPENDIX III
Verbatim Notes

VERBATIM NOTES OF THE EIGHTH VIRTUAL MEETING OF THE JOINT SELECT COMMITTEE ON HUMAN RIGHTS, EQUALITY AND DIVERSITY HELD (IN PUBLIC) ON FRIDAY, FEBRUARY 11, 2022, AT 10.20 A.M.

PRESENT

Dr. Nyan Gadsby-Dolly	Chairman
Mrs. Lisa Morris-Julian	Vice-Chairman
Mrs. Hazel Thompson-Ahye	Member
Ms. Jearlean John	Member
Mr. Kazim Hosein	Member
Ms. Anita Haynes	Member
Mr. Esmond Forde	Member
Ms. Donna Cox	Member
Ms. Khisha Peterkin	Secretary
Mr. Brian Lucio	Assistant Secretary
Ms. Aaneesa Baksh	Graduate Research Assistant

MINISTRY OF HEALTH

Ms. Melanie Noel	Deputy Permanent Secretary (Ag.)
Dr. Hazel Othello	Director, Mental Health Unit
Ms. Keisha Lewis	General Manager, Mental Health Services, NWRHA
Dr. Venkata Ramana Vedula	Primary Care Physician II, ERHA
Dr. Pravinde Ramoutar	Director of Health, SWRHA
Prof. Gerard Hutchinson	Regional Coordinator/Head, Psychiatry Services NCRHA
Dr. Samual Shafe	Medical Director, St. Ann's Hospital

Madam Chairman: Good morning everyone and welcome to the Eighth Virtual Meeting of the Joint Select Committee on Human Rights, Equality and Diversity. This is our Committee's first public hearing to determine whether there is discrimination faced by persons with mental illnesses and with a specific focus on their ability to access quality mental health care.

I want to remind all participants that this is a virtual meeting and therefore we are asking you to mute your microphone when you are not speaking to help keep background noise to a minimum, and adjust your camera so that your face is fully visible, and ensure that notifications from your cell phones are not disturbing this meeting. So they should be muted.

Members of our listening and viewing audience you are invited to post or send your comments via the Parliament's various social media platforms, Facebook page, *ParlView*, the Parliament's YouTube channel and Twitter.

I would like to at this time introduce myself. My name is Dr. Nyan Gadsby-Dolly, Chairman of this Committee, and I would like to ask the members of this Committee to now introduce themselves starting with our Vice-Chairman, Minister Lisa Morris-Julian.

[*Introductions made*]

Madam Chairman: I think that is it for the members of the Committee who are present here this morning. At this time, I would like to invite the officials from of the Ministry of Health to introduce themselves to the rest of the hearing. Starting with the PS.

[*Introductions made*]

Madam Chairman: Do we have any other members? Yes.

[*Introductions made*]

Madam Chairman: Is there anyone else in the Ministry of Health? If no one else, I want to thank all members and all officials from the Ministry of Health for joining us today.

A civilization is measured by how it treats its weakest members or put differently, the greatness of a nation can be judged by how it treats its most vulnerable. It is globally acknowledged by the UN that if one has a mental health problem one should be treated with dignity and respect by staff and service providers. The right to adequate treatment is also included in the rights which should be afforded to every citizen. In 2013, the WHO recognized mental health as a global health priority. It is therefore appropriate that this Joint Select Committee examines the treatment afforded our fellow citizens who have mental health challenges with a view to establishing our objectives, the State's capacity to provide quality mental health care to persons with mental illness in Trinidad and Tobago, and to examine whether discrimination is faced by persons with mental illnesses in Trinidad and Tobago in terms of access to quality health care.

At this time, I would like to remind members to direct your questions through the Chair, and I would like before we go to questioning to ask Ms. Noel, the Deputy Permanent Secretary of the Ministry of Health to make a brief opening statement.

Ms. Noel: Thank you very much, Madam Chair. Good morning, Madam Chair, members of the Joint Select Committee, fellow colleagues of the Ministry of Health, and the viewing public. I take this opportunity to reaffirm the commitment of the Ministry of Health to the provision of mental health services across our country.

Our Ministry continuously provides technical guidance and support as it relates to the management of mental health services across our network of public health institutions through our mental health unit. We recognize that there are challenges and shortcomings being experienced and are taking steps to advance provision of mental health services using a behavioural change model approach.

The Ministry of Health through its approved 2019—2029 National Mental Health Policy seeks to ensure that mental health is addressed throughout the life course of an individual using a public health approach. Mental illness does not discriminate and can impact all members of the community. In this regard our primary objective to work towards realizing full integration of services into primary and secondary healthcare, and we are committed to increasing access to mental health services throughout Trinidad and Tobago.

This policy initiative takes cognizance of the broad range of social problems that are linked to mental health, such as childhood maltreatment, domestic violence, abuse, substance misuse, workplace stress, discrimination, unemployment, and poverty. Consequently, it seeks to promote collaboration amongst all relevant sectors that will result in improved programmes for members of our diverse population needing such services to build resilience, achieve faster recovery, be reintegrated into society, and to continue to live productive and healthy lives.

And so it is envisaged that today's proceedings will be insightful towards promoting the treatment and care of mental health care services towards better health care outcomes. Thank you, Madam Chair.

Madam Chairman: Thank you very much, Deputy Permanent Secretary of the Ministry of Health. So, a reminder again as we begin the questioning that you direct your questions to the Chair, and also remember to activate your microphones when you are speaking, and when you are complete please turn them off so that we do not have too much feedback and disruption of our proceedings.

At this time I would like to direct a question to the Ministry of Health officials, and this one I am not sure which person will take this one, PS, it may be you. But I would like to just, based on your submission you did outline some conventions that Trinidad and Tobago are signatory to which deal with mental health and the treatment of persons with mental health challenges and their rights. Could you just outline for the benefit of those who are listening and viewing those conventions which deal with mental health and the treatment of persons with mental health?

Ms. Noel: Thank you very much for your question, Madam Chair. We note that the Ministry of Health is signatory to several conventions that we have been signatory to. We are guided by our Mental Health Act, as well as the RHA Act. And there are also some conventions that are from the WHO and PAHO, and I would invite Dr. Othello to give a more comprehensive response with regard to this.

Madam Chairman: Doctor Othello.

Dr. Othello: [*Inaudible*]

Madam Chairman: You have to un-mute, sorry.

Dr. Othello: Good morning. The delivery arm of the mental health services lies within the regional health authorities through their mental health services. The Ministry provides the technical and policy guidelines that help guide that process. From the perspective of the Ministry, we are guided by all documents—all of these documents that the Government is signatory to. The one that is most relevant to mental health is the one that speaks to the human rights of persons with mental health disorders. And we ensure that our clinical guidelines, our operational policies, our treatment methods are all in alignment with that document. In addition, the Mental Health Act of Trinidad and Tobago also reflects the values that that document espouses.

Madam Chairman: Thank you so much. So we have quite a few and I know that there is the 1991 convention or resolution of the General Assembly that was adopted. That is the UN Principles for the Protection of Persons with Mental Illnesses and the Improvement of Mental Health Care. So I would imagine that that is a key one that plays a role in policy formation. And so let us move to the National Mental Health Policy 2019—2029, and if I may ask, are there any international benchmarks that this policy is tied to or was modelled after?

Dr. Othello: In the creation of the policy best practices were looked at globally so that we were very cognizant of what was happening in other regions in terms of mental health care. That guidance allowed us to be mindful of the fact that a decentralized approach to mental health care is currently believed to be the best approach, and it is the approach that most countries are pursuing in that regard. That policy document is very heavily weighted in the direction of decentralization, and we are currently moving towards the implementation phase of that policy which would allow us to provide more services to persons with mental health disorders, closer to where they live and reduce the reliance on hospital-based care.

Madam Chairman: Is there any body that does external evaluation of health care provisions in terms of mental health care?

Dr. Othello: Well, all the policies that we are developing and all the practices that we recommend, we work in close collaboration the Pan-American Health Organization and we seek their guidance and their direction and advice whenever we are doing the new things. So that we are always mindful of their advice. And that helps us to ensure that what we are doing is in fact in alignment with what is deemed acceptable at a global level.

Madam Chairman: Is there—but—so I get that but is there any type of evaluation that is done? Is that a feature of mental—best practice in mental health care?

Dr. Othello: Audits are done at the hospitals from time to time. We audit the wards in terms of their clinical practices, we audit the clinics periodically and that allows us to evaluate what is happening, how services are

provided, how clinical records are kept, how documentation takes place. And that allows the facilities or the institutions to have a good idea of where they are at and where improvements are required.

Madam Chairman: And who does these audits?

Dr. Othello: At the level of the regional health authority, they have audit departments that perhaps, I do not know if Ms. Lewis would want to speak to the issue of the audit department at the North-West RHA. But I am aware that they have audit departments who are responsible for all the auditing within the RHA.

Ms. Haynes: Madam Chair, I just had a follow-up question—

Madam Chairman: No, sorry, before you even—sorry. I just want to get to the person Dr. Othello would have identified to just hear a little bit more about this, the auditing, and I will come right to you Ms. Haynes.

Ms. Haynes: No problem.

Madam Chairman: [*Inaudible*]—yes.

Ms. Lewis: Auditing and evaluation of services is currently facilitated through the quality department. We have a quality department based at St. Ann's Hospital who is responsible for monitoring services, inpatient services as well as outpatient services. So an example of a recent audit they did was the waiting time at the admission department in terms of time presented as opposed to time assessed by a medical officer. Those are the types of things, and we also have service user feedback questionnaires.

Madam Chairman: So these are all internal audits?

Ms. Lewis: These are internal audits.

Madam Chairman: Is there any practice of external auditing being done that you have seen around the region or internationally? Is there any country that does external auditing, any body that does external audits for any country? Have you seen that as a feature of mental health care?

Ms. Lewis: There are countries that do external auditing. We have not done any external auditing.

Madam Chairman: And do you think that that would be something that would be useful and helpful in terms of gauging where we are internationally, as we consider whether we are meeting the needs of the conventions that we are signatory to, whether we are meeting those requirements and so on. Do you think that external auditing, it may be time for us to look at some level of external auditing for our mental health care?

Ms. Lewis: I think it certainly would be beneficial, yes.

Madam Chairman: All right. Ms. Haynes please.

Ms. Haynes: Thank you, Madam Chair. Well, I am glad, Ms. Lewis, in your answer you touched something that I was going to ask which is this idea of quality and whether or not you are getting feedback from patients and persons who are accessing the health care. And so, you did mention that there is a customer feedback and so that you are getting that. But from that, I do not know if you would be able to give us a sense—I know you are assessing waiting times and what not, but can we get a sense as a committee, overall, what the sentiment is from persons who are accessing the health care services? And do they feel adequately safe, from the audits that you may have had access to thus far?

Ms. Lewis: From the audits, yes they do. So there are two categories of persons that are engaged. One, is relatives and carers, and one is the patients themselves, those who are able to, are stable enough to engage in that process. Yes, there is some feedback that, you know, for example, the length of time it takes for prescription renewal. Some of the recent feedback was patients would in the community outpatient setting, would like to see a bit more emphasis placed on their physical care. For example, monitoring of blood pressure, those sort of things, in the clinic. Yeah, those are some of the things.

Ms. Haynes: Thank you very much.

Madam Chairman: Any other member wants to come in at this point in time? I see your hand is raised, member Forde.

Mr. Forde: Yes. Thank you, Madam Chair. Again, welcome to the officials from the Ministry of Health. We are talking about the auditing factor, all right, and once the auditing factor is being done efficiently and timely, from these reports we should be able to identify scenarios, we should be able to identify whether the services are being done on a proper basis. I would like to go to page 9 of the report submitted, all right, where it is stated that:

> The WHO-AIMS Report 2018 to 2019 also highlighted that
>
> And I quote:
>
> > There continues to be a poor collection of data regarding diagnosis, use of restraints and the number of involuntary admissions. Facilities produce internal reports, but there is a need for official national reporting on mental health.

Right, and as I said page 9, and those were the findings of the WHO-AIMS Report 2018 to 2019. And my question is: Based on the comment by WHO has the Ministry undertaken to provide a national report on mental health in which we are discussing today? Again, Madam PS, over to you through the Chairman. And well, whoever can give us some feedback on that please?

Ms. Noel: Thank you, member. I will ask Dr. Othello to respond to that question please.

Dr. Othello: Thank you for that question and the answer is yes, we are. In fact, even before the WHO-AIMS report we had already identified that need, and we had already began to work on it. So we are currently in the process of setting up a national mental health information system which would allow the services that actually provide mental health care in the communities across Trinidad and Tobago to input their data into a computer system at that point of care, and allow us at the Ministry of Health in the Mental Health Unit to receive that data directly. That would allow us to get feedback on a wide range of indicators that we have identified, and to be able to report on those indicators in a timely manner whenever that information is required of us. So we are actually working to correct that.

Mr. Forde: Okay. Madam Chair, a follow up please. Again, through you probably to Dr. Othello again. What percentage of admissions of these mental patients are basically involuntary? Are we able to identify? Or it is only when persons are considered, you know, based on their illness, what percentage of it is involuntary coming to the various institution?

Dr. Othello: I do not have an accurate percentage for you on that at this point in time. That can be provided subsequently. But the decision as to whether somebody is admitted voluntarily or involuntarily is made at the point where the person presents to the service by a clinician who evaluates the person's current mental state, as well as their competence. Because somebody may be willing to sign a voluntary admission form but if their symptoms are such that they are not competent to sign that form at that point, then a relative or someone may have to sign on behalf of them, or in some circumstances they may have to be admitted involuntarily. So it is a patient by patient decision that is made based on clinical findings and statistics on that can be provided subsequently.

Mr. Forde: Madam Chair, last question please. Again, what are the factors used to determine which persons receive inpatient as opposed to outpatient treatment services? How do we determine outpatient versus inpatient?

Dr. Othello: The majority of patients are treated in outpatient settings. Inpatient care is reserved for when persons' symptoms are at such a level of severity that adequate care cannot be provided for them in the community. In some cases inpatient care is also provided to provide relatives with a bit of respite because sometimes a person's caregivers may be a little bit overwhelmed from the process of providing that care, and may need some respite. So sometimes, we do admit patients for varying periods of time in order to provide relatives with that. But the majority of patients who are inpatients are there because of the severity of their symptoms, and because of the need for inpatient care so that they can have round the clock nursing supervision and care, and so that medication compliance can be monitored, and they can receive additional counselling on the importance of continuing their medication compliance when they are discharged back into the community.

The whole aim of the decentralization process is to provide as many people as possible with outpatient

care and to reduce the need for admission to hospital.

Mr. Forde: And all what you are saying are available at all—basically all the centres throughout Trinidad and Tobago? East, west, north, south, Tobago are available?

Dr. Othello: As indicated in our response, in the north, the St. Ann's Hospital provides care, psychiatric care, inpatient care. In the north central region we have the psychiatric ward at the Eric Williams Medical Sciences Complex. In the south we have the San Fernando General Hospital psychiatric ward. In addition to which the new Point Fortin Hospital was built with a psychiatric ward, and the new Arima Hospital was built with a psychiatric ward. In Tobago the psychiatric hospital also has a psychiatric ward. And the new central block that is being built at Port of Spain Hospital will also have a psychiatric ward.

Mr. Forde: Okay, thank you. Thank you, Madam Chair.

Madam Chairman: If I may, just to follow up on a point that member Forde raised, the WHO report was in 2018/'19 and Dr. Othello, if I am not mistaken you said even before the completion of that report the Ministry of Health would have started work on getting that national mental health information system up. So that is 2018/'19, we are in 2021. Could you let us know what is the targeted completion date for that system, that platform to be available for use?

Dr. Othello: I am not able to provide that at this point in time. I do not have that information in front of me.

Madam Chairman: Maybe the PS can assist us in this regard.

Ms. Noel: Unfortunately, I am not able to provide that information. We can subsequently give it to you in writing.

Madam Chairman: That would be appreciated because it directly impacts exactly what the issues are and getting that system up as you would explain would be very important. Minister Morris-Julian, and then we will have Sen. Thompson-Ahye.

Mrs. Morris-Julian: Thank you very much, Madam Chair. Through the Chair, Dr. Othello, the submission by the Ministry of Health indicated that for the period 2016 to 2021, 7,425 persons were assessed and diagnosed with a mental health disorder. Can you please—I have several follow ups—what are the major categories of mental illness identified? Could you also let us know how many persons received routine outpatient treatments? And then, can you tell me what was the age range which had the highest number of persons diagnosed with a mental illness for males and females respectively?

Dr. Othello: Okay. The vast majority of persons who accessed our services are treated for depressive disorders, anxiety disorders, and psychotic disorders. So that is what we see on a day-to-day basis in the

outpatient clinics. Usually when they are at the clinics, they are not severely ill and they are able to continue with their outpatient care, stay at home, and attend the clinics periodically for these conditions. We also have some substance abuse disorders as you would imagine and a lot of that care is also provided on an outpatient basis. I think your question had several components; the first was the major categories. I think you mentioned the age range of patients.

Mrs. Morris-Julian: Yes—[*Inaudible*]

Madam Chairman: Go ahead.

Dr. Othello: Yes. Care is provided for the entire life course as needed. So that, we have the child guidance clinics that provide outpatient care to children. Those are located in San Fernando and in Tobago as well the CALM clinic at Mt. Hope.

Mrs. Morris-Julian: Dr. Othello, please, through the Chair. How many persons received the routine outpatient treatments?

Dr. Othello: Okay, I would have to go back to the submission for that. I think the data that we were provided for—we provided the data by RHA. We did not provide the totals in terms of the total numbers of persons. So I do not have that in front of me at this point—

Mrs. Morris-Julian: Okay.

Dr. Othello:—but that can be provided.

10.50 a.m.

Mrs. Morris-Julian: Yes, I would like to request that. And I would also like you—with regard to member Forde, you spoke about the different wards in the RHAs, in Eric Williams, Arima, et cetera. Can you tell us how the services differ between those received at the mental health wards as compared to the services received at the St. Ann's Psychiatric Hospital? Who goes where? What determines what?

Dr. Othello: Where people go is largely a function of geography. The aim is to treat everybody as close as possible to where they live. So persons who live in the south are generally treated at San Fernando General Hospital, people who live in Tobago, et cetera. So that it is largely a matter of geography. However, from time to time, St. Ann's hospital receives patients from across Trinidad and Tobago.

Mrs. Morris-Julian: So there is no difference in treatment?

Dr. Othello: No. The principles of clinical care are the same across the board. It is a multidisciplinary approach whereby we have psychiatrists, psychologists, social workers, mental health nurses and so on, and our diagnostic process follows the Diagnostic and Statistical Manual of Mental Disorders or the International

Classification of Diseases. We use the same criteria for diagnosing and we use the same medications across the board.

Mrs. Morris-Julian: We noticed that the general trend in the data show that there were more male patients at the public health care facilities. Could you tell the Committee what factors may account for the higher number of male patients?

Dr. Othello: A number of factors contribute to that. One is that women are sometimes more willing to access outpatient care voluntarily, so that their illnesses get treated earlier in the course of the illness, reducing the likelihood of the illness progressing to a severe enough state for them to need to be admitted.

Other issues include outpatient compliance after discharge. The extent to which you are compliant with medication and with clinic visits afterwards contributes to the likelihood of a relapse and if the relapse is severe enough, the likelihood of re-admission. We also have other factors, such as substance abuse, that contributes to mental illness in which we have a higher prevalence among males than among females.

Mrs. Morris-Julian: Because of that particular trend, what measures can you state that the Ministry implemented to address these factors?

Dr. Othello: To address the higher prevalence of admission among men?

Mrs. Morris-Julian: Yes.

Dr. Othello: At the level of the RHAs, the mental health officers who are trained psychiatric nurses—sorry, community psychiatric nurses, they visit patients in the community and follow them up when patients do not keep their appointments. So that they have the ability during those visits to encourage persons, to share information with them, to educate them and so on, on the importance of their follow-up care and in an attempt to reduce the likelihood of a relapse and of readmission.

Mrs. Morris-Julian: Okay. Thank you very much, Dr. Othello. Madam Chair, thank you.

Madam Chairman: Thank you. Just before Sen. Thompson-Ahye comes in, I would like to ask a quick follow-up question about the clinical principles which, Dr. Othello, are followed across all of the institutions that treat with our patients with mental health care. That question really deals with: How up to date are our treatment and those clinical principles? Are those updated regularly based on best practice internationally and so on? And who determines what those principles are? And are we up to date?

Dr. Othello: The answer to that lies in training. We have in Trinidad and Tobago a post-graduate programme in psychiatry, so many of our doctors are coming through the University of the West Indies and receive state-of-the-art training in post-graduate psychiatry. So they come into the service as senior doctors well-trained.

Part of their training exposes them to international literature and continuing medical training is encouraged. So that prior to the COVID situation, we had ongoing what we call "CME", continuing medical education sessions at meetings that would be hosted by the Association of Psychiatrists of Trinidad and Tobago and at those meetings we would discuss important topics and updates in psychiatry. In addition to which the Association also used to host an annual conference at which we would have both local and international speakers, again providing updates in psychiatry. I do not know if that answers your question adequately.

Madam Chairman: So therefore, we can be assured as citizens of Trinidad and Tobago that our clinical principles, the treatment of our mental health patients are in line with what would happen internationally, regionally, as best practice? Yes?

Dr. Othello: To the best of our ability to provide it, yes, that is our guiding principle.

Madam Chairman: Okay. All right. Sen. Thompson-Ahye. Still muted, Senator.

Mr. Forde: Madam Chair, can I go in the interim, if Sen. Ahye—

Madam Chairman: No. We actually have—

Mr. Forde: You have a line?

Madam Chairman: —Sen. Kazim Hosein after.

Mr. Forde: No problem, Chair.

Madam Chairman: Let us take Minister Hosein and we will take Sen. Thompson-Ahye when she sorts out her issues. Right so, Mr. Hosein and we will take you after—

Mr. Hosein: Thank you very much, Madam Chairman, and thanks to my good friend for giving way. Chairman, I just have a couple of questions that are can kind of bothering me. I heard the doctor mention just now about some main areas where these hospitals are, like in Port of Spain San Fernando, Tobago. I want to know: Would the Ministry take measures to ensure that their services are provided to persons who reside in rural areas and other settlements that are not easily accessible to the regional health authorities? For example, transportation may be a possible issue that may arise in this area, in particular, for mental health illness.

The other question is: Given that many socially displaced persons suffer from mental illness, what approaches will be utilized to provide health care for these people? And the last one I have is—I will come back to you, Madam Chairman. Thank you very much. I wrote it down here and I just cannot find it. Thank you.

Madam Chairman: Sen. Hosein, can you just repeat your first question? You have to unmute again.

Mr. Hosein: Right. In rural areas, for example, and other settlements which are not accessible like in Port of

Spain, San Fernando and Tobago, and so on, I do not know what they could say—what the Ministry of Health could say to make this more easily accessible for the people living in rural communities?

Madam Chairman: I am not sure who wants to take that from Ministry of Health. PS, maybe you can tell us?

Ms. Noel: This is part of our decentralization thrust which is a central part of our national mental health policy. Dr. Othello would be able to give some further information on that.

Dr. Othello: Certainly. Decentralization of mental health services is in progress, as I spoke before, and the whole idea of community-based psychiatry is not a novel concept. Trinidad and Tobago has been providing psychiatric care in communities for quite some time. In that regard, we have clinics across the length and breadth of Trinidad and Tobago where patients can get care close to where they live.

What we are doing now is expanding upon that, building upon that and diversifying the services that can be accessed in those clinics. But those clinics, to a large extent, currently exist. So, for instance, we have clinics in the east in Toco, Sangre Grande, Mayaro. We have clinics in Point Fortin, in Rio Claro. We have clinics across Trinidad and Tobago and as the decentralization process continues, we would be in a better position to identify whether additional areas need that kind of service.

What has been happening in the interim is that the RHAs that provide those services have what they call outreach clinics in areas where they do not have a full-scale clinic. So they have smaller outreach clinics in some of the more far-flung areas, in addition to which, as I mentioned before, we have mental health officers who are trained psychiatric nurses whose responsibility it is to do home visits when necessary and there is nowhere in Trinidad and Tobago that is outside of their reach in terms of distance.

Madam Chairman: Thank you. Minister Hosein, is there a second question I think you raised? You want to just remind the Ministry of Health officials at this time?

Mr. Hosein: Yes. Thank you very much, Madam Chairman. Through you, Madam Chairman, given that parents are the primary caregivers to children who suffer from mental illness, will regional clinics or other appropriate bodies offer training services to parents so they would become more adept at dealing with these children's needs? I do not know if it is place but I would like to know. Thank you very much, Chairman.

Madam Chairman: So the training of parents to deal with children's mental illness. Dr. Othello.

Dr. Othello: Taking care of children is holistic. I will probably ask Prof. Hutchinson to expand after I am finished, since they have the CALM clinic in the North Central RHA. But as a general rule, you cannot provide mental health care for children without involving the parents. So the parents are always an integral part of that process. I will hand over to Prof. Hutchinson if he may want to expand further.

Prof. Hutchinson: Yes, hi. Good morning again. So as Dr. Othello has mentioned, treating children invariably incorporates some degree of treatment of the parents and the parental relationship that exists both between the parents and the children.

So in terms of the individual provision of treatment to children, parental interaction is an inevitable dimension of that process. From a more general sense, in terms of parent training, the various clinics work in conjunction with Student Support Services Division at the Ministry of Education and when particular issues are identified in particular areas and in particular circumstances, sessions are set up, either through school PTAs or directly through the Student Support Services Division to provide additional inputs in terms of training for parents in the management of the mental health problems of their children.

Mr. Hosein: Thank you very much, Madam Chair.

Madam Chairman: Thank you very much. We are going now to Sen. Thompson-Ahye.

Mrs. Thompson-Ahye: Thank you, Madam Chairman. I do apologize. My finger was too anxious and I pressed the wrong button. Now, I was pleased to hear Dr. Othello at the start of the session speak of the fact that the Ministry was guided by the—well, my words are the international instruments or the conventions which govern their operations.

I want to ask her specifically if the Ministry of Health, and especially her department, received any—the members of the department, especially the heads, have received training in the Convention on the Rights of the Child? If they are really very familiar with Articles, particularly 24, which is:

> "…the right of the child to the enjoyment of the highest attainable standard of health…"

Particularly also Article 25 which deals with the:

"…periodic review of…placement."

Because over the years we have heard about children who are in institutions and, of course, parents who cannot cope want them to remain there. So that the periodic review of placement is not as it should be. And also, Article 39, Rehabilitative Care.

In addition, there are other UN documents that we should be looking at, which the Committee on the Rights of the Child in their concluding report on Trinidad and Tobago have said, we should be acting in conformity even though it is not something that we have ratified, the JDL rules, the United Nation Rules for the Protection of Juveniles Deprived of their Liberty. So with Article 25 and the JDL rules, we are looking at periodic review of placement and also the limitation of the physical restraint and use of force.

There have been cases in Trinidad and Tobago where the courts have pronounced on children who

have been restrained and the rule is that if you have children who are restrained or you need to restrain, that the people who are running the institution should consult with medical and other relevant personnel and guide them in the use of restraint because some of these uses can and in fact have resulted in injury to the child.

So have bodies like the Children's Authority, that run institutions and people who run institutions been consulting with you, as they should, with regard to the use of force, the use of restraint which, to all intents and purposes, from the reports, are used sometimes indiscriminately? Quite a mouthful, I am sure, but if you can just respond to some of my concerns I would be grateful.

Madam Chairman: I was jumping to make sure we had the two issues that, I think, the main things, which are the training in international conventions and instruments, whether that is something that is highlighted. And also, I think you pulled out of those things, the use of restraints on children and whether the Ministry of Health provides guidance to institutions that deal with issues where that might arise.

Mrs. Thompson-Ahye: Excellent.

Madam Chairman: Dr. Othello.

Dr. Othello: Okay. At the Ministry of Health, I cannot remember any specific training on those instruments but I can tell you that when we are doing research for various purposes, we do look to see what guidance we can find from documents of that nature. I cannot recall to a specific training exercise. Okay?

With respect to the issue of restraints and children, as a general rule, that is not our goal or our purpose or our intention in terms of the care of children. There are not many situations in which, to my knowledge, restraints are used widely in children. I am not aware of that as a frequently occurring phenomenon. The places where children are treated—for instance, right now the children's evaluation and treatment unit at the St. Ann's Hospital does not use restraints. So I am not aware of that being an ongoing problem. There may have been isolated incidents but I am not aware of that being an ongoing or persistent or common problem. It certainly would be something that would cause us concern because we are aware that it is not the best practice.

In that regard, we firmly believe in treating everyone with the least restrictive environment. That has long been our mantra. So that the least restrictive environment a person can be treated in, be it adult or child, is the environment that we prefer to treat them in. That is why in days gone by, we had more open wards at St. Ann's hospital. Unfortunately, we have had to surrender some of them for other purposes. For instance, where the children's evaluation and treatment unit is now, used to be one of our most open wards, where it was only locked at night when people were going to bed. Keisha could bear me out on that, Ms. Lewis, in terms of which wards are still open.

But if you visit St. Ann's hospital, you should see patients walking around the compound and the

patients who are well enough to do so are allowed to leave the ward to walk around and to come back to the ward for mealtime and ward activities and things like that. So that the use of restraints is really a last option and it is not a preferred option for children. In addition to which, the hospitals have restraint policies. So if they are using restraints it is supposed to be done in accordance with the restraints policy.

Mrs. Thompson-Ahye: Well, the cases that we have heard about are generally from the children's homes, complaints and so on. Some of them have reached the courts. But what I am saying is that they are supposed to confer with you all because you are the experts. So it means that they are using those restraints because they want to prevent the children, maybe from self-harm or harming others, without recourse to you as the experts to guide them in the process and that is why we are having problems.

Madam Chairman: If I may—and let me come in here to just broaden the point that I think Sen. Thompson-Ahye is making and it is a question I myself wanted to ask. In terms of regulation—because we have heard Sen. Thompson-Ahye referring to cases that she has heard of that may have reached the courts. A couple of years ago, we saw a situation where there were mentally ill persons in cages and when the whole thing was established and it was uncovered, the family members, in some cases, had brought them there for treatment and so.

So maybe I could broaden that question to ask: What is the role of the Ministry of Health in regulating and providing guidance to, not just the State institutions, but also private institutions that offer care to mentally ill persons? Where does the Ministry of Health come in? Is there a regulatory role? What is in place in terms of human resource to provide that guidance, to provide that regulation? What exactly is happening in that regard?

Dr. Othello: Okay. The Ministry of Health has developed what we call "approved homes guidelines", guidelines for the provision of care to persons with mental health disorders in homes that are approved and we are in the process of completing the regulations that will go with those guidelines. Those guidelines are being communicated so that people contact us from time to time, even though it is not fully rolled out as yet, and people contact from time to time and we advise them to ensure that the homes that they are setting up are in conformity.

The process also puts in place a mechanism for periodic visits, so that those homes can be examined to see whether or not they are in conformity with the guidelines and a process for what should happen if they are not in conformity. So right now, because we have not fully rolled it out yet, we are working informally with the homes to help them to get in conformity. So that when it is fully implemented, they can continue to provide care, knowing that the care that they have provided is of the standard that is acceptable.

Madam Chairman: And that includes the homes run by the State?

Dr. Othello: That includes—when we say the homes? The homes run by the State?

Madam Chairman: The children. I am specifically now referencing Sen. Thompson-Ahye's—

Dr. Othello: Sorry about that. From our perspective, yes, the homes run by the State must certainly be in compliance with those regulations.

Madam Chairman: Sen. Thompson-Ahye, is there anything else you wanted to address at this time?

Mrs. Thompson-Ahye: I have another question, so I would be finished with—[*Technical difficulties*]—yes. I have a concern about the statistics and especially suicides. And I ask this in the context of: How do you classify something as a suicide when, you know, you have not really gathered all of the evidence? And having gathered all of the evidence, where you have classified a death as a suicide, do you then go back when you realize that, in fact, this was an accident which was an apparent suicide involving a child and say, well, you know, this is not at it seemed or is it that it remains in your statistics as suicide? Because suicides, as you would I am sure be aware, are not always suicides. Husbands poison wives and wives poison husbands, and they do all sorts of things, and children involved in play may also end up in a situation which is an apparent suicide.

So are you convinced that the statistics that you have put forward here as suicide are, in fact, cases that have been thoroughly investigated and you can say, well, you know, they are in fact suicides or does it remain so? I do not want to be specific but you may know what I am speaking about.

Dr. Othello: I am not sure if I know what you are speaking about but that is an interesting question. At the Ministry of Health we do not investigate suicides. We receive reports—we receive reports from the Trinidad and Tobago Police Service or from the regional health authorities but we do not do the investigating that would determine if something was looking like a suicide at one point, turned out to be a homicide or an accident. So we have to accept the report—the statistics that are provided to us.

Mrs. Thompson-Ahye: So any wrong information would be the fault of the police?

Dr. Othello: Well, we have to work with what we are provided with.

Mrs. Thompson-Ahye: I quite understand. I am very glad I asked that question. So I realize it was the wrong entity. Thank you.

Madam Chairman: We have member Forde and then member Morris-Julian.

Mr. Forde: Thank you, Madam Chair. Again, it seems like Dr. Othello is in the hot seat for most of the questions. I know we spoke about training. You talk about the training for the doctors, the nurses, medical personnel, psychiatric nurses, parents and even also children in certain instances. But with regard to the Trinidad and Tobago Police Service, I know they play a critical—well, a role—I am not sure how critical it is—in this whole mental care situation because remember, we have individuals that are on the streets.

In your submission, identified again on pages 5 and 6, you spoke about the development of a pilot programme to provide mental health training for police officers. My question is: What is the proposed timeline for the roll out of this programme and also the length of the programme? If you could just share briefly what the training will entail. Because we have some instances whereby some people may consider that policemen "abuse" their situations, when they are dealing with a mental case patient. So could you shed some light on that for us, please, with regard to the whole training?

Dr. Othello: The training that is provided for the police officers—first to begin, with respect to a timeline, unfortunately, I cannot give you that at this point in time because the pilot project was rolled out. The curriculum has to be accredited and we are waiting for that to happen. So that once the curriculum is accredited, it can be rolled out in a more holistic manner. However, with respect to the actual curriculum, what we do is we provide information on general aspects of mental health that they should be aware of.

We provide specific training in the area of control and restraint, what we call "prevention and management of aggression and violence". That is a particular programme that we engaged in several years ago and continue to deliver to various stakeholders, including the police. And by doing so we teach them to de-escalate situations. So instead of taking a—well, I do not want to use the word "aggressive", but learning how to use tone and mannerisms and so on, in a way that gets the person's confidence and gets the person to more than likely comply in a safe manner, reducing the risk of harm to the patient. So that we provide both theoretical training as well as practical training.

That training is currently actually being rolled out to the municipal police. We were supposed to start training with them last week. We did it with the Port of Spain Corporation already and we were supposed to do some more last week but there was a logistic problem and we had to reschedule it, but that is ongoing with the municipal police.

Mr. Forde: Doing it through the municipalities, again, we would be doing it through all 14 municipalities?

Dr. Othello: Absolutely.

Mr. Forde: And THA also will be included—well, Tobago?

Dr. Othello: As long as they are willing to participate, we are more than willing to roll it out to Tobago as well.

11.20 a.m.

Mr. Forde: Madam Chair, could I go to a next question? Madam Chair.

Madam Chairman: Yes, please, member Forde.

Mr. Forde: Right. Again we are going back to the WHO age report 2018 to 2019, where it was indicated, and I

quote:

> Medications remain available in all classes for the entire population in the public mental health services.

Again, on page 9, and my question is, given that these findings pertain to the 2018/2019 report, how has the COVID-19 pandemic affected the availability of medication for persons within the mental health fraternity?

Madam Chairman: And if I could just jump in right there because I have a question on that as well. Could you just in your answer clarify whether the mental health drugs are available free of charge through the CDAP programme? So as you address all of that could you just put that in there, thanks.

Dr. Othello: Okay. Mental health drugs are available free of charge. Not all of them are on the CDAP list as you would know that, that is a very limited list with a few drugs for each type of illness. So there are some mental health drugs on that list. Even if a drug is not on CDAP, you can access it from the hospital pharmacy or the health centre pharmacy once it is prescribed for you by your psychiatrist or your doctor working in a psychiatric clinic across Trinidad and Tobago. And we have drugs for all the major classes, antidepressants, antipsychotics, mood stabilizers, antiepileptic's the whole range. Drugs to prevent side effects of other drugs we have them. Right? So we do have a wide range of drugs.

In terms of the impact of the pandemic I would have to defer to Ms. Lewis or Prof. Hutchinson who are on the delivery side of things, in terms of whether they have been having any difficulties that are specific to the pandemic.

Madam Chairman: Ms. Lewis or Prof. Hutchinson, who wants to take that one? Okay, Ms. Lewis.

Ms. Lewis: I do not know if Dr. Shafe is on. Perhaps he might be better suited as the medical director—

Dr. Shafe: Thank you, Chair, for the opportunity to answer that question. In terms of the supply of medication, the same effect of the pandemic in terms of supplies, so we had limited effect with supply of medication, but that has not impacted us severely on the delivery of services to patients. So we were able to maintain the supply of, the range of medication that are needed to treat with many of the conditions that we manage within the North West Regional Health Authority. And, so, I would not say that has impacted severely on us, providing medication for the patients.

Madam Chairman: Member Forde.

Mr. Forde: Yeah, okay, I am good, Madam Chair, I am good.

Madam Chairman: Okay. If I may just slip in a question here before anybody else comes in. My question has

to deal with success and the success factors. What do we count as success in mental health care?—we have the policy, we have the procedures and we have decentralization moving on. What is it that—what goals are we striving to meet in terms of the provision of mental health care to our citizens and are we meeting those goals?

Dr. Shafe: Madam Chair, if I may answer that question. So when we look at the success we also look at the reason why we are managing individuals with mental illness. So they present to us with symptoms or mental symptoms and as a result for the mental symptoms there is the impairment infunctioning. So in terms of when we then look at success or failures is that being able to provide some level recovery to the functioning of the patient. And when we are talking about functioning being able to either go back out to work; being able to go back out to school; being able to maintain relationships; being able to may be start back working, they have lost their jobs; in terms of attendance at work and reliability if they are employed in any area. Those are the kind of measures we look at in terms of success. And also for those who need rehabilitation, those are also the measures we look at if they go to the rehabilitative process, ability to function in the society is our goal.

Madam Chairman: And, with respect to how we are able to achieve that goal, would you say, Dr. Shafe, you are intimately involved, are we achieving that goal for the majority of the patients that were sent to the mental health institutions around the country? Are there particular concerns about, particular classes of persons that may present more challenges or are there any trends or patterns we are seeing now that we need to be aware of a citizen that present a particular challenge to the provision of mental health care in Trinidad and Tobago now?

Dr. Shafe: Okay, so, Madam Chair, the answer to that is that the range of mental disorders that are managed, they are very wide. And so what the impact or being able to achieve those goals would depend on the severity of your symptoms and the type of mental disorder that you suffer from. And the trend that we know, coming to us, those of us who practice on the ground, those that present disorders that are less severe like depression and anxiety, we were more able to get them to achieve those goals as compared to individuals who present with things like schizophrenia. And when I talk about schizophrenia, it also has different severities, you can have mild, moderate and very severe presentation in terms of symptoms.

So individuals with mild, moderate, severity of symptoms, schizophrenic and also physically engage and they can also improve and function within the society. This is the very, very, severe cases of schizophrenia that tend not to do too well based on our interaction with these patients.

Madam Chairman: So you would say then that based on the treatment being offered the decentralization that the Ministry has been implementing along the way and so on, you would say that the patients that come to be treated are able for the most part to gain normal function except for those who are severely challenged.

Dr. Shafe: Correct, Madam Chair. And so many of our patients ascribed—the one I categorized as with

depression and anxiety, even bipolar disorder are able to maintain their job once the other things are in place in terms of compliance with treatment, compliance with therapy, being psychotherapy or occupational therapy, they are able to maintain their job. And also social support is very, very, important, family support is very, very, important especially if we are talking about individuals being able to comply with treatment that is being provided more so in the outpatient clinics and the different clinics all over Trinidad.

Madam Chairman: I see Sen. Thompson-Ahye, please proceed.

Ms. Thompson-Ahye: Thank you, Madam Chair. Now I wish to find out, I do not know who could answer, if the Ministry is satisfied with the extent of its outreach programmes for public education and awareness of the nature of mental illness, the treatment for mental illness, so that the public can differentiate between what is mental illness, you know, to understand it is an illness that it is not a spirit lash or obeah. How do they recognize the signs and symptoms so that you could eliminate discrimination against children? Because I remember doing training with Dr. Shafe, we were doing a joint workshop and I was horrified to learn that a lot of the children we have in our institutions, sent there by the court, are children with mental illnesses.

So children are subjected, because people are not aware of the presenting symptoms, to bullying, to abuse and neglect. So parents might be beating children at home, you know, and saying this child cannot behave not being aware that this child has an illness. So how do we target, how do we roll out a programme? Is sufficient being done so that everybody is aware of what is happening with a particular child? Because people who should be—we expect to be more intelligent, even lawyers—I heard a lawyer speak in disparaging terms about a colleague who has a problem.

We have had lawyers committing suicides. So across the spectrum, even doctors, you know, so even in the professional institution is there a component or a module where you can educate different professionals, whether they are in teaching or different professions about how mental illness is presenting and also parenting programmes. Anybody.

Dr. Othello: Thank you for that question Senator and I would like to assure you and your colleagues that that the process of public education is an ongoing process. I do not think there will ever be a time where we would be satisfied that we do not need to do that anymore, that is something we would always need to be doing.

Ms. Lewis to talk a bit about the outreach unit at the St. Ann's Hospital which has been doing a lot of work. They actually have a drama club which unfortunately due to the pandemic has not been able to do some of the types of things that they did, but previously they would go out, for instance, on World Mental Health Day on Brian Lara Promenade and do skits and plays to highlight different mental health topics. So, you know, even the creative arts are utilized so that you can present the information in a way that people find it easy to receive.

At the level of the Ministry we do what we can, we do engage in some public education programmes. At the individual levelseveral doctors in their personal capacity engaged in a lot of that kind of activity, Association of Psychiatrists of Trinidad and Tobago has done quite a bit of that. Up to last night I did a presentation at a meeting to talk a bit about—and it was a topical issue to talk about, you know, mental health and the pandemic and its effect on mental health.

So public education is ongoing, it is important, it is a priority and it is something that will never cease to be priority no matter how much we have done we will always need to do more. So I turn over to Ms. Lewis to talk about the outreach unit at the North-West RHA.

Ms. Lewis: Yes, thank you. So we have developed over the past two years a mental health outreach team. We do various mental health promotional sensitization for various organizations and Ministries including: bpTT, Amplia, Airports Authority, the defence force we have worked with. So we have a pool of persons that would go through how to recognize signs and symptoms; how to recognize—how does stress present; coping mechanisms and how and where to access help.

I must say we have found that organizations and persons are reaching out more than they perhaps were doing five years ago for mental health support for their staff. We also do various presentations at churches, et cetera, but we do have a team and I invite you or the listening public, you know, our email address is mental.healthservices@nwrha.gov.tt and we will respond to any request for any mental health promotional activity. We have on our team two art therapists, a music therapist within our psychology department. So there are various professionals that can be engaged in how we present material.

Madam Chairman: Thank you so much and I am sure all of the Members of Parliament are noting this, [*Laughter*] because it is something that we also would like to present for our constituents. Sen. Thompson-Ahye is there anything else you would like to add at this time?

Ms. Thompson-Ahye: No, Ma'am.

Madam Chairman: All right. Let me jump in with a question here about the infrastructural needs of the mental health facilities and that was part of the submission through the Committee. And what I want to ask is, how severely are the infrastructural requirements that are yet to be completed, how severely are these affecting the ability of the different institutions to offer access to quality mental health care? Not sure who wants to take that one, PS with the overarching view, do you want to give us some insight into that?

Ms. Noel: We know that there are challenges with the infrastructure at some of our facilities. However, the Ministry and the RHAs do have ongoing works at all of the facilities that need infrastructural rehabilitation and I believe the different representatives from the RHAs can expand on the works that are being done at their institutions.

Madam Chairman: Feel free who wants to come in.

Ms. Lewis: Yeah, if I may it only seems right to start with St. Ann's Hospital—

Madam Chairman: Yes.

Ms. Lewis: You know the institution is over 100 years old. There are continuing works that are being done and the nature of the patients here as well means that works are continuously ongoing because you might fix something this morning and then you have to go back and fix it this evening. But we do have roof works ongoing, we do have repair work going on with regard to our forensic unit, we have ongoing works at the Arima Rehabilitation Centre—

Madam Chairman: But if you—sorry to interject, but what I am trying to focus on is, are the challenges that you are facing are they impacting your ability to have better care? Are they impacting your ability to, your capacity to deal with the patients that require being hospitalized? That is what I really want to focus on, not necessarily exactly what is happening, but how it is affecting your ability to deliver and your capacity as well.

Ms. Lewis: It is not affecting in a negative way. When we have repair works to be done to a ward, for example, we relocate and works are done. So there is usually a lot of internal movement going on, but we get it done internally. So it does not affect, for example, the number of beds available for admission.

Madam Chairman: So is any of this work meant to increase your capacity?

Ms. Lewis: No.

Madam Chairman: No.

Ms. Lewis: In keeping with the decentralization model, we want to reduce admission and increase discharge. St. Ann's Hospital currently has a bed capacity of 725 beds which are usually almost always filled. It is not to increase bed capacity at the psychiatric hospital.

Madam Chairman: Okay. If we can get a response from the others who are represented here.

Prof. Hutchinson: So good morning again. At the North Central Regional Health Authority the psychiatric services are located in the general hospital which is at the Eric Williams Medical Sciences Complex. So that infrastructural issues are related to those that pertain to the entire hospital. Because of that and because in some sense we are limited by the space that is available within the hospital, the psychiatric unit at the Arima Hospital was commissioned as part of the new Arima Hospital. But because of COVID and it being a COVID hospital we have not been able to utilize that space to expand the services that we could deliver to the population who live within the catchment of the NCRHA. So once that becomes possible that capacity will increase and we would better be able to serve particularly the environs of Arima, where we do have a large sector that requires

mental health support and treatment.

Madam Chairman: That is what could be the services are for, not just mental health but in terms of other health services. Anyone else wants to weigh in here from their different perspectives?

Dr. Vedula: Madam Chair, in the eastern region our mental health services are basically outpatient services being forwarded by the Secretary of the St. Ann's Hospital. The challenge is for the physical space. We have to share the same space where we have the regular health centre clinics going on and in the same area we need to have the mental health clinics on these specific days as well. And especially with the COVID-19 we have the guidelines to maintain the physical distance and certain guidelines to follow. So the physical space to accommodate these mental health clinics while the health centre clinical services are going on is a challenge in the eastern region.

Madam Chairman: Dr. Ramoutar I see you wanted to contribute as well.

Dr. Ramoutar: Yes, thanks, Madam Chair. So, yes, at Southwest RHA, at the outpatient facilities is the challenge of getting space and because of the Ministry's thrust to have more community based psychiatric services to deliver, we are recommending that we create what we call mental health, we call behavioral and wellness centres which would be basically centres operating five days a week that could provide adult psychiatric services as well as the pediatric and developmental clinics that we have to deliver to the outpatient.

So we are having a current infrastructural upgrade of the inpatient ward but the aim is, again, not to increase capacity. We are currently, as well, aiming to have the facilities at the new horizon and the Couva ECC brought up to standard so that in case there is an emergency at the San Fernando psychiatric facility we can have a decanting centre where we can hold some of our inpatients.

The ECCs have also are in need of infrastructural upgrade but we are within capacity there. The main challenge is really finding outpatient space because, you know, we have to serve a wide geography. So we need to go out and have clinics. And as the eastern region has rightly said, we compete for the primary care—at the primary care centres and the space, physical distancing, et cetera, that is required is in adequate.

Madam Chairman: Thank you very much. I see—I saw the hand of member Forde and then member John.

Mr. Forde: Right. Before I go to my question, my direct question, what I want to come in and, Madam Chair, just a little feedback on some of the comments made by the various are RHAs and so on, right. And with all of them we are hearing about the use for space, the logistics of space and so on, but what I did not hear coming out of it in the constituency of Tunapuna where we have two health centres, and I know specifically for the one on the Tacarigua Health Centre, on El Dorado Road, where they have designated different days for different services. I did not hear that coming out to say that on Monday is psychiatric, on Tuesday is pediatrics, on

Wednesday is children or whatever. I think they even have the designated days for where they gave out vaccines also at these different centres.

So, again, rather than to hear back from each one of them if probably whether through Dr. Othello or from the PS if it is that there are designated days for designated health services at these various outlets throughout Trinidad and Tobago? Thanks for a feedback.

Dr. Othello: I can answer that. And thanks for your question. The answer is that right now we have a bit of a mixed bag. Traditionally that is how mental health services were provided in health centres where on a given day the mental health team would come in, they would do the clinic and they would leave. Over the years we realized that that was not adequate and at the level of the North West they began the process of transitioning to a different type of service.

So within the North-West RHA they now have standalone community health and wellness centres where from Monday to Friday during normal working hours there is always a mental health presence. There are days when there are clinics, but there are days when there are other activities and they are able to use that space now to do health promotion activities, to have, you know, the various types of therapists in office on different days, so that different services can be provided. And that is what we are moving towards when we talk about the decentralization.

We are moving towards a scenario where that kind of service will be available at various locations across Trinidad and Tobago. So that you will not be limited to one day a week when a psychiatrist leaves a hospital somewhere and comes to your community. There will be a community mental health team that works in your community, that is comprised of: psychiatrist, psychologist, social workers, creative art therapists, occupational therapists, nurses, attendants, clerical and administrative staff, the entire team. So that over time we want to have five days a week, an eight to four type availability of mental health services across Trinidad and Tobago. And what we also want to add on top of that is an emergency response component.

In other words, a 24-hour a day ability to respond to crisis situations which would require on call arrangements and so on. So those things are being planned, they are not there yet, but they are being planned because we understand the need. If we are able to do all of that we will not need to increase capacity for inpatient services because we will be able to do a lot more on an outpatient basis and reduce the need for people to be admitted to hospital.

Mr. Forde: And again Dr. Othello hence the reason why I ask because that is information that is pertinent to our listening public today. Right, I would like to go, through you, Chairman, again to Dr. Ramoutar, and it is a question with regard to the five behavioural health and wellness centres at the SWRHA. These five locations are presently available? I would like to know if it is that they presently and if we can identity where they are

located or if it is something to come, something in the future that is to come forward?

Dr. Ramoutar: No, that is our recommendation for the future. We have—currently we do have outpatient clinics functioning at several of the health centres: Princes Town, Siparia, Couva, Barrackpore, Gasparillo, Point Fortin, Cedros and all of these centres they have their days when people, when the psychiatrist will go and conduct those clinics. But similar to what Dr. Othello was saying, that just going out and having a clinic on one day is not sufficient to meet the needs and that if we establish these centres we can have a bigger presence in the community and deal with the patients in the community and hence obviate the need for having a bigger inpatient facility.

Mr. Forde: Right, thank you, thanks, thanks, Madam Chair.

Madam Chairman: Thank you member Forde, we now have member John.

Ms. John: Thank you, hon. Chairman. I just want to make the point and I think Dr. Othello kind of alluded to it with respect to the vision of a community health team. And the point I want to make is that there is a fierce urgency of now, Madam Chairman, because particularly with the pandemic this has elevated the need, I think Ms. Lewis said that they are getting more—more folks are calling in, requesting service. But you know in Trinidad and Tobago there is a kind of stigma attached to you, for people are saying that they are overwhelmed and stressed. And basically we have to find a way to destigmatize this, the need for support for mental health because everybody macho. But you are seeing children who were very vibrant now they have become very quiet and similarly women or even men who have lost their work or women who are facing the supermarket. You know we have real problems now coming out of this pandemic.

So, you know, I think our team probably has to be more active in articulating what is available and not only have these discussions within closed doors and a little team here and a little team there on demand. But to bring it out in the open, the same way in response to the question previously posed, where the response was—this community mental health team where within the community they will set up all of these various professionals. I think it will become normal, it will become normal within the various communities to have access to the services and to go and say I am not feeling so well and it is in my head.

11.50 a.m.

I think it will become normal, it will become normal within the various communities to have access to these services and to go and say I am not feeling so well and it is in my head.

Madam Chairman: Well said, well said, member John. That issue of the stigma and the public education, I think our—I see Dr. Othello nodding because it is a serious matter, I think maybe cultural. I think we are coming away from it slowly, slowly but I do not—there is always, as Dr. Othello would have said, a role for more

exposure, more education to ensure that people utilize the services that are available and that would help them. Right. We have Sen. Thompson-Ahye.

Mrs. Thompson-Ahye: Thank you, Madam Chair. I must say that I think Dr. Othello came here this morning, armed and well prepared and I must compliment her for how she has handled this enquiry. Because before she spoke, my next question was to ask her about an emergency response team to deescalate explosive situations and it seems that that is coming on stream so I thank her for that because there have been too many instances of police coming on the scene to, you know, supposedly to deescalate a situation and it has ended up with people being killed because, of course, the police do not know to shoot at hands and feet but too many fatal injuries. So I would just like to thank her for enlightening us about that.

And I would want to take this opportunity, even though it may not be appropriate, to thank this lady who writes in the newspaper Dr. Ravello because she has certainly opened up the question of mental illness and people's understanding of it. So that I hope that what would happen is that this team will be able to function very quickly and effectively and efficiently to assist because there are many instances where you need that help. I remember way back when an excellent Common Entrance teacher in a prestigious boys' school in Port of Spain, he used to trip off and once there was a situation where he was attempting to throw a boy through the second floor window and I mean this is an excellent teacher otherwise but there have been cases where, you know, things did not go too right and there are other cases where you things, you know, you need to help people or provide the required assistance for persons with mental illness. So it seems that we are getting somewhere.

I go back to the earlier enquiry where she spoke about the police and the work that is being done in training the police and I hope that she took up my suggestion that in every station, you have someone who will be equipped to deal with a situation such as occurs involving a member of the public who is putting other members of the family at risk or members of the community because really and truly, we are about saving and building a society where people feel safe, agencies as well including the mental illness personnel. So thank you for the work that you do. To assist persons in the community to recover from their problems and also to keep the other people safe. Thank you.

Madam Chairman: Thank you so much, Sen. Thompson-Ahye. Before Minister Morris-Julian comes in, I just want to ask a question regarding the Mental Health Act and the amendments to that Act. And I want to ask what would be the impact of the amendments that are suggested and in light of the fact that those amendments have not been enacted just yet, is it the view of the Ministry of Health that this is in anyway impacting the human rights of persons with mental health challenges and when do we expect to see that Act brought before the Parliament with the amendments that are required.

Dr. Othello: Okay, with regard to the amendments that need to be made to the Act, I do not believe they are in

any significant way contributing to people's rights being violated but they provide mechanisms that would assist us to do things better and have a legal basis for doing those things better. In other words, we already recognize patients' rights, we already talk to them, for instance, about informed consent and things like that, but what we are doing is through legislation making it mandatory. So that it makes it easier from the point of view of training and mentoring junior staff to say, look, this is a legal standard that you have to adhere to as opposed to it just being a principle. So that we are working towards that. We, unfortunately, do not have a delivery date available for you at this point in time because of the steps that have to be followed that have not yet, all of them, been done. But it is very, very high on our priority list because we understand the importance of it.

There are some issues, for instance, the issue of persons who do not, after discharge from hospital, willingly comply with outpatient care and by so doing, are prone to relapse and when unwell can became violent. Those kinds of situations are being looked at in the amendments to the Act so that we can have a legal provision that puts in place a process for supervision of those persons when they are outside of hospital so that they begin to understand their responsibility in regard to taking care of themselves and the impact of that failure to live up to that responsibility on others and they are aware that there are guardrails, in other words, do what is required of you, these are the possible consequences. So that we are very, very mindful of the urgency and we are working to get it move forward as quickly as possible.

Madam Chairman: Thank you. Member Morris-Julian.

Mrs. Morris-Julian: Thank you very much, Madam Chair. Madam Chair, through you to Dr. Othello, I have a question from public which actually is close to home. I had a mentally-ill relative who came off his medication and literally walked into a truck where he died and the question from the public is: What is the prevalence of outpatients coming off their medication before the prescribed time and relapsing? And I also have a follow-up.

Dr. Othello: [*Technical difficulties*] understand that you are ill and appreciate your need for treatment and although we do a lot of work as mental health care providers to help to build that insight, it can sometimes be quite difficult. So that unfortunately, it is quite frequent that patients with those types of disorders may come off their medication. There are, however, available tools for treating with that, for instance, for persons who are known to not be willing to take oral medication tablets, we now have medication available in an injectable form that can last as long as a month in their blood stream so that once they get that monthly injection, they are more than likely to remain well and to not be at risk of that kind of outcome.

With regard to availability of medication, sometimes an individual drug may not be available but more often than not, there are other drugs in that class of drugs that can be relied on to care for that person. So that usually when a particular drug is not in the system, practitioners tend to switch the person to something else. So I cannot speak to what happened in that specific situation but usually the person would be switched to

another drug that can benefit them during that particular period until the one that they prefer or that is preferred for them is back within the system.

So we continue to work towards ensuring that the supply chain is intact so that patients receive their medication regularly and in a timely manner because we understand the impact of deliberate refusal to comply or to continue with medication but we also understand that that refusal is often a part of the illness in itself so that we do not judge those persons, we do our best to take care of them.

Mrs. Morris-Julian: Thank you very much, Dr. Othello. But, of course, you will note my concerns because it is really sad when something as simple as a pill could help and the lack of access or the inability to understand the importance of taking the pill, it is quite traumatic. Thank you very much.

Madam Chairman: I see hands from member Forde, member Thompson-Ahye and we are going to try to wrap up in a little bit. I am going to take ladies first so I am going to take Sen. Thompson-Ahye and then member Forde and then I would come in with one last question. And of course, member Forde is a pure gentleman so he will give way and then—

Mr. Forde: Just keeping in mind that Sen. Thompson-Ahye "doh" not take up the whole period. [*Laughter*]

Madam Chairman: [*Laughter*] Certainly not, certainly not. And then we will wrap up with a question from me and I think that would be the end of our session today, so Sen. Thompson-Ahye.

Mrs. Thompson-Ahye: My question is very short and Dr. Othello, tell me, and any of the doctors there, tell me: Is there a problem of confidentiality in your profession that hampers people from getting help? Frankly speaking.

Dr. Othello: I can say that the Ministry of Health has a policy with respect to confidentiality of documents and of patient information and that policy is widely known among members of staff. So that while we cannot speak to outlying situations, as a general rule, confidentiality, the importance of it is known and people are encouraged to adhere to that policy. No patient information should be released to the public without the proper process. If a patient themselves wants a medical report stating their patient information, they have to go through a process of requesting it in writing and signing written informed consent so that that information can be disclosed. If a patient wants a copy of their medical records, they go through the same process. If someone else wants a copy of a patient's records, that is not allowed except in certain situations such as when the court asked for records as part of a legal proceeding. So we do not in any trivial way disclose patient information and we really want the public to understand that because we do not want fear of a breach of confidentiality to be a barrier to care.

Mrs. Thompson-Ahye: Do you have complaints?

Dr. Othello: I am not currently in the service delivery arm so I cannot say that I have recently heard of complaints so I would have to defer that to persons who are functioning on the ground at this point in time in terms of whether or not there have been recent incidents of such breaches.

Madam Chairman: I see Dr. Shafe wants to come in.

Dr. Shafe: Thank you, Madam Chair. In terms of patient data, in the past, there may have been issues with individual's information being passed to family members without their knowledge. What has happened in the past three years or thereabout with North West Regional Health Authority, for you to get any information about any patient currently, you have to go through the Legal Department of NWRHA. So we put in that requirement so that the Legal Department would then do the screening process and determine who you are, who is trying to obtain information about any particular patient from North West Regional Health Authority relating to their data and diagnosis and treatment. So that is the current approach in North West.

Mrs. Thompson-Ahye: Thank you.

Madam Chairman: Thank you so very much. Let us now have member Forde.

Mr. Forde: Yes, thank you, Madam Chair and thank you very much, Sen. Thompson-Ahye. The Children's Evaluation and Treatment Unit, CETU, which is based at the St. Ann's hospital, is it in operation, Madam PS to one of your colleagues there?

Ms. Noel: Thank you, member. Dr. Shafe should be able to respond to that question.

Dr. Shafe: Yes, Madam Chair, the CETU is operational. We have four beds for males and four beds for females and the purpose of establishing the unit in 2019 or so was to facilitate the Judiciary in terms of assessment and providing our reports on time for children that need assessment and report. So that the court can then make determination as to what to do going forward.

Mr. Forde: Any collaboration?

Dr. Shafe: Yes, we do. We do collaborate with the Children's Authority, we collaborate with the courts as well, the Children's Court, the Family Court, we collaborate with different agencies.

Mr. Forde: All right. And in terms of mechanism to ensure no abuse of the children, you know, they are well taken care of because remember they are minors, you know. So all those things and systems and parameters I believe are in place?

Dr. Shafe: Okay. We have different policies that govern most of the engagement that patients have with staff in the St. Ann's hospital, be it treatment, be it if we think that the patient is suicidal, if we think that maybe there are issues with family members. So those policies, let us say for instance, the suicide policy requires that

a child that is suicidal therefore would get a one-to-one nurse. So within the unit, you have eight beds, so there are instances where we actually have more staff than patients just to ensure that we give them the optimum care and protection. And I know in the past, we talk about restraints and physical—we do not do physical restraints on the ward because of the intensity of the support and service that we provide in CETU division.

Mr. Forde: Sorry. Last question, Madam Chair, on the same topic. Out of these eight beds, I know at varied times it may vary but is it that some are orphans or they still have parents, you know? How is the ratio in terms of the probability of and going forward? Is it that they have parents or they are orphans? Just give us a little synopsis.

Dr. Shafe: Okay, let me just come back a little bit again. I know the purpose was for assessment and evaluation but we are also limited in terms of we cannot admit children to adult wards so there are incidents where family members would come with their children who have mental health problems and we admit them to CETU without coming through the courts. But most of the patients come through the courts, they come through the Judiciary, most of the patients that we see and most of them are also via the Children's Authority who approach the Judiciary and then they are sent to the CETU.

Mr. Forde: Thank you. Thank you very much.

Madam Chairman: Thank you so much. And the last question comes from me and I just want to quickly know if someone is dissatisfied with the level of care that their family member is receiving or even the patient themselves, what are the options for making complaints and getting redress? This is an important part of your rights being able to say, you know, I am not satisfied and getting some manner of redress. What are the provisions in place for that?

Dr. Othello: I will ask perhaps Ms. Lewis to talk about the role of the Quality Department.

Ms. Lewis: Yes, so the Quality Department would normally do service user feedback but at all our outpatient units, our assessment department and admission wards, we also have suggestion boxes, so that they would routinely look at the feedback from the suggestion boxes, but family members, patients are more than welcome to talk to any of the quality officers who are based at the hospital and they do that.

Madam Chairman: What is the process by which—just for the education of those who may be looking—what is the process by which you can actually get in touch with the Quality Division or Department?

Ms. Lewis: You just contact the hospital, you call the hospital at 624-1151 and you ask for the Quality Department.

Madam Chairman: All right. I do not see any other hands and I think we have exercised the officials from the—Dr. Shafe, you want to say something, sorry?

Dr. Shafe: Yes, Madam Chair, just to let you know there are also patients and relatives who call directly the office of the Medical Director to complain and we do address their issues. Also the office of the General Manager of Mental Health Services to complain and we do address their issues. Sometimes even some of these complaints come from the Ministry of Health and we take each one case by case.

Ms. Cox: Madam Chair, if I may.

Madam Chairman: Sorry. Thank you very much, Dr. Shafe for that. And Minister Cox, you wanted to raise something?

Ms. Cox: Yes. Thank you, Madam Chair. Just wanted to find out because normally when there is a situation that you can have a form of redress, most of the times, this is not advertised. So sometimes persons may be calling all around trying to figure out where should I go and I think that that is one area that needs to be addressed where persons would know that okay, you have a form of redress, if there is a situation that you do not agree with, where you can go. Has this been happening?

Madam Chairman: I think Minister Cox is speaking to the measures that we just spoke to that are in place. Is it generally known by the public and can they really follow a set procedure to lodge their complaint?

Ms. Cox: Yes, Madam Chair. Do you advertise this information? Is that information put out to the public that they know that they can come to you if they have issues?

Ms. Lewis: Patients who are—

Dr. Ramoutar: Madam Chair, I can speak for the South West RHA that yes, we do advertise it and we also have the numbers to contact for mental health support as well as to complaints to the quality authority on our web page at the South West and it is advertised, yes.

Madam Chairman: Okay. Ms. Lewis.

Ms. Lewis: It is the same for the North West. Lots of people also use the mechanism for our social media pages but it is advertised on our website and once you are admitted to the hospital, you are informed of, you know, the procedure as well as the outpatient clinics.

Dr. Vedula: Madam Chair?

Madam Chairman: Yes, please.

Dr. Vedula: In the Eastern region, similar the other units, we have the Quality Department and the numbers are also advertised but in addition to that, in all of clinics, most of the clinics, we have customer service representatives who command the Quality Department. They are placed in most of the clinics and they will make their presence known by addressing the clients before the start of the clinic, who they are, what is their

purpose, what they do and the clients, if they have any concerns, they can approach them, they are easily available and we also have the client feedback forms that are readily available in all the health centres. So once the customer service representatives realize that there is a concern, they will give the form to the client and they can make a complaint anonymously and put it in the box and our Quality Department will go through all these complaints and they address the issues and they have a specific time period within which they have to get back in contact with the person who made the complaint. So there are systems in place.

Madam Chairman: So, at this time, I would really like to thank the members of the Committee as well as our officials from the Ministry of Health who have given us a lot of information and I am going to do just a quick summary after, but before I do that, I would like to invite the Deputy Permanent Secretary from the Ministry of Health to make brief closing remarks.

Ms. Noel: Thank you very much, Madam Chair and I would also like to thank the members of the Committee and my colleagues and from the RHAs. We appreciate this forum for the discussion that has taken place for your questions and feedback and rest assured that our team at the Ministry of Health will review any recommendations that were made by the Committee towards promoting greater treatment and care for mental health care services. Thank you very much.

Madam Chairman: Thank you very much, very much and I would like to just summarize what we have discussed. It is quite a bit so I am going to go as quickly as I can.

The National Mental Health Policy 2019—2029 did take into consideration the international and regional mental health care policies and procedures and guidance from PAHO is sought on these matters. Where we have internal audits, they are done by the RHAs' Quality Departments, however, no external audits are done at this time even though there is international best practice that shows that it can be done and it would be a good thing for our Ministry of Health to engage in an external audit of our mental health care procedures and policies.

Feedback from relatives and caregivers as well as the patients can be obtained and it is routinely obtained by the institutions and some of these concerns include prescription renewal, et cetera, and this can be formalized. Persons who are dissatisfied with the level of care or have concerns can use the suggestion boxes that are provided at the institutions or client feedback forms or they can get in touch with the Quality Departments. The medical directors and general managers have also received complaints and they do pass them along to be addressed.

The WHO has identified the lack of a national mental health report as a shortcoming. This is being worked on and addressed to the creation of a national mental health information system which would allow the Ministry to collect and analyze data. We do not have a completion date for that project but the Ministry is

progressing and has this as one of their priorities.

The majority of the mental health patients are outpatients and inpatient care is reserved where there is a critical need for—where there are severe symptoms or medical compliance is really critical. Where care is provided for children and adults across all of the RHAs, parents are also involved where there are children being treated and they are part of the treatment process. And the geography where patients are treated really depends on where they present themselves because the Ministry is embarking on a decentralization drive—has embarked and is continuing to provide these services into all the rural areas to increase the access to mental health care.

In terms of our clinical procedures of dealing with mental health care challenges, we have our doctors that have postgrad degrees in psychiatry and they are supplied to our institutions and so they, through continuous professional development, ensure that they are up to date on the treatment that is given to our citizens. In pre-COVID times, there were annual conferences that would have assisted in ensuring that we are up to date in terms of the care we provide to our citizens.

Concerns have been raised about the availability of mental health services and again, the emphasis is on decentralization and where there are not established clinics or health centres, there are the outpatient, or outreach clinics, I should say, that are operating. All right.

In terms of the heads of the Ministry of Health being trained, specifically trained with respect to the international instruments and conventions, there is no specific training, however, these are constantly referred to when policies and procedures are put in place to ensure that we are referencing these instruments and we are in line with what we are supposed to be signatories to.

The Ministry of Health has guidelines for the provision of mental health care for approved homes. That is now in transition, it is being finalized and perfected for legislation to be enacted and that is a critical part of allowing the regulatory role of the Ministry of Health to be fully enforced where it speaks to the provision of health care in the private homes especially.

12.20 p.m.

At this point, however, the Ministry of Health does provide informal guidance at these institutions, both private and public, to allow for proper management and procedures of the persons with mental health challenges. There is a need for training with the defence force, the police service on de-escalating situations involving mental health patients and that is imminent. There has been some training and that should be on-going with our defence force. There is a view that this type of skill should be resident in every police station to avoid situations where mentally challenged persons have been dealt with and there have been maybe—sometimes death is the result of it. So that is important to increase the effectiveness of our defence force in

dealing with persons with mental health challenges in the communities.

In terms of drugs for mental health care, these are available free of charge, whether it is CDAP or through the hospital or health centre pharmacies, and whereas COVID-19 did not affect significantly the supply, they are available for patients. Our success in mental health care speaks to the level of recovery for the patient, and that is how the mental health institutions mark their success whether they are able to take the clients and allow them to resume their normal functions and that is the emphasis, and the Ministry of Health has noted success in terms of the treatment of a majority of patients that come to the clinics especially where you have the outpatient clinics.

The Ministry of Health has an important role to play in public education with respect to mental health and mental illness, and this is very important especially in the cases of parents dealing with young children who may not understand what they are dealing with in terms of the behaviours of their children. Though there is on-going education and exposure that is never enough, and the Ministry of Health has engaged different ways of treating with this involving drama, creative arts, trying to involve the young people in this, and they continue this because it is important in this time with the pandemic to remove the stigma that is attached to mental health care and to expose the availability of care for all of our citizens so that there is a need in another way to normalize mental health care in our society.

Institutions that are also in mental health care, these require infrastructural upgrades, that is acknowledged, however, the upgrades are meant to deal more with the quality of services and the breadth of services required instead of capacity because the Ministry is really focusing on decentralizing these services. So where these infrastructural works are on-going they are dealing with really the effectiveness of the care and not so much the capacity and these works continue. What has been noted, however, is that the COVID-19 protocols may have affected in some way the ability to provide care because with the social distancing, et cetera, it is really a competition for space in some cases. So that is one of the challenges that the Ministry of Health has to deal with.

In terms of the amendments we made to Mental Health Act, these are necessary for increasing the efficiency of services, however, the Act as it stands, is now addressing all mental health rights of persons with mental health challenges. And so, though a delivery date for that legislation is not given, the Ministry has this as one of its greatest priorities. In cases where patients come off their medication, that is a challenge for the Ministry of Health, and some litigation has been seen by using the injections which gives a longer period of protection or of effect, but that is something that the Ministry has had to deal with, and what is important in these cases is the social support. Another issue that comes up is the availability of the drugs because some patients may not be necessarily voluntarily coming off the medication, but where the drugs are not available that presents a challenge. So it is noted and a concern that the Ministry continue to use drugs that are readily

available so that patients would not have to be without medication which may lead to disastrous effects.

In terms of confidentially, the Ministry has a strict policy which is well publicized to all staff members, and the Ministry does encourage adherence to that policy because it is important to build confidence in the treatment and we know that if persons believe that their personal information is out there it will be a barrier to seeking care. In the past three years in some cases, the legal department has been involved in ensuring that persons requesting information on patients are actually valid family members and are authorized to do so. So all of that describes that what we have discussed today as we are focusing on the human rights of persons with mental health challenges, our ability as a country to offer them quality mental health care and the possibility of any discrimination meted out to these persons.

So I want to thank our officials who really contributed with frankness and with a breadth of the completion especially Dr. Othello. I think we called upon you a lot today, Dr. Othello. Thank you very much, and to all other members who would have contributed to us as having such a rich and productive discussion. Thank you to members of our listening and viewing public who would have submitted their questions, and thank you so much to the Secretariat of the Parliament who ensures that we have all things in place for these most important hearings to take place. I want to wish everyone a wonderful rest of the day, and above all I advocate to everyone please do stay safe. Thank you very much.

Members: Thank you.

Officials: Thank you.

12.26 p.m.: *Meeting adjourned*.

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