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Role of Intersectoral Collaboration in Mental Health Policy Formulation

And

Service Delivery in Saint Lucia

By

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## **ABSTRACT**

Saint Lucia a small island developing country with limited resources, is faced with a number of socio-economic challenges which require creative and innovative solutions to address. Combining resources across sectors to address the social, economic and environmental determinants of health has proven to be a useful strategy for improving population health in particular mental health.

This study, the first of its kind for Saint Lucia sought to examine the extent to which the availability of a national mental health policy led to intersectoral action for mental health promotion and service delivery. In addition the study examined the level of intersectoral collaboration which actually exist between agencies which provide direct care and support services to people with mental illnesses and significant mental health problems. The study also aimed to identify the factors which promote or hinder intersectoral collaboration and generate recommendations which can be applied to extremely small countries with similar socio-economic profiles.

Data generated from three (3) sources was synthesized to form a broad picture of the issues. An evaluation of the mental health policy of 2007, an assessment of the extent to which intersectoral action currently exist in mental health service delivery and the administration of semi-structured interviews with program managers from different agencies across sectors to identify implementation issues.

The study concluded that despite the availability of a mental health policy which clearly and explicitly articulates intersectoral collaboration as a priority area for action, very little exists in the current service delivery system. Services providers across sectors acknowledge the benefits of intersectoral collaboration and that there are significant barriers to intersectoral collaboration, which in turn hinders a national approach to service planning and delivery. Intersectoral collaboration is not possible if sectors themselves are dependent on a top-down health sector driven and dominated approach, or if the general atmosphere is clouded by stigmatization of mental health illnesses.

## **Key Words**

Mental Health Service Delivery System, Mental Health Policy, Policy Formulation, Policy Analysis, Intersectoral Collaboration, Social Determinants of Health

## RESUMO

Santa Lúcia pequena ilha de país em desenvolvimento com recursos limitados e é confrontada com uma série de desafios socioeconômicos que exigem soluções criativas e inovadoras. É comprovado que a combinação de recursos entre setores para estabelecer os determinantes social, econômico e ambiental da saúde são uma estratégia útil para melhorar a saúde da população, principalmente a sua saúde mental.

Este estudo, o primeiro do seu tipo em Santa Lúcia, procurou examinar até que ponto a disponibilidade de uma política nacional de saúde mental levou a ação intersetorial para o fornecimento de serviços e promoção da saúde mental. Além disso, o estudo examinou o nível de colaboração intersetorial que existe entre as agências que prestam cuidados diretos e serviços de suporte para pessoas com doenças mentais e problemas sérios de saúde mental. O estudo também teve como objetivo identificar os fatores que promovem ou dificultam a colaboração intersectorial e gerar recomendações que possam ser aplicadas para países muito pequenos e com perfis socioeconômicos semelhantes.

Os dados gerados a partir de três (3) fontes foram sintetizados para formar uma visão ampla das questões. Uma avaliação da política de saúde mental de 2007, uma avaliação que identifica até que ponto a ação intersetorial atualmente deixa a prestação de serviços de saúde mental e a administração de entrevistas semiestruturadas nas mãos de gestores do programa de diferentes agências em todos os setores.

O estudo concluiu que, apesar da disponibilidade de uma política de saúde mental, que articula clara e explicitamente a colaboração intersetorial como área prioritária para ação, quase não existe no sistema de fornecimento atual do serviço. Os provedores de serviços em todos os setores reconhecem que há os benefícios da colaboração intersectorial e com entraves significativos em relação à colaboração intersetorial, que por sua vez, impede uma abordagem nacional para o planejamento e o fornecimento do serviço. A colaboração intersetorial não será possível se os próprios setores dependerem da abordagem direta do setor da saúde ou se a atmosfera geral for ofuscada pela estigmatização das doenças mentais.

## Palavras-chave

Sistema de fornecimento de serviço de saúde mental, política de saúde mental, formulação de políticas, análise política, colaboração intersetorial, determinantes sociais da saúde

## **RESEÑA**

Santa Lucía, un pequeño país insular en desarrollo y con limitados recursos, se enfrenta a una cantidad de desafíos socio-económicos que requieren un abordaje con soluciones creativas e innovadoras. La combinación de recursos entre sectores a fin de abordar los factores determinantes a nivel social, económico y ambiental en relación con las condiciones de la salud prueban ser una estrategia útil para mejorar la salud de la población, en particular la salud mental.

Este estudio, el primero en su tipo en Santa Lucía, buscó examinar la medida en la que la disponibilidad de una política de salud mental a nivel nacional llevó a la acción intersectorial en relación con la promoción de la salud mental y la prestación de servicios (al respecto). Asimismo, el estudio examinó el nivel de colaboración intersectorial que existe realmente entre las agencias que proporcionan los cuidados directos y los servicios de soporte a las personas con enfermedades mentales y con significativos problemas de salud mental. El estudio también apuntó a identificar los factores que promueven o dificultan la colaboración intersectorial y genera recomendaciones que pueden ser aplicadas en países extremadamente pequeños con perfiles socio-económicos similares.

La información generada a partir de las tres (3) fuentes se sintetizó para crear un panorama general de las cuestiones involucradas: una evaluación de la política de salud mental del año 2007, una evaluación de la magnitud de la acción intersectorial existente en la actualidad en la entrega de servicios de salud mental y la administración de entrevistas semi-estructuradas con los gestores de programas de las diferentes agencias en los diferentes sectores.

El estudio concluyó que a pesar de la disponibilidad de una política de salud mental que clara y explícitamente articula la colaboración intersectorial como un área prioritaria para la acción, muy poco se ve reflejado en el actual sistema de entrega del servicio. Los proveedores de servicios de los diferentes sectores reconocen los beneficios de la colaboración intersectorial así como que existen importantes

barreras para la colaboración intersectorial, lo que a su vez dificulta un enfoque a nivel nacional para la planificación y entrega del servicio. La colaboración intersectorial no es posible si los propios sectores son dependientes de un enfoque impulsado y dominado por un sector de salud centralizado descendente o si la atmósfera general está ensombrecida por la estigmatización de las enfermedades mentales.

## **Palabras Claves**

Sistema de entrega de servicios de salud mental, Política de salud mental, Formulación de la política, Análisis de la política, Colaboración intersectorial, Determinantes sociales de la salud

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# 1 INTRODUCTION

## 1.1 Mental Health Global Perspective

Within recent times mental health issues are being recognized as important issues on the global development agenda (Prince, Patel, Saxena, & al, 2007). There is growing recognition within the international community that mental health is an essential development issue in achieving the Millennium Development Goals (MDGs). Mental health represents a critical indicator of human development, serves as a key determinant of well-being, quality of life, and hope, has an impact on a range of development outcomes, and is a basis for social stability (Miranda & Patel, 2005), (World Health Organization, 2010).

The definition of mental health as “.....*a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community*” (WHO & World Health Organization, 2000) points to the central role that mental health play in an individual’s general wellbeing, social and intellectual functioning and by extension the wellbeing and productivity of their community and nation.

On the other hand poor mental health is both a cause and a consequence of poverty, compromised education, gender inequality, ill-health, violence and other social and economic challenges (Desjarlais & Kleinman, 1997). The Declaration of the Alma-Ata, the Ottawa Charter for Health Promotion and the Jakarta Declaration all subscribe to an intersectoral approach to public health (and by extension mental health). This approach is based on the premise that good health (physical and mental) is fundamental for a strong economy and vibrant society. Further

the relationship between mental health and social and economic factors calls for action from a number of sectors (education, criminal justice, labour etc.). In addition in most instances the health sector does not have the mandate or capacity to make the required policy, systems and environmental actions, which fall within the mandate of other agencies (Herrman, Saxena, , & Moodie, 2005).

## 1.2 Country Context

Saint Lucia an independent island state is situated in the region of the Americas in the eastern Caribbean. The country has an area of 616 sq. kilometres or 238 sq. miles. The country’s official language is English, however a French-based creole language is spoken by the majority of the population.



Figure 1: Map of Saint Lucia and the Caribbean (Source: www.worldatlas.com)

The capital city of Castries is the centre of government and commerce. The country follows a parliamentary democracy system of Government headed by the Prime Minister. The Governor

General, whilst the head of state and the Queen's representative (as a commonwealth country), plays mainly a ceremonial function.

Whilst the country is divided into 11 parishes or administrative districts the system of government is centralized and the work of government is carried out through fifteen (15) Ministries:

1. Ministry of Agriculture, Food Production, Fisheries, Co-operatives and Rural Development
2. Ministry of Commerce, Business Development, Investment and Consumer Affairs
3. Ministry of Education, Human Resource Development and Labor
4. Ministry of External Affairs, International Trade and Civil Aviation
5. Ministry of Finance and Economic Affairs
6. Ministry of Health, Wellness, Human Services and Gender Relations
7. Ministry of Home Affairs and National Security
8. Ministry of Infrastructure, Port Services and Transport
9. Ministry of Legal Affairs
10. Ministry of Physical Development, Housing and Urban Renewal
11. Ministry of Public Service, Information and Broadcasting
12. Ministry of Social Transformation, Local Government and Community Empowerment
13. Ministry of Sustainable Development, Energy, Science and Technology
14. Ministry of Tourism, Heritage and Creative Industries
15. Ministry of Youth Development and Sports.

Over the last twenty (20) years the country has transitioned from an agricultural-based mono-crop economy dependent on the production and export of bananas to a more service-oriented economy dependent on tourism. The total contribution of Travel & Tourism to Saint Lucia's GDP in 2013 was XCD<sup>1</sup>1, 404.2mn (US\$520.07mn) or 38.8% of GDP. The country is considered an upper middle income country, however despite its upper middle income status, the country's economic achievements are fragile and vulnerable to external shocks and good social indicators exist alongside high and increasing levels of poverty (Blank, 2008). The Human Development Report of 2015 indicates that the country has a human development index of 0.729 with a global ranking of 89 (United Nations Development Program, 2015).

### 1.2.1 Demographics

The table below provides details on the main demographic characteristics of the country.

<b>Population</b>	<b>Statistics -2012</b>
<b>Population total- Est. Mid-yr</b>	<b>169,115</b>
<b>Population under age 18</b>	<b>46,470</b>
<b>Population under age 5</b>	<b>11,233</b>
<b>Under-5 mortality rate (Deaths per 1000 Live-Births)</b>	<b>24.3</b>
<b>Infant mortality rate ( Deaths per 1000 Live-Births)</b>	<b>16.2</b>
<b>Life expectancy at birth</b>	<b>78 –Women -72-Men</b>
<b>Total fertility rate</b>	<b>1.5</b>
<b>Urbanized population</b>	<b>n.a</b>
<b>Population growth rate (%)</b>	<b>1.05</b>
<b>Urban population growth rate</b>	<b>n.a</b>

*Table 1: Saint Lucia Vital Statistics (Source: Central Statistical Office)*

<sup>1</sup> XCD – Eastern Caribbean Dollar (1US = 2.7XCD)

### 1.2.2 Health Care

The health systems profile for Saint Lucia for 2008 indicates that “The country is in a stage of epidemiological transition, characterized by a decline in infectious diseases and an increase in chronic non-communicable diseases; and declining malnutrition. Notably, the prevalence of overweight and obesity among adults has increased. Epidemiological and demographic concerns include: increased incidence and prevalence of chronic non-communicable diseases; relatively high rate of teenage pregnancies and sexually transmitted infections in adolescents; increasing incidence and prevalence of HIV infection; increase in the ‘proportion of the population aged 45 and older; increasing infant mortality and relatively high perinatal mortality; increasing levels of trauma; and high burden of mental illness and substance abuse” (Pan American Health Organization, 2010).

Services are delivered through a network of facilities which include:

<b>LEVEL</b>	<b>SERCIVES, FACILITY AND LOCATION</b>	<b>NO.</b>
Tertiary	Mental Health and Substance Abuse located in capital city Castries	1
Secondary	General care and support services <ul style="list-style-type: none"> <li>- Victoria Hospital (Castries)</li> <li>- St. Jude Hospital (Southern town of Vieux Fort)</li> <li>- Tapion Hospital (Private hospital located in the city of Castries)</li> </ul>	3
Primary	Poly clinics (Gros Islet, Soufriere, Dennery) Wellness Centres (Castries)	22

Table 2: Saint Lucia Health Care Facilities

### **1.2.3 Management and Functions of the Health Care System**

The Ministry of Health under the stewardship of the Minister of Health is the principal provider and financier of public health services. The Ministry is the national lead on health policy development and implementation which are either enshrined as legislation or as policies. The regulatory role of the Ministry of Health is carried out through such bodies as the Public Health Board, the General Nursing Council, the Medical Council, the Medical Board, the Pharmacy Council and the Allied Health Council.

The Chief Accounting Officer of the Ministry of Health, is the Permanent Secretary who has oversight over the operations and programs of the overall health care system. Service delivery at all levels is the direct responsibility of the Chief Medical Officer. Program development and health planning is undertaken through the Corporate Planning Unit. The Ministry also has the primary responsibility for the management and dissemination of health related information.

### **1.2.4 Health Care Financing**

Saint Lucia's health care is funded from four principal sources: the Consolidated Fund (Government budget), donor contributions, out-of-pocket payments and private insurance schemes. For the 2013/2014 financial Ministry of Health accounted for 10.6% of the national budget. (XCD101.5mn out of XCD950mn). Specialist mental health services including substance abuse treatment services had a budget allocation of XCD6.2mn or 6.1% of the health budget.

## **1.3 Mental Health and Substance Abuse**

### **1.3.1 Treatment Gap**

On a global level the World Health Organization in 2000 indicates a point prevalence for neuropsychiatric disorder in adults to be about 10 % and approximately 25 % individuals will develop one or more mental or behavioural disorder in their lifetime (World Health Organization, 2001). In the absence of population-based prevalence data for Saint Lucia one can extrapolate and estimate that about seventeen thousand (17, 000) Saint Lucians may be affected by mental health problems in any given year. In light of this the treatment gap for mental disorders cannot be accurately determined.

### **1.3.2 Substance Abuse**

Outside of the statistical reports generated from residential treatment services at the Turning Point facility there are currently no organized statistical data available on the incidence of substance use disorders in St Lucia. However casual observation indicates that substance use problems are widespread and are increasing particularly among youth. The most common substances of abuse are alcohol, marijuana, crack and cocaine.

The 2005 National Survey of Substance Use among Secondary School Students found that alcohol was the number one substance that secondary school students reported using in 2005. Although the legal drinking age in Saint Lucia is 18 years, approximately 88.2 per cent of secondary school students in the sample reported having consumed an alcoholic drink at least once during their lives, 77.3 per cent in the past year and 63.8 per cent within the past month

prior to the survey. A substantially higher percentage of students currently use alcohol (63.8%) than use cigarettes (5.9%), or inhalants (3.3%).

About fourteen per cent (14.3%) of the secondary school sample were current users of an illicit drug, including marijuana. Marijuana was the most commonly used illicit drug. 25.6% of the students in the sample reported that they had used marijuana at least once in their lifetime.

Among students in the sample, 9.0 per cent used marijuana, 3.0 per cent used tranquilizers and 2.2 per cent used stimulants in the month prior to the survey. Other drugs were consumed by 5.5 per cent of secondary school students in the month prior to the survey (Substance Abuse Advisory Council, Saint Lucia, 2007).

### **1.3.3 History of Mental Health Services in Saint Lucia**

Saint Lucia like the rest of the Caribbean has many of its institutions mostly influenced by European customs and traditions, in particular the British, Spanish, the Dutch and French. The early mental health deliver system and accompanying legislation was carried over from the British colonial era. The countries also share a history of colonization by European settlers from 1492, followed by a history of slavery which left behind social and cultural legacies.

Written records were difficult to obtain but oral history has it that laws governing the treatment of the mentally ill dates back to the late 19<sup>th</sup> century. Frederick Hickling gives accounts of very harsh and inhumane treatment for the mentally ill in the Caribbean (Hickling, 1988)

In 1879 an asylum was opened in Grenada where severely disturbed persons from Saint Lucia were sent for custodial care. This was facilitated by the Lunacy Transfer Act of 1881.

This act was repealed in 1895, and gave way to a new ordinance, which allowed for the detention of “lunatics, idiots, and persons of unsound mind” in a colonial lunatic asylum as well as a criminal lunatic asylum. The Lunacy Ordinance was revised in 1916, and the present building at La Toc in Castries was designated as a colonial mental hospital, exclusively for persons of unsound mind. The name was later changed to the Golden Hope Hospital.

In 1959, a judicial order was enacted, which made certification a prerequisite for admission to the mental hospital. These laws marked a milestone in the development of mental care in St. Lucia, and the gradual change in the perception of mental illness.

Since then, there have been steady improvements in mental health care services in St. Lucia. These included formal training of mental health care personnel, improvements to the physical structure of the hospital and changes in care practices including the provision of continued care through the primary health care system.

Turning Point, the Alcohol and Drug Detoxification and Rehabilitation Center, a twenty-bed facility located on the La Toc Road in Castries within walking distance from the then psychiatric facility was opened in May 1988. This was an early example of intersectoral collaboration

involving the Non-government organization Friends of Golden Hope Hospital Society (Mental Health NGO), the Government of St. Lucia, with financial and technical contributions from nationals (individuals, groups, and businesses) and aid from international donor agencies.

Despite the many changes, the level of care continued to be inadequate and service planners recognized the need for a more holistic approach to mental health care. The physical conditions of the Golden Hope Hospital continued to deteriorate and there was often public outcry for change.

#### **1.3.4 Mental Health Reform**

In the early part of the twenty-first century, the health sector embarked on a program of reform, which was guided by the National Health Strategic Plan 2006 – 2011. The formulation of this strategic plan was informed by contributions from stakeholders, civil society, regional and international agencies.

As part of the planned reform of the mental health services, the Ministry of Health commissioned a number of studies which included:

- **Assessment of Long-stay Patients for Community Placement**

In 2006 a study was conducted to identify the needs and characteristics of ninety-two (92) patients of Golden Hope Hospital to determine the best possible placement for them if discharged.

*“Of the ninety-two patients assessed 44 or 47.8% were assessed as having moderate problems in relation to community placement. This means that they would require suitable support, but their*

*problems are likely to be manageable. 9.8% of the group was assessed as having severe problems, which may be hard to manage in a community setting even with high level of support. Such individuals are likely to place high demands on staff and others around them. 6.5 % of the patients were assessed as having very severe problems, that it is hard to envisage community placement”* (Ministry of Health, Saint Lucia, 2006).

The results suggest that for many of the long-stay patients assessed, the factors which prevented or delayed discharge were not confined to psychiatric symptoms. For many individuals, the combination of clinical factors, behavioural tendencies as well as socio-economic problems necessitated their continued hospitalization in some and in others their frequent admissions. The study also concluded that the absence of a range of community-based supports and services required to meet the needs of people with psychosocial disabilities, necessitated long term hospitalization.

### **Assessment of Community-based Supports and Services**

Not as the heading suggests, this study mainly looked at housing for older persons and for the homeless. The study concluded that whilst these facilities house a significant number of individuals with mental disorders, the human resource capacity was inadequate to meet their needs. In addition the facilities studied provided very little activity therapy and stimulation for residents. The report summarized the findings as follows:

*“For the most part, the issue is not only one of providing alternative community based care for persons with existing mental disorders. As the population ages worldwide, we can anticipate that the number of older St Lucians with psychiatric disorders will grow rapidly over the coming years.*

*Therefore, in addition to the issue of alternative community based care and support for persons with existing mental health concerns, the Government of St Lucia need to plan for the challenge of providing services for elderly people with mental disorders and other mental health concerns in the coming years. It is therefore worth investing in training and other physical rehabilitation that not only meet current needs but provide a solid basis for future services as well” (Ministry of Health, Saint Lucia, 2007)*

### **Mental Health Attitude Survey**

In November 2006 the Ministry of Health commissioned a survey to determine people’s attitudes towards mental health and mental illness in general as well as their knowledge and attitudes of specific mental disorders and their help seeking behaviors. Approximately seven hundred and seventy (770) persons were interviewed. They were selected from districts all around the country in proportion to the district’s population size, age and gender distribution.

The results of the survey indicates that generally Saint Lucians have some information about mental illness and show care and concern for persons with mental illness however respondents reported being reluctant to interact with such individuals. The stigma attached to mental illness is an obstacle to better mental health care and the better quality of life of people who have the illness, of their families, of their communities and of health service staff that deal with psychiatric disorders. The results of the survey provided the framework for the development of a comprehensive anti-stigma campaign regarding mental illness in Saint Lucia.

*“The process of changing attitudes is a gradual one. Whereas the Ministry of Health must be the lead in mental health promotion and de-stigmatisation activities, success requires a multi-sectoral and multi-dimensional approach. Reducing stigma requires community action and a willingness among individuals to challenge others when discrimination occurs, or when negative stereotypes are used to describe those who have mental illness. The activities aimed at education and the fight to end stigma and discrimination, ultimately centres around client welfare, promoting the worth and dignity of every person and the opportunity to live a better life for all Saint Lucians”*

(Ministry of Health, Saint Lucia, 2008)

### **Mental Health Reform Program (2007 – 2010)**

Initiatives for mental health program included the following components.

- The development of policies to guide the implementation of reform initiatives
- The development of new legislation to support the various changes in the system
- The construction and commissioning of a new mental hospital.
- The development of community mental health.
- The development and implementation of a communication strategy to promote mental health wellness.

In 2000, the Government of St. Lucia announced that plans had been finalized for the construction of a new psychiatric facility. The thinking at the time was that this new facility would incorporate new approaches to mental health practices, principles and treatments. After much discussion the Ministry of health decided to build a one hundred and ten (110) bed facility,

with initial funding from the government of the republic of China and then completed by the Government of the Republic of China on Taiwan. This facility was built adjacent to a site proposed for the construction of a new general hospital and part of a larger medical complex under one management. The Turning Point substance abuse treatment center was later moved into the complex.

In 2006 the Ministry appointed a Director Mental Health Services, to oversee the implementation of activities related to reform of the sector. A Mental health reform project office was also opened at the same time. This project came to an end in 2010 following the commissioning of the new mental health facility.

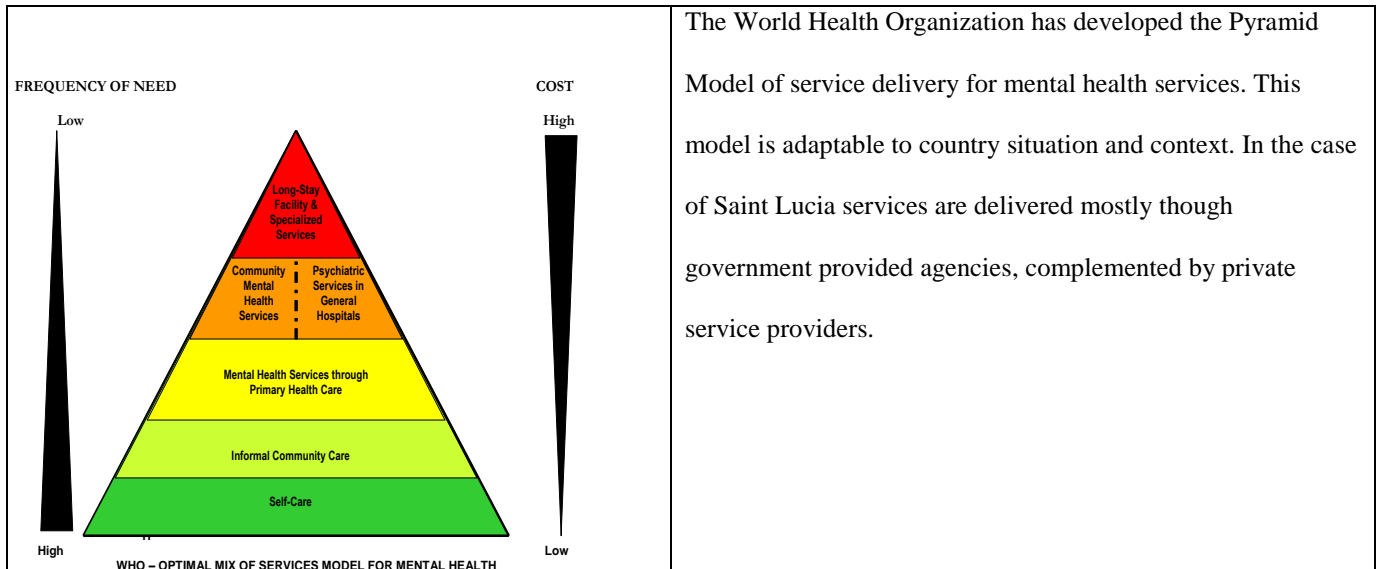
The Saint Lucia National Mental Wellness Centre prior to its opening was hailed as a new model of care where a comprehensive range of services would be offered on one site. This was termed “Levels of Care” model to treatment. This meant that clients would be treated in specialized units based on acuity ranging from high dependency acute care to transitional living for high functioning individuals to prepare them to return to community living.

The following table outlines the services provided in each unit and a comparison of bed assignment at the time of opening and in 2013.

Population	Level of Care Units	Description	Bed assignment at time of commissioning	Current bed assignment
Children and Adolescents ( 5-18)	Acute Care	Short-term assessment and/or inpatient treatment for children and adolescents who have a severe emotional disturbance.	6	0
Children and Adolescents	Partial Hospitalization (Day)	An integrated therapeutic and educational program for young people with behavioral difficulties.	Open	0
Adults (18+ to 64)	Acute Care	Highly intensive treatment provided in a secure environment.	12	20
Adults (18+)	Secure Extended Stay	medium to long-term inpatient treatment and rehabilitation for people who have unremitting and severe symptoms of mental illness	16	15
Adolescents and Adults (18+)	*Extended Stay	Medium to long-term treatment and rehabilitation for people who have social problems and difficulty with community-based alternative placements.	16	14
Adolescents and Adults (18+)	Rehabilitation Unit	Medium term treatment and rehabilitation for people with social and behavioural impairments requiring support and supervision before moving on to independent living.	16	16
Adolescents and Adults (18+)	Transitional/ Independent Living	Medium to long-term accommodation, clinical care and rehabilitation services for people with serious mental illness and associated psychosocial disability.	30	37
Older Adults (65+)	*Extended Stay	Medium to long-term inpatient care for older adults who have social problems and difficulty with community-based alternative.	12	0
<b>TOTAL</b>			<b>108</b>	<b>(82)102</b>

Table 3: Saint Lucia National Mental Wellness Center, Programs and Bed Compliment

### 1.3.5 Organization of Mental Health Services



<p>The Saint Lucia National Mental Wellness Center and the Turning Point Substance Abuse Treatment Center are the tertiary level specialist mental health facilities.</p>
<p>There are no community-based mental health treatment facilities. Persons with mental disorders are admitted and receive care at the two (2) state general hospitals St. Jude Hospital in the South and the Victoria Hospital in the capital city of Castries. The country has (1) private hospital who also admit patients with mental disorders. Private Psychiatrists as well as Psychologists and other therapists deliver services out of their offices.</p>
<p>Mental health services are integrated into primary health care and provide country-wide coverage. Currently three (3) qualified Mental Health Nurse Practitioners provide services at the various health centers around the island. The mental health professionals are supported by the primary health care professionals including General Doctors.</p>
<p>The country has its own cultural belief systems and some people make use of traditional healers for medical issues including mental illnesses. There are also a large network of religious groups and organizations who provide psychosocial support to the community.</p>
<p>Self-care is usually an individual decision and this is encouraged through ongoing health education and generally practicing healthy living. Proper diet and exercise, developing healthy coping and stress management skills.</p>

Figure 2: Organization of Services, Saint Lucia superimposed on WHO Pyramid Model

### **1.3.6 The Criminal Justice System**

The criminal justice system also play a significant role in the mental health services delivery system. The police play a role in bringing in patients suspected of having mental health problems in for treatment. An estimated 75 % of admissions to the psychiatric facility are police assisted.

Individuals suspected of having a mental illness or those with a known history of mental illness and have committed criminal offences go either through the Magistrate's court or the High Court. The Courts often request psychiatric or psychological evaluations to determine sentencing options. The country's lone penal institution, the Bordelais Correctional facility has approximately seventy (70) diagnosed mentally ill out of a total population of about five hundred (500). The vast majority of prisoners with mental disorders (over 90%) have a diagnosable psychotic disorder. Some have a primary or comorbid seizure or behavioural disorder and many have comorbid substance abuse disorder. The primary health care staff provide continuing care for patients at the prison. This is supported by the Psychiatrists from the SLNMWC and the prisons in-house medical services.

### **1.3.7 Children and Adolescents**

Population based data was not available for prevalence of mental health problems in children and adolescents. However available data suggests that 16.7% of first time admissions to the psychiatric facility for 2012 were under the age of twenty (20). Patient contacts at the Out-Patient clinics for the same year and the same age cohort was approximately 3.5%. For the years 2011 and 2012 admissions for person below the age of twenty (20) were 20% and 25% respectively.

Children and adolescents receive various elements of mental health care from agencies across sectors as indicated in the following table:

<b>HEALTH</b>	<b>SOCIAL SERVICES</b>	<b>EDUCATION</b>	<b>JUVENILE JUSTICE SYSTEM</b>	<b>NON GOVERNMENT AGENCIES</b>	<b>PRIVATE PRACTITIONER</b>
<b>SLNMWC</b> -In patient Treatment -Outpatient treatment	<b>Department of Human Services</b> -Psychosocial interventions -Referrals	<b>School Counseling Program</b> -Career Counseling -Psychosocial Interventions -Referrals	<b>Probation, Court Diversion Program</b> -Psychosocial interventions.	<b>Child Guidance and Development Center</b> -Physiotherapy -Speech and language therapy - Assessment and diagnostic services -Psycho-social interventions.	<b>Psychologist, Psychiatrist, Therapists</b> -Assessment and diagnostic services -Psychological services
<b>Turning Point</b> Residential Treatment Day Services Support group	<b>New Beginnings Home</b> -Residential support and supervision -Psychosocial interventions		<b>Boys Training Center</b> -Residential support and supervision -Psychosocial interventions	<b>Crisis Center</b> -Individual and family psychosocial interventions - Residential care (Temporary)	
<b>General Hospitals</b> Emergency Care In Patient Treatment Outpatient care			<b>Upton Gardens Girls Center</b> -Day Program support and supervision -Psychosocial interventions	<b>Religious Organizations</b> -Spiritual support  -Psychosocial interventions	
<b>Primary Health Care-</b> Child Care Clinics- General Clinics- Psychosocial intervention			<b>Bordelais</b> -General Psychiatric services		

*Table 4: Mental Health Service Providers for Children and Adolescents*

### **1.3.8 Resources for Mental Health and Socio-economic Burden**

The burden of mental health problems and mental illnesses is difficult to quantify due to the absence of data. Specialist mental health services including substance abuse treatment services had a budget allocation of XCD6.2mn or 6.1% of the health budget for the 2013/14 financial year. The estimated expenditure for mental health in primary health care is difficult to estimate, since the payment to staff and other expenditure are included in a global budget. All services are provided free of charge to consumers of public mental health services.

### 1.3.9 Medications

Psychiatric medications are purchased through a regional mechanism the Organization of Eastern Caribbean States – Pharmaceutical Procurement Service (OECS/PPS) and paid for and distributed by a centralized unit of the Ministry of Health. The cost of drugs for an eighteen month period is as follows:

PRODUCT GENERIC NAME	ISSUE UNIT	Total Cost (US\$)
Chlorpromazine 100mg tablet	TAB	-
Chlorpromazine 25mg/ml Inj, 2ml amp	AMP	124.40
Chlorpromazine 25mg tablet	TAB	1,216.95
Haloperidol 100mg/ml Inj	AMP	3,930.00
Haloperidol 10mg tablet	TAB	528.00
Haloperidol lactate 5mg/1ml Inj.	AMP	2,146.50
Haloperidol 5mg tablet	TAB	1,308.48
Risperidone 1mg tablet	TAB	1,536.00
Risperidone 2mg tablet	TAB	5,760.00
Risperidone 4mg tablet	TAB	1,272.00
Trifluoperazine 2mg tablet	TAB	288.00
Trifluoperazine 5mg tablet	TAB	5,520.00
Zuclopenthixol Decanoate 200mg/ml IM Inj	VIAL	18,900.00
Zuclopenthixol 50mg IM Ij	AMP	10,890.00
		<b>53,420.33</b>

Table 5: Psychotropic Medications and Costs (Source OECS/PPS, 2015)

### 1.3.10 Psychosocial Supports and Services for the mentally ill

Psychosocial supports and services are offered to the general population from various agencies and sectors. These are not specially targeted at persons suffering from mental illnesses, however they benefit, once they meet the criteria set out by the relevant agency. Services include:

Financial aid

Medical assistance

Housing for the indigent

Shelter for the homeless  
Feeding Programs  
Crisis Intervention  
Legal Aid  
Skills Training  
Home building programs  
Employment Programs  
Home Care for the elderly

### **1.3.11 Services Review**

In 2013 the Ministry of Health again commissioned a situational analysis and response of the mental health service needs of the country. The study concluded that:

- *“Mental health and mental illness issues have not been given sufficient importance in the discourse on national development despite the fact that poor mental health is implicated in issues of poverty and social deprivation, deviance, and criminal behavior, productivity, learning and education.*
- *Present information on prevalence of mental illness and mental health issues, information on needs for treatment, care and services in addition to a comprehensive economic evaluation of the impact of poor mental health is limited. Such information is useful in setting priorities and formulating a strategic plan.*
- *Various agencies both government and non-government provide mental health services in one form or another, however their activities are not coordinated, monitored or regulated for best possible clinical and social outcomes.*

- *The Ministry of Health is the agency primarily responsible for the delivery of inpatient care and continuing out-patient care to the seriously mentally ill, however the Ministry has no clearly defined policies, programs and plans for the current period.*
- *Inconsistent and inadequate provision of mental health services in primary care has severely hampered the delivery of care at the Saint Lucia National Mental Wellness Center in oversubscription of the use of the outpatients' clinics and high levels of acute admissions.*
- *Service provision for the severely mentally ill are highly focused on pharmacological intervention. Psychosocial supports and services need to be better coordinated to address the varied needs of service users.*
- *Services for children and adolescents are underdeveloped and not formalized in the current system of care.*
- *The criminal justice system is overwhelmed with the high numbers of persons with mental health issues presenting in the courts and incarcerated at the Bordelais Correctional facility” (Ministry of Health, Human services, Family Affairs and Gender Relations, 2013).*

## **2 LITERATURE REVIEW**

### **2.1 Intersectoral Collaboration in Health Care**

It is a widely known fact that health is determined by a number of social and economic factors. This admission has set the justification for advancing service delivery models to address this complex interplay of issues. Reducing the impact of the social and economic determinants of health cannot be achieved by the health sector alone (Herrman, Saxena, , & Moodie, 2005). The declaration of Alma Ata in 1978 set the foundation for achieving positive population health by addressing non-health concerns on the community level and on the national level. Thus different models of intersectoral action have been developed with varying reported health outcomes.

A positive association was reported for collaborative action and the reduction of smoking and alcohol use (Collins & al, 2007). Collaboration was also positively associated with the promotion of heart health, the reduction of tobacco use and in the prevention of injury (Kukn & al, 1999). Another study showed positive association between multi-sector action and a reduction in substance abuse behaviour and related health problems (Crowley & al, 2000).

### **2.2 Intersectoral Action for Mental Health**

There is growing evidence of the global impact of mental illness and of the significant impact of mental health and wellbeing on social and economic life (World Health Organization, 2001).

Mental health problems are amongst the most important contributors to the global burden of disease and disability worldwide (Murray & Lopez, 1996). Predictions indicate that this trend is

likely to continue. It is therefore imperative that countries in particular those with little resources seek creative and effective service delivery models.

It is widely acknowledged the impact of the social, economic and environment factors on mental health and well-being and conversely risk factors for mental illnesses and mental health problems are linked to social inequalities. As is the case in other areas of health tackling the social determinants of mental health yields greater benefits to the individual, the community and the nation in general, than addressing or bringing relief to the immediate medical concerns. There is ample evidence to support the view that addressing the social determinants of health leads to better outcomes in mental health and general well-being (Doughty, 2005).

Proponents for the intersectoral approach believe that lessons can be learnt from the successful public health initiatives for the control of infectious and cardiovascular diseases and can be applied to mental health care. The conclusion therefore is that the road to improved mental health among populations lies less in the investment on mental health services and more in coordinated public mental health promotion and prevention activities. This approach to mental health promotion, prevention and intervention establishes the central role which can be played by intersectoral action in mental health care (Herrman, Saxena, , & Moodie, 2005).

In the study entitled “Mental health is everybody’s business: Role for an intersectoral Approach in South Africa” the authors discussed their findings on a study aimed at assessing the country’s progress in intersectoral collaboration for mental health. An assessment of the existing system was used utilizing the WHOAIMS instrument as well as evaluating the perceptions of

stakeholders from across sectors. The study concluded that intersectoral collaboration has been a key element in the country's approach to public health. However in spite of the widespread awareness of the cross cutting nature of mental health issues, the same level of collaboration did not exist. The paper also outlined roles and responsibilities for various sectors which include the importance of developing programs alongside legislation, employing targeted awareness-raising to engage sectors, and developing a structured approach to intersectoral action (Skeen & al, 2010).

### **2.3 Mental Health Service Delivery in Saint Lucia and the Wider Caribbean**

As discussed earlier the mental health service delivery system of the English speaking Caribbean territories evolved out of the system inherited from the British post-colonial era. This was characterized by a heavy emphasis on custodial care for the seriously mentally-ill. Overtime this system began to change into a model with element of community-based services. Few studies exist which document the existing situation of mental health issues in individual countries, however reports produced by the Pan American Health Organization (PAHO) indicate that mental and neurological disorders account for 22% of the total disease burden in Latin America and the Caribbean (Pan American Health Organization, 2011). The Caribbean has a significant treatment gap; i.e.; a high proportion of people with mental disorders do not receive any type of care in the health services (Kohn R. , 2013).

The region is also plagued by social, economic and environmental issues which impact on mental health and well-being. In the case of Saint Lucia which is considered to an upper middle

income country, the conclusion is that despite its upper middle income status, many challenges exist which impact on mental health and wellbeing.

A situational analysis conducted in 2013 identified a number of issues confronting the mental health services which include substance abuse, homelessness and vagrancy, the sudden spike in the incidence of suicide and the involvement of the seriously mentally ill with the criminal justice system. The report concluded that mental health needs have not been given sufficient attention in the national development agenda and are not tackled from a broad national level, but by individual agencies meeting the specific needs of their constituents (Ministry of Health, Human services, Family Affairs and Gender Relations, 2013).

As discussed in previous chapter other country based assessments point to an inadequate system of supports and services for the seriously mentally ill. This limits people's ability to live successfully in the community and results in over use of the in-patient treatment facility.

Reviews of the role of intersectoral collaboration for the region reveal that with few exceptions Caribbean countries lack legislative provisions for employment for people with disabilities. With regard to housing, only two countries Trinidad and Tobago and Turks and Caicos have legislative provisions for people with severe mental disorder, but they are only applied in the former. It is further reported that mental health programming agencies in all the countries and territories do collaborate with other institutional actors inside and outside the health sector, but not uniformly (World Health Organization, 2011).

## **2.4 Contribution of this study**

In general there is a dearth of writing on the mental health situation in Saint Lucia and the small island states of the eastern Caribbean. There was no evidence of any work on intersectoral collaboration. This study will therefore open up the discourse on mental health and contribute to the body of knowledge in the area of mental health and public policy with emphasis on intersectoral collaboration. The study will also generate recommendations for the successful implementation of intersectoral action for a small island developing countries like Saint Lucia.

### **3 PERSONAL CONTRIBUTION**

#### **3.1 The Research Problem**

Despite the growing evidence of the impact of poor mental health on individuals, families and societies, enough has not been done in the area of developing and implementing a comprehensive national mental health system for Saint Lucia. In addition many people with mental health problems and mental illnesses, sometimes find themselves being assessed and receiving care in settings outside of the state-provided health care delivery system. This include services provided by private professionals and facilities or through services provided in the non-health care sectors like the prison, schools, long-term care homes etc.

In addition to the need for medical and psychological interventions , the complex interplay of the social determinants of health and their contribution to mental illnesses and their outcomes calls for an array of complementary supports and services many of which are located in sectors outside of health. These include assisted housing, financial assistance, and legal aid, educational support and other adjunct therapies. These agencies and sectors develop and implement policies and programs which address mental health issues relevant to their specific mandate.

The question is whether any collaboration or even coordination exists between these various sectors to enhance outcomes for people with mental health problems and mental illnesses.

### **3.2 Purpose of the Study**

This study aims

To ascertain the existence or nonexistence of intersectoral collaboration for the delivery of mental health care in Saint Lucia and

To advance a framework for a joint and coordinated strategy for the delivery of mental health services across sectors and agencies in Saint Lucia.

### **3.3 Objectives of the study**

- To determine whether the country has a mental health policy document which guides service delivery on a national level and the extent to which intersectoral collaboration is given attention.
- To determine the extent to which various sectors had an input into the formulation of the policy,
- To determine the level of collaboration which exists in the delivery of mental health services across sectors.
- To solicit recommendations from agencies for strengthening intersectoral collaboration.

### **3.4 Methodology**

This study used a combination of quantitative and qualitative method with a stronger emphasis on the qualitative (Tashakkori & Teddlie, 1998). Qualitative research methods are increasingly used in health care research with social and cultural dimensions such as mental health. Unlike quantitative research, which is deductive and tends to analyse phenomena in terms of trends and

frequencies, qualitative research seeks to determine the meaning of a phenomenon through description. It aims to develop concepts that aid in the understanding of natural phenomena with emphasis on the meaning, experiences and views of the participants (Cresswell, 2002).

The quantitative aspect of the study utilized the WHOAIMS tool to measure the extent to which intersectoral collaboration exists as part of the mental health care service delivery system in Saint Lucia.

Qualitative methods included the use of a WHO tool to evaluate the national mental health policy for the country. Finally data was collected through the use of a semi-structured interview and assessed based on themes relevant to the study.

### **3.5 Data Collection**

The study collected and analysed data using three methods:

#### **3.5.1 Policy Evaluation**

An evaluation of the current national mental health policy, its formulation process and its implementation. The purpose of this evaluation was to determine who led the process of policy formulation and who were the key players involved. In addition this assessment sought to determine whether the input or contributions of the players or stakeholders were reflected in the final outputs. Finally the assessment sought to determine whether “Intersectoral Collaboration” was explicitly identified in the policy as a priority area for action and whether the required activities and required resources were explicitly articulated.

The tool used for this evaluation **CHECKLIST FOR EVALUATING A MENTAL HEALTH POLICY** is an instrument developed and recommended by the WHO to assess and evaluate whether certain processes have been followed that are likely to lead to the success of the policy; and whether various content issues have been addressed and appropriate actions included in the policy.

The domains being assessed are scored as follows:-

- 1 - Yes/ to great degree
- 2 - to some extent
- 3 - no/not at all
- 4 - unknown

These scores are not weighted or used in any mathematical calculations, but are merely descriptive.

The WHO admits that the tool is limited in that it does not enable assessment of the *quality* of the processes or contents of the policy, evaluators are encouraged, when completing the checklist, to consider the *adequacy* of both the process and content. Particularly where a response is “no” or “to some extent”, it is suggested that they provide either an action plan to remedy the situation or a comment (in some instances the comment may, for example, merely be that a particular action is covered in a different policy, or that it is not possible to implement given the current resources available. Data collected from the tool was measured against a framework developed by the WHO for the formulation of mental health policy.

*(This tool was developed by Dr Michelle Funk, Ms Natalie Drew and Dr Edwige Faydi, Mental Health Policy and Service Development, Department of Mental Health and Substance Abuse,*

*World Health Organization, Prof Melvyn Freeman, Human Sciences Research Council, Pretoria, South Africa and Dr Sheila Ndyabangi, Ministry of Health Uganda.)*

### **3.5.2 Assessment – Current Intersectoral Collaboration**

The application of the WHOAIMS tool specifically ***Domain 5 – Public Education and Links with Other Sectors*** to the current mental health service delivery system in Saint Lucia. The information generated here gave an indication of the level of collaboration which exist between mental health and other sectors in public education and service provision.

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) is a tool developed by the WHO for collecting essential information on the mental health system of a country or region, the goal of which is to improve mental health systems and to provide a baseline for monitoring changes over time. The instrument covers six (6) domains, Policy and Legislative Framework, Mental Health Services, Mental Health in Primary Health Care, Human Resources, Public Education and Links with Other Sectors, Monitoring and Research. The data collected is entered into WHO-AIMS Excel Data Entry Programme which automatically calculates percentages and ratios for the quantitative items. A report is then generated from this data. The WHO-AIMS provides a template and guidance for writing the report.

### **3.5.3 Semi-Structured Interviews- Service Providers across Sectors**

Qualitative research is the “development of concepts which help us to understand social phenomena in natural (rather than experimental) settings, giving due emphasis to the meanings,

experiences and views of the participants” (Pope & Mays, 1995). Qualitative research allows us to take in-depth explanatory data from a small sample and the analysis allows us to draw out patterns from concepts and insights to produce illustrative explanations as well as individual responses. Semi-structured interviews were conducted with program managers from different agencies across sectors who have direct and significant contact with individuals with mental health issues. A purposive sample of six (6) individuals were identified for the research, five (5) government agencies and one (1) private. The following themes were examined:

- i. Roles played within the overall mental health service delivery system.
- ii. Mental health issues addressed.
- iii. Organizational policies and plans relating to mental health
- iv. Involvement in the national policy development and planning process
- v. Level of intersectoral collaboration which exist with agency and others
- vi. The need for intersectoral collaboration.

An interview schedule was developed based on the objectives of the study, interviews were conducted with selected agencies/sectors and then transcribed. Familiarization with the data was the first step taken. The transcripts of sector interviews were then analyzed using an inductive approach (using the emergent framework to group the data and explaining the patterns and themes identified). Thematic analysis was used to determine emerging themes describing and explaining aspects of the data. These themes formed the categories for analysis and divergences and convergences were noted in the findings. This approach gives emphasis to the experience and perceptions of the sectors interviewed providing a summative analysis.

## **4 RESULTS**

### **4.1 Evaluation of Mental Health Policy 2007**

For the purpose of this paper a mental health policy is defined as an organized set of values, principles and objectives for improving mental health and reducing the burden of mental disorders in a population (World health Organization, 2004). The policy defines a vision for the future and helps to establish a model for action. It also states the level of priority that a government assigns to mental health in relation to other health and social policies and generally formulated to cover a long period.

At the time of writing the Ministry of Health was in the process of developing a new strategic plan, which includes updating current policies. Therefore the 2007 document is the most recent, mental health policy of the country.

An instrument developed by the WHO –Checklist for Evaluating a Mental Health Policy was used to examine the policy, the main components of which are highlighted below. Special emphasis was placed on Intersectoral Collaboration.

#### **4.1.1 Saint Lucia National Mental Health Policy 2007 – Key Elements**

The following are direct extracts from the policy document:

<p><b>VISION:</b> <i>We envision that all people in St. Lucia have access to a coordinated system of supports and treatment that promotes mental wellness and recovery from mental disorders.</i></p>
<p><b>MISSION:</b> <i>To provide high quality, evidence-based, equitable mental health care which upholds human and civil rights, is integrated into the health care system, is community focused and is delivered at all levels of care, by well-trained, skilled and motivated personnel</i></p>
<p><b>VALUES AND GUIDING PRINCIPLES</b></p> <p><b>1. Equity and Accessibility</b>  <i>Services shall be affordable and accessible to all people, regardless of their geographical location, economic status, gender, race, social condition, mental or physical disability, sexual orientation, religion, HIV/AIDS and health status.</i></p> <p><b>2. Human Rights</b>  <i>People with mental disorders shall enjoy full human rights, including the right to appropriate health care, shelter and employment, and the freedom from discrimination, exploitation, harm, abuse and unlawful restraint.</i></p> <p><b>3. Integration</b>  <i>Mental health services shall- be integrated into existing health care services at all levels (primary, secondary and tertiary).</i></p> <p><b>4. Quality Services</b>  <i>Services shall reflect the highest standard possible according to current scientific knowledge and the resources available.</i></p> <p><b>5. Evidence-Based Care</b>  <i>Scientifically validated evidence shall be the primary source of information used to inform decision making for services and interventions.</i></p> <p><b>6. Community Involvement and Participation</b>  <i>Mental health services shall be available in the communities in which people live, work and receive other services.</i></p> <p><b>7. Rehabilitation</b>  <i>Mental Health services shall be designed with a focus on rehabilitation and recovery within communities.</i></p> <p><b>8. Inter-sectoral Collaboration</b>  <i>Mental health services shall be appropriately linked to other sectors (such as social services, criminal justice system, housing, education, employment, religious etc.)</i></p> <p><b>9. Mental Health Prevention and Promotion</b>  <i>Some mental health problems and illnesses can be prevented through early identification and treatment. Therefore rigorous screening services shall be provided for people across the lifespan.</i></p>
<p><b>PRIORITY AREAS OF ACTION</b></p> <p>1). <i>Organization of services</i>  2). <i>Intersectoral collaboration,</i>  3). <i>Legislation and human rights,</i>  4). <i>Mental health promotion and prevention</i></p>

Table Key Elements of Saint Lucia National Mental health Policy 2007 (Government of Saint Lucia 2007)

#### 4.1.2 Checklist for Evaluating a Mental Health Policy (WHO) Applied to the Saint Lucia National Mental Health Policy 2007

## Process Issues

<p><b>Please use the following rating scale to rate each item:</b>  <b>1 = yes/to great degree</b>  <b>2 = to some extent</b>  <b>3 = no/not at all</b>  <b>4 = unknown</b></p>	<p><b>Rating</b></p>	<p><b>If 'yes' or 'to some extent' please state how.</b>   <b>If not, please state reason.</b></p>
<p>1a. Was there a high-level mandate to develop the policy (e.g. from the Minister of Health)?</p>	<p><b>1</b></p>	<p>The government of Saint Lucia embarked on a program of health sector reform, which identified mental health as a priority area for action. This led to the establishment of a full-time project office and for the first time the appointment of a Director of Mental health Services. The development of a national policy was one of the mandates of the mental health office.</p>
<p>1b. At what level has the policy been officially approved and adopted? (e.g., the department of mental health, Ministry of Health, Cabinet, Minister of Health).</p>	<p><b>2</b></p>	<p>The policy was unofficially adopted by the Ministry of Health. Elements of various priority areas of action were implemented and included:</p> <ul style="list-style-type: none"> <li>• Enhancement of services in primary care setting.</li> <li>• Drafting of new legislation.</li> <li>• Development and launch and implementation of public education campaign.</li> <li>• Identification of minimum data set in collaboration with the PAHO</li> <li>• Development of a human resource plan.</li> <li>• Commissioning of a new mental health facility.</li> </ul>
<p>2. Is the policy based on relevant data:</p>		
<p>-From a situation assessment?</p>	<p>1</p>	<p>Policy was based on data and information collected by a foreign consultant.</p>
<p>-From a needs assessment?</p>	<p>1</p>	<p>The finding of several national health related studies informed the development of the mental health policy: These included:  <b>National Health Strategic Plan</b> , Volume 2 Annex 8, Volume 4 Action Plan, Pages 5- 12 and Pages 17-21  <b>Health Research For Action</b> – UHC Impact Assessment Final Report August 2005  <b>National Health Strategic Plan</b> - Volume 6 – Human Resource for Health , Page 9; Pages 17-19; Pages 23-29  <b>Minutes of Previous Meetings</b></p>
<p>3. Have policies relating to mental health that have been utilized within the country and in other countries with similar cultural and demographic patterns been examined and integrated where relevant?</p>	<p><b>2</b></p>	<p>A number of policies from different countries were consulted, not necessarily countries with similar cultural and demographic patterns.</p> <p>In addition the WHO Mental Health Policy and Service Guidance package provided guidance in developing the policy. The modules consulted at the time provided a framework for including relevant components of a mental health policy document taking into consideration local needs and resources.</p>
<p>4. Has a thorough consultation process taken place with the following groups:</p>		<p>Stakeholder consultations were held at the district level and finally a national consultation was held. Participants included the Governor General, Ministers of Government, Heads of Government agencies, service users, carers,</p>

		members of civil society organizations. (See Appendix....) In addition the document was presented the PAHO regional office for review.
-- Representatives from the Health Sector, including planning, pharmaceutical , human resource development, child health, HIV/AIDS, epidemiology and surveillance, epidemic and disaster preparedness divisions.	2	Through consultations and meetings
-- Representatives from the Finance Ministry?	2	Through consultations and meetings
-- Representatives from Social Welfare and Housing Ministries?	2	Through consultations and meetings
-- Representatives from the criminal justice system?	2	Through consultations and meetings
-- Consumers, or representatives of consumer groups?	2	Through consultations and meetings
-- Family members or their representatives?	2	Through consultations and meetings
-- Other NGOs?	2	Through consultations and meetings
-- Private sector?	2	Through consultations and meetings
-- Any other key stakeholder groups? If so, please list them	2	Through consultations and meetings
5. Has an exchange taken place with other countries concerning their mental health policies and experiences?	3	The policy was reviewed by the Eastern Caribbean office of the PAHO.
6. Has relevant research been undertaken to inform policy development, (e.g.pilot studies)?	3	Assessment of in-patients for possible community placement.  Assessment of Community-based supports and services.

*Table 6: Results, Process Issues in Policy Development*

## SUMMARY – Process Issues

The drafters of the national mental health policy for Saint Lucia appears to have followed all the accepted processes for developing a comprehensive document. A total of sixteen (16) questions were scored with scores ranging from 1 to 3. The score of 4 does not really count because it means that information was not available. (See details at the top of table). Out of a total of sixteen, fourteen (14) received scores of 1 and 2.

<b>Score</b>	<b>Frequency</b>
1	3
2	11
3	2
	<b>16</b>

*Table 7: Frequency of Scores, Process Issues*

#### 4.1.3 Content Issues with Special Emphasis on Intersectoral Collaboration

1. Is there a realistic vision statement?	<b>2</b>	The vision is realistic in that it is measurable and based on the resources available in the country is realistic.
	<b>1</b>	

2. Are values and associated principles which inform the policy included?		
3. Do these values and associated principles emphasize and/or promote:		
-- Human rights?	<b>1</b>	Clearly articulated in policy document
-- Social inclusion?	<b>1</b>	Clearly articulated in policy document
-- Community care?	<b>1</b>	Clearly articulated in policy document
-- Integration?	<b>1</b>	Clearly articulated in policy document
-- Evidence-based practice?	<b>1</b>	Clearly articulated in policy document
-- Intersectoral collaboration?	<b>1</b>	Clearly articulated in policy document
-- Equity with physical health care?	<b>1</b>	Clearly articulated in policy document
4. Have clear objectives been defined?	<b>1</b>	Clearly articulated in policy document
5. Are objectives consistent:		Clearly articulated in policy document
-- With the vision?	<b>1</b>	Clearly articulated in policy document
-- With the values and principles?	<b>1</b>	Clearly articulated in policy document
6. Are the areas for action clearly described to indicate the main policy directions and what will be achieved?	<b>1</b>	Clearly articulated in policy document
7. Are the areas for action written in a way that commits the Government (e.g. do they state “will” instead of “should”)?	<b>2</b>	Clearly articulated in policy document
8. To what extent do the areas for action comprehensively address <b>coordination &amp; management</b> ?	<b>3</b>	There is no definitive statement on coordination and management of mental health service delivery.
(a) Does the policy specify a dedicated mental health position/post within the Ministry of Health to coordinate mental health functions and services?	<b>4</b>	The mental health policy document is not accompanied by a plan of action with clear objectives, activities and timelines.
(b) Does the policy establish or refer to a multisectoral coordinating body to oversee major decisions in mental health?	<b>4</b>	The mental health policy document is not accompanied by a plan of action with clear objectives, activities and timelines.
9) To what extent do the areas for action comprehensively address <b>financing</b> ?	<b>4</b>	The mental health policy document is not accompanied by a plan of action with clear objectives, activities and timelines.
(a) Does the policy indicate how funding will be utilized to promote equitable mental health services?	<b>4</b>	The mental health policy document is not accompanied by a plan of action with clear objectives, activities and timelines.
(b) Does the policy state that equitable funding between mental health and physical health will be provided?	<b>4</b>	The mental health policy document is not accompanied by a plan of action with clear objectives, activities and timelines.
(c) If health insurance is utilized in the country, does the policy indicate whether/how mental health would be part of it?	<b>4</b>	The mental health policy document is not accompanied by a plan of action with clear objectives, activities and timelines.
10. To what degree do the areas for action comprehensively address <b>legislation and/or human rights</b> ?	<b>1</b>	A result of this policy was the drafting of a modern legislative framework.

(a) Does the policy promote human rights?	2	A result of this policy was the drafting of a modern legislative framework
(b) Does the policy promote the development and implementation of human rights-oriented legislation?	2	A result of this policy was the drafting of a modern legislative framework
(c) Is the setting up of a review body envisaged to monitor different aspects of human rights?	2	Not articulated in policy, but introduced in draft legislation.
11. To what extent do the areas for action comprehensively address <b>organization of services</b> ?	1	Clear and in-depth policy statements, however the policy document is not accompanied by a plan of action with clear objectives, activities and timelines
(a) Does the policy promote the integration of mental health services into general health services?	1	Clear and in-depth policy statements, however the policy document is not accompanied by a plan of action with clear objectives, activities and timelines
(b) Does the policy promote a community-oriented mental health approach?	1	Clear and in-depth policy statements, however the policy document is not accompanied by a plan of action with clear objectives, activities and timelines
(c) Does the policy promote deinstitutionalization?	3	Clear and in-depth policy statements, however the policy document is not accompanied by a plan of action with clear objectives, activities and timelines
12. To what extent do the areas for action comprehensively address <b>promotion, prevention and rehabilitation</b> ? Does the policy make provision for:	1	Clear and in-depth policy statements, however the policy document is not accompanied by a plan of action with clear objectives, activities and timelines
(a) The prevention of mental disorders?	1	Clear and in-depth policy statements, however the policy document is not accompanied by a plan of action with clear objectives, activities and timelines
(b) Interventions that promote mental health?	2	Clear and in-depth policy statements, however the policy document is not accompanied by a plan of action with clear objectives, activities and timelines
(c) Interventions for the rehabilitation of people with mental disorders?	2	Clear and in-depth policy statements, however the policy document is not accompanied by a plan of action with clear objectives, activities and timelines
13. To what extent do the areas for action comprehensively address <b>advocacy</b> ?	2	Clear statements, however the policy document is not accompanied by a plan of action with clear objectives, activities and timelines
(a) Is the policy supportive of consumers and family organizations?	2	Clear policy statements, however the policy document is not accompanied by a plan of action with clear objectives, activities and timelines
(b) Is there emphasis on raising awareness of mental disorders and their effective treatment?	2	Clear policy statements, however the policy document is not accompanied by a plan of action with clear objectives, activities and timelines
(c) Does the policy promote advocacy on behalf of people with mental disorders?	2	Clear policy statements, however the policy document is not accompanied by a plan of action with clear objectives, activities and timelines
14. To what extent do the areas for action comprehensively address <b>quality improvement</b> ? Does the policy	2	Clear policy statements, however the policy document is not accompanied by a plan of action with clear objectives, activities and timelines
(a) Make a commitment to providing high quality, evidence- based interventions?	2	Policy stated, but no clear operational guidelines were written.
(b) Include a process to measure and improve the quality of services?	2	Policy stated, but no clear operational guidelines were written.

15. To what extent do the areas for action comprehensively address <b>information systems</b> ?	2	At the time of writing of the policy the Ministry of Health was in the process of introducing an electronic health information system to include mental health.
(a) Will mental health information systems be set up to guide decision-making for future policy, planning and service development?	1	At the time of writing of the policy the Ministry of Health was in the process of introducing an electronic health information system to include mental health
16. To what extent do the areas for action comprehensively address <b>human resources and training</b> ?	1	The Ministry of Health' strategic plan addressed human resource issues for mental health.
(a) Does the policy commit to putting in place suitable working conditions for mental health providers?	2	The Ministry of Health' strategic plan addressed human resource issues for mental health
(b) Have appropriate management strategies been discussed to improve recruitment and retention of mental health providers?	3	The Ministry of Health' strategic plan addressed human resource issues for mental health
(c) Are training in core competencies and skills seen as central to human resources development?	3	The Ministry of Health' strategic plan addressed human resource issues for mental health
17. To what extent do the areas for action comprehensively address <b>research and evaluation</b> ?	3	
(a) Does the policy emphasize the need for research and evaluation of services and of the policy and strategic plan?	3	
18. To what extent do the areas for action comprehensively address <b>intrasectoral collaboration</b> within the health sector? Does the policy::		<p>In the policy document Intersectoral Collaboration was articulated both as a Value/Guiding principle and as a priority area for action.</p> <p>The stated <b>objective</b> - " Provide a comprehensive, uninterrupted mental health program for the rehabilitation and effective reintegration of clients to families and to society through community empowerment, and through intersectoral collaboration"</p> <p>As a <b>Value and Guiding Principle</b> the policy document stated that "Mental health services shall be appropriately linked to other sectors (such as social services, criminal justice system, housing, education, employment, religious etc.)</p> <p>Services shall be designed to connect with and utilize complementary care providers, and to integrate all available, evidence-supported facets of health care and prevention.</p> <p>Collaborative links with local, national, regional and international institutions, organizations and agencies should be promoted.</p>

		<p><b>As a Priority Area for Action</b></p> <p>Development of mental health care services and the design and implementation of mental health programs necessitates collaborative partnership of multiple sectors in addition to health including, but not limited to, social welfare; education; housing; labour, criminal justice, employment and the voluntary sector, private service providers. Inter-sectoral collaboration is essential to the provision of comprehensive, uninterrupted continuity of care.</p> <p>The Ministry of Health shall therefore</p> <ul style="list-style-type: none"> <li>• Introduce a case management system for the overall coordination of client care across various agencies to facilitate the delivery of an array of medical, self-help, social, supportive, and rehabilitative services designed around the needs and desires of the individual, family and community.</li> </ul>
(a) Emphasize collaboration with planning, pharmaceutical, human resource development, child health, HIV/AIDS, epidemiology and surveillance, epidemic and disaster preparedness divisions, within the health sector?	2	The sections on Intersectoral collaboration not specific on relationships with non-mental health agencies and sectors.
(b) Contain clear statements of what role each department will play in each area for action?	3	The sections on Intersectoral collaboration not specific on relationships with non-mental health agencies and sectors
19. To what extent do the areas for action comprehensively address <b>intersectoral collaboration</b> ? Does the policy:	2	The sections on Intersectoral collaboration not specific on relationships with non-mental health agencies and sectors
(a) Emphasize collaboration with all other relevant government departments?	2	The sections on Intersectoral collaboration not specific on relationships with non-mental health agencies and sectors
(b) Emphasize collaboration with all relevant NGOs, including consumer and family groups?	2	The sections on Intersectoral collaboration not specific on relationships with non-mental health agencies and sectors
(c) Contain clear statements of what role each sector will play in each area for action?	4	The sections on Intersectoral collaboration not specific on relationships with non-mental health agencies and sectors
20. Have all of the following groups been considered:		The sections on Intersectoral collaboration not specific on relationships with non-mental health agencies and sectors
-- People with severe mental disorders?	2	The sections on Intersectoral collaboration not specific on relationships with non-mental health agencies and sectors
-- Children and adolescents?	2	The sections on Intersectoral collaboration not specific on relationships with non-mental health agencies and sectors
-- Older persons?	2	The sections on Intersectoral collaboration not specific on relationships with non-mental health agencies and sectors
-- People with intellectual disability?	2	The sections on Intersectoral collaboration not specific on relationships with non-mental health agencies and sectors
-- People with substance dependence?	2	The sections on Intersectoral collaboration not specific on relationships with non-mental health agencies and sectors

-- People with common mental disorders?	2	The sections on Intersectoral collaboration not specific on relationships with non-mental health agencies and sectors
-- People affected by trauma?	3	The sections on Intersectoral collaboration not specific on relationships with non-mental health agencies and sectors
21. Given resources available in the country, has a reasonable balance been achieved between the above groups?	3	The sections on Intersectoral collaboration not specific on relationships with non-mental health agencies and sectors
22. To what degree have the key mental health policy issues been integrated with/or are consistent with the country's:		
-- Mental health law?	1	Proposed updated legislation.
-- General health law?	1	
-- Patients' rights charter?	1	United nations charters were reviewed as part of the policy development process.
-- Disability law?	3	Not specifically
-- Health policy?	2	Not specifically
-- Social welfare policy?	2	Not specifically
-- Poverty reduction policy?	2	Not specifically
-- Development policy?	2	Not specifically
<b>Taking into account the financial and human resources available in the country, comment on the general feasibility for implementation of the policy.</b>		

Table 8: Results Content Issues of National Policy

## SUMMARY – Content Issues

The results indicate that the policy contains all the relevant issues necessary for a national mental health delivery system. More than fifty (50) responses out of a total of seventy (70) received scores of 1 and 2. In the area of Intersectoral Collaboration which was investigated in questions 18 and 19, a total of twenty-two (22) responses were scored. Fourteen responses received a score of 2, which means that almost two thirds of the issues were addressed “to some extent”. Only three (3) responses received a 1 or “yes”.

Whilst the results here were positive, the results demonstrates a lack of depth and possible sincerity in the pronouncements of the policy in the area of Intersectoral Collaboration.

#### 4.1.4 Analysis and Results

The data generated above was measured against the WHO’s framework for the development of a mental health policy outlined below:-

Phase	Focus	Activities
<b>The mental health policy</b>		
1.	Information & data for policy development	Information is gathered through formal research and rapid appraisal to understand the mental health needs of the population and the mental health system and services offered.
2.	Evidence for effective strategies	Local services are visited and national and international literature reviewed (previous policy, plans and programmes, pilot projects and local experiences, evidence from countries or regions with similar cultural and socio-economic features).
3.	Consultation and negotiation	Consult with various stakeholders, draft proposals that blend different views with evidence from national and international experience, and available technical and resource base. Obtain political support for proposed policy.
4.	Exchange with other countries	Investigate the latest advances in more developed countries and lower-cost interventions in less developed countries, engage with international experts about proposals for the policy.
5.	Vision, values, principles and objectives	Set out the vision, values, principles and objectives for mental health in a draft policy. Objectives should focus on improving the health of the population, responding to people’s expectations (human rights, client -focused orientation) and providing financial protection against the cost of ill-health.
6.	Areas for action	Translate the objectives of the mental health policy into areas for action, including those related to financing, legislation and human rights, organization of services, human resources and training, promotion, prevention, treatment and rehabilitation, essential drug procurement and distribution, advocacy, quality improvement, information systems, research and evaluation of policies and services and intersectoral collaboration.
7.	Roles and responsibilities of different sectors	Consult governmental agencies (health, education, employment, social welfare, housing, justice); academic institutions; professional associations; general health and mental health workers; consumer and family groups; providers; nongovernmental organizations (NGOs); & traditional health workers.

Table 9: WHO Policy Framework

The directorate of the Ministry of Health in Saint Lucia closely followed the guidelines and general framework established by the World Health Organization for the formulation of a national mental health policy. The policy contains all the key elements identified in the WHO framework. Where the policy is lacking is that it is not supported by a comprehensive action plan

which clearly identifies achievable targets with timelines and required resources. Policy objectives were not accompanied by clear leadership, operational and financing mechanisms.

Intersectoral Collaboration whilst clearly identified as a Value/Guiding principle and an area for action suggest a high level of priority. However the mechanism for achieving this was not outlined. There was no evidence or indication of agreements by the various sectors for their roles and contributions.

#### 4.2 WHO ASSESSMENT INSTRUMENT FOR MENTAL HEALTH SYSTEMS (WH0-AIMS) 2.2 DOMAIN 5 – Link With Other Sectors: Formal Collaboration Applied To Saint Lucia - 2015

<b>FACET 5.2</b>	<b>Links with other sectors: formal collaboration</b>	
<b>DEFINITION</b>	<b>Formal collaboration in the form of laws, administration, and programmes with (other) health and non-health sectors aimed at improving mental health</b>	
<b>ITEM 5.2.1</b>	<b>Legislative provision for employment</b>	
<b>DEFINITION</b>	Existence of legislative provisions concerning a legal obligation for employers to hire a certain percentage of employees that are disabled	
<b>MEASURE</b>	Existence of legislative provisions concerning a legal obligation for employers to hire a certain percentage of employees that are disabled A = no such legislative provisions exist B = legislative provisions exist but are not enforced C = legislative provisions exist and are enforced	<b>A</b>
<b>NOTES</b>	Only include if the legislation includes those with mental disabilities (i.e., either there is specific legislation pertaining to mental disabilities, or the legislation on disabilities includes those with mental disabilities).	
<b>ITEM 5.2.2</b>	<b>Legislative provision against discrimination at work</b>	
<b>DEFINITION</b>	Existence of legislative provisions concerning protection from discrimination (dismissal, lower wages) solely on account of mental disorder	
<b>MEASURE</b>	Existence of legislative provisions concerning protection from discrimination (dismissal, lower wages) solely on account of mental disorder A = no such legislative provisions exist B = legislative provisions exist but are not enforced	<b>A</b>

	C = legislative provisions exist and are enforced	
ITEM 5.2.3	Legislative or financial provisions for housing	
DEFINITION	Existence of legislative or financial provisions concerning priority in state housing and in subsidized housing schemes for people with severe mental disorders	
MEASURE	Existence of legislative or financial provisions concerning priority in state housing and in subsidized housing schemes for people with severe mental disorders A = no such legislative or financial provisions exist B = legislative or financial provisions exist but are not enforced C = legislative or financial provisions exist and are enforced	<b>A</b>
NOTES	The definition of severe mental disorder will vary across countries and settings. In most countries, severe mental disorder is considered to cover schizophrenia, other psychoses, bipolar disorder, and major depression.	
ITEM 5.2.4	Legislative or financial provisions against discrimination in housing	
DEFINITION	Existence of legislative or financial provisions concerning protection from discrimination in allocation of housing for people with severe mental disorders	
MEASURE	Existence of legislative or financial provisions concerning protection from discrimination in allocation of housing for people with severe mental disorders A = no such legislative or financial provisions exist B = legislative or financial provisions exist but are not enforced C = legislative or financial provisions exist and are enforced	<b>A</b>
NOTES	The definition of severe mental disorder will vary across countries and settings. In most countries, severe mental disorder is considered to cover schizophrenia, other psychoses, bipolar disorder, and major depression.	
ITEM 5.2.5	Formal collaborative programmes with other health and non-health agencies/departments	
DEFINITION	Formal collaborative programmes addressing the needs of people with mental health issues between (a) the department/agency responsible for mental health and (b) the department/agency responsible for:	
MEASURE	1. Primary health care/ community health 2. HIV/AIDS 3. Reproductive health 4. Child and adolescent health 5. Substance abuse 6. Child protection 7. Education 8. Employment 9. Housing 10. Welfare 11. Criminal justice 12. The elderly 13. Other departments/Agencies (specify in comments section) Y/N; NA= not applicable	<b>Y</b> <b>Y</b> <b>Y</b> <b>Y</b> <b>Y</b> <b>N</b> <b>N</b> <b>N</b> <b>N</b> <b>N</b> <b>N</b> <b>N</b> <b>N</b> <b>N</b>

NOTES	A formal collaborative programme is defined here as a programme that involves (a) a written agreement of collaboration and/or (b) a joint activity or publication.	
<b>FACET 5.3</b>	<b>Links with other sectors: activities</b>	
<b>DEFINITION</b>	<b>Extent of activities outside the mental health sector that address the needs of people with mental health issues</b>	
ITEM 5.3.1	Provision of employment for people with severe mental disorders	
DEFINITION	Provision of employment for people with severe mental disorders, through activities outside the mental health facility	
MEASURE	Users have access to programs that provide outside employment for users at: A= no mental health facilities (0%) B = a few mental health facilities (1-20%) C = some mental health facilities (21-50%) D = many mental health facilities (51%-80%) E = all or almost all (81%-100%) UN = unknown	<b>A</b>
NOTES	· Exclude work that takes place on the premises of mental health facilities (e.g. sheltered workshops). In 'comments' column, either (a) indicate data source or (b) write 'BE' if response is based on a Best Estimate:	
ITEM 5.3.2	Primary and secondary schools with mental health professionals	
DEFINITION	Proportion of primary and secondary schools with either a part-time or full-time mental health professional (e.g., psychologist, social worker, nurse specialized in mental health)	
MEASURE	Proportion UN = unknown	<b>0%</b>
NUMERATOR	Total number of primary and secondary schools with either a part-time or full-time mental health professional (e.g., psychologist, social worker, nurse specialized in mental health)	<b>8</b>
DENOMINATOR	Total number of primary and secondary schools	<b>98</b>
ITEM 5.3.3	Promotion and prevention activities in primary and secondary schools	
DEFINITION	School-based activities to promote mental health and to prevent mental disorders	
MEASURE	Promotion or prevention activities are provided in: A= no primary and secondary schools (0%) B = a few primary and secondary schools (1%-20%) C = some primary and secondary schools (21%-50%) D = many primary and secondary schools (51%-80%) E = all or almost all primary and secondary schools (81%-100%) UN = unknown	<b>UN</b>
NOTES	· Promotion and prevention activities include all organized activities aimed at promoting mental health and/or preventing the occurrence as well as the progression of mental disorders. Examples of activities include those aimed at improving: (a) social skills, (b) emotional communication, (c) stress management, and (d) skills for coping with adversity.	

	In 'comments' column, either (a) indicate data source or (b) write 'BE' if response is based on a Best Estimate:	
ITEM 5.3.4	Educational activities with police officers	
DEFINITION	Police officers participating in educational activities on mental health in the last 5 years	
MEASURE	Police officers participating in educational activities on mental health in the last 5 years A= no police officers (0%) B = few police officers (1%-20%) C = some police officers (21%-50%) D = many police officers (51%-80%) E = all or almost all police officers (81%-100%) UN = unknown	<b>C</b>
NOTES	· Educational activities include trainings, educational meetings, or sessions to build practical skills In 'comments' column, either (a) indicate data source or (b) write 'BE' if response is based on a Best Estimate:	
ITEM 5.3.5	Educational activities with judges and lawyers	
DEFINITION	Judges and lawyers participating in educational activities on mental health in the last 5 years	
MEASURE	Judges and lawyers participating in educational activities on mental health in the last 5 years A= no judges and lawyers (0%) B = few judges and lawyers (1%-20%) C = some judges and lawyers (21%-50%) D = many judges and lawyers (51%-80%) E = all or almost all judges and lawyers (81%-100%) UN = unknown	<b>A</b>
NOTES	· Educational activities include trainings, educational meetings, or sessions to build practical skills In 'comments' column, either (a) indicate data source or (b) write 'BE' if response is based on a Best Estimate:	
ITEM 5.3.6	Persons with psychosis in prisons	
DEFINITION	Percentage of prisoners with psychosis	
MEASURE	Percentage of prisoners with psychosis A = less than 2% B = 2-5 % C = 6-10% D = 11-15% E = greater than 15% UN=Unknown, NA= not applicable	<b>D</b>
NOTES	In 'comments' column, either (a) indicate data source or (b) write 'BE' if response is based on a Best Estimate:	
ITEM 5.3.7	Persons with mental retardation in prisons	

DEFINITION	Percentage of prisoners with mental retardation	
MEASURE	Percentage of prisoners with mental retardation A = less than 2% B = 2-5 % C = 6-10% D = 11-15% E = greater than 15% UN=Unknown, NA= not applicable	<b>A</b>
NOTES	In 'comments' column, either (a) indicate data source or (b) write 'BE' if response is based on a Best Estimate:	
ITEM 5.3.8	Mental health care of prisoners	
DEFINITION	Prisons with at least one prisoner per month in treatment contact with a mental health professional, either within the prison or outside in the community	
MEASURE	Prisons with at least one prisoner per month in treatment contact with a mental health professional, either within the prison or outside in the community A = no prisons (0%) B = a few prisons (1 - 20%) C = some prisons (21 - 50%) D = majority of prisons (51 - 80%) E = all or almost all prisons (81 - 100%) UN = unknown	<b>E</b>
NOTES	In 'comments' column, either (a) indicate data source or (b) write 'BE' if response is based on a Best Estimate:	
ITEM 5.3.9	Social welfare benefits	
DEFINITION	Proportion of people who received social welfare benefits because of disability due to mental disorder	
MEASURE	Proportion; UN = unknown; NA = not applicable (e.g. disability benefits do not exist for any type of disability)	<b>UN</b>
NUMERATOR	Number of people who received social welfare benefits because of disability due to mental disorder	
DENOMINATOR	Number of people who received social welfare benefits because of disability due to any mental or physical disorder	
NOTES	Social welfare benefits are benefits from public funds that are payable, as part of a legal right, to people with health conditions that reduce a person's capacity to function. These are often known as disability pensions.	

Table 10: WHOAIMS Spreadsheet:

#### 4.2.1 Analysis and Results

#### **4.2.1.1 Formal collaboration in the form of laws, administration and programmes with (other) health and non-health sectors aimed at improving mental health.**

Items 5.2.1 – 5.2.5

The country has no legislative or financial provisions for employers to hire a certain percentage of individuals with disabilities and for the protection against discrimination at work solely on the account of having a mental disorder. On the issue of protection in the housing sector, the country does not have state housing or subsidized housing, therefore no relevant legislation.

In measuring formal collaborative programs with other health and non-health sectors, a total of five (5) out of thirteen (13) or about 40% of the agencies have such programs. The agencies with collaboration are all departments within the Ministry of Health.

There are no formal written agreements and/or joint activity or publication between mental health and agencies responsible for child protection, education, employment, housing, welfare, criminal justice, the elderly and other non-mental health agencies.

#### **4.2.1.2 Links with other sectors: Activities**

#### **5.3.1 – 5.3.9**

No special provisions exist for the employment of people with serious mental disorders.

- 0% of schools have designated specialist mental health professionals.

- Some police officers (between 21% - 50%) of police officers participated in educational activities with the last five (5) years. In September 2015 a total of fifty-five (55) senior officers attend training on mental health and safety. No (0%) judges and lawyers have participated in educational activities on mental health in the last five years.
- Approximately 11% - 15% of persons on the prison has a diagnosis of psychosis. The proportion of prisoners with mental retardation is estimated to be less than 2%. (The country has only one prison).
- Data was not available to estimate the proportion of people who receive social welfare benefits because of disability due to a mental disorder.

#### **4.3 Results – Levels of Collaboration with Mental Health and Other Sectors**

A total of six (6) interviews were conducted with the following agencies Private Sector, Ministry of Education, Social Services Department, Ministry of Social Transformation, Department of Youth and Sports, Prison and themes were explored through these questions:

1. What is the mandate of your Organization? (general and specific to mental health)
2. What is the relationship between your organization's mandate and mental health services?
3. If yes what are the mental health issues impacting on your organization's function?
4. What are the current or planned initiatives/services to address those issues?

5. How were these developed?
6. Is there a role in your organization's portfolio for mental health promotion?
7. Is there a role in your organization's mandate for prevention of mental health problems and mental illnesses?
8. Is there a role in your organization's mandate for planning for national MH services?
9. Have your organization ever been invited to participate in planning for national mental health programs? (If yes give details)
10. Is there a place for intersectoral collaboration for the planning and delivery of mental health services?
11. What would be the benefits?
12. Has there been any collaboration between your organization and any other agencies to address mental health?
13. What are the possible barriers to intersectoral collaboration for mental health?

#### **4.3.1 Private Sector Analysis**

The mandate of the private sector organisation interviewed is "*A sole-enterprise private sector business, offering psycho-therapeutic interventions, training and Employee Assistance Programs services locally and regionally*". This organisation services mainly adolescents and adults.

The private sector organisation identifies a positive relationship between their mandate and mental health services. They identify a *“bi-directional relationship between my business and mental health services”*, giving examples such as referrals for mental health services as part of a medical management of client symptoms, as well as liaisons with psychiatrists across the public and private services. The major mental health issues impacting on the private sector organization’s target group/service recipients are depression and anxiety. *“Most commonly, underlying the experience of depression, seems to be difficult past and present relationships, a history of sexual abuse and complicated loss. Further, more often in the last year, we are seeing more cases of clients with chronic pain issues and other medical complaints that seem to be psychosomatic”*.

The current initiatives/services in place to address the mental health issues being seen by the private sector organization includes, therapeutic interventions, training and EAP services. There are also free seminars periodically offered to the public *“to learn more about depression and anxiety and to have their questions answered”*. These initiatives/services were developed *“based on the observed numbers of clients presenting with depression and anxiety and also because of the correlation that seems to exist between this and medical complaints”*.

Mental health promotion was identified as an important part of this private sector organization’s portfolio. There is an individual role that includes *“empowering people to take health decisions which impact their overall health and well-being”*. On the public level this organisation offers

free education sessions to schools, workplaces and community based groups, they also incorporate mass media including television and print media to address current mental health topics.

This organisation has a very limited role in its mandate for the prevention of mental health problems and mental health illnesses. They however include free screening, education and early intervention on a small scale. In addition they are only involved in planning for national mental health services if invited to serve on a committee.

The private sector organisation suggests that there is a natural place for intersectoral collaboration for the planning and delivery of mental health services because mental health in its nature is global, it affects the whole person; for example on an everyday basis, social and legal and physical well-being etc. *“Therefore conceptually it makes sense that any well-designed and effective mental health services, must be intersectoral by its very nature”*, using seamless integration between the sectors and speaking to each other in ways that benefit the clients and reduces frustration.

The benefits of intersectoral planning include multi-tiered services/approaches paying close attention to prevention, early detection and intervention. The private sector organisation suggests *“there needs to be a strong relationship between mental health services and the education system...a strengthening of the relationship between mental health services and physical health services will help with early detection and brief interventions that may mitigate against more serious mental health disorders later”*. Additional benefits are the reduction in stigma around

mental health issues, diagnosis and treatment; a seamless path to receiving services so that clients can be followed through the system at all levels; potentially avoiding wastage of resources through duplication of efforts. Also, more efforts at prevention may have long term benefits for reducing the health bill overall.

This private sector organization rarely has intersectoral collaboration but when it periodically happens it is with education and training services. The barriers to intersectoral collaboration include stigma and discrimination; lack of sustainable frameworks for these collaborations; lack of understanding of the importance of good mental health to national development.

#### **4.3.2 Social Transformation (Community Development)**

The mandate of this sector is to *“promote, support and facilitate the participation, development and organization of our people in utilizing their resources to effect self- directed change towards the economic, social, cultural, political and spiritual advancement of themselves, their communities and the nation. Social Transformation: To build or enhance local capacities for initiating, implementing and maintaining community programmes and activities towards developing resilient communities”*. The target community is all persons including men, women, boys and girls.

The Ministry identifies a positive relationship between their mandate and mental health services. *“The Ministry is a service oriented organization, our programs and activities are people-*

*cantered, community focused*". Although the clients face various challenges, mental health is significant, presenting with issues such as psychiatric conditions, homelessness, apathy, depression, drug and alcohol abuse. Current initiatives to address these issues include *"targeted public education meetings; improved dialogue with the Ministry of Health and the Mental Wellness Centre; greater efficiency in the administering of the Cast Transfer Grant"* which includes updated medical records, and monitoring with the medical agencies involved. These programmes are developed through the Public Assistance Program (PAP).

The Social Transformation sector does not participate in prevention of mental health problems and mental illnesses. Their mandate speaks specifically to the areas of promotion and protection; which they implement through the use of advanced training and education campaigns. This ministry uses its seat on the Mental Health Committee of the Ministry of Health to participate in the planning for national mental health services.

Being a part of the Mental Health Committee allows a greater opportunity to share and to implement. As such there is a place for intersectoral collaboration for the planning and delivery of mental health services for the Social Transformation sector, by way of Integrated Development Planning initiatives that once noted as a critical component can be integrated into national planning. The benefits of intersectoral collaboration would be an improvement in the monitoring, health statistics, and delivery of care. The representative of the Ministry of Social Transformation identified the Ministry of Health as the only sector with which some level of collaboration exist for mental health service delivery. The barriers to collaboration between the

two sectors include her Ministry's current priorities does not include mental health. The accepted leadership role of the Ministry of Health as the driving force of the process of intersectoral collaboration and the general lack of community engagement and participation are also considered by the respondent as barriers to intersectoral collaboration.

### **4.3.3 Youth and Sports**

The mandate of the Youth and Sports sector is to *“Facilitate the development, coordination, implementation and evaluation of policies, programmes and other initiatives that would empower citizens particularly the youth with unconscious competence in leadership, fitness and wellness and nation building for sustainable global recognition”*. There is a positive relationship between the sector's mandate and mental health services, with issues such psychotic behavior, suicide, depression, substance abuse, abuse, behavioral problems and youth violence presenting. There are no planned programmes to address these issues.

There seems to be a role in the sector's mandate for the promotion of mental health through the implementation of general health and wellbeing programmes, training and capacity building programmes. Although their main mission is to promote high performance in sports, the sector considers that *“this is not possible without positive mental health”*. Their initiatives for fitness and wellness are considered as a preventative measure for mental health problems; however there is no proactive role in the sector's mandate to plan for national mental health services.

There is a place for intersectoral collaboration with the Ministry of Health to address mental health services. The benefits would be the fulfillment of the Youth and Sport sector's mandate of "gaining wellness among the youth population", allowing them to target young people with mental health issues and to address them. There, however, has not been any collaboration with any other agencies to date to address mental health. The barrier to this is lack of multi-sectoral approach to addressing mental health issues.

#### **4.3.4 Education/Pupil Support Services**

The mandate of the Education/Pupil Support Services sector is *"To help foster student's social, emotional, educational and career development"*. There is a definite relationship between this sector's mandate and mental health services; *"In addition to providing career guidance and counselling to students part of our responsibility is to identify, assess and make decisions about their emotional, psychological and behavioural problems"*. In order to ensure proper decision making they also assess the social needs of the clients. Developmental disorders in children and adolescents e.g. Attention Deficit Hyperactivity Disorder, Behavioural Disorders, Substance use, stress related problems and early-onset psychotic disorders are the main disorders affecting the target group for this sector. Services such as counselling and parent education programmes are being implemented and psychiatric and severe behavioural problems are referred to the mental health hospital for assessment and management. These initiatives were developed through internal policy development and programme planning as well as through the implementation of international manuals and established programmes.

There is a role for mental health promotion in this sector's portfolio; however, there are no specific programmes or campaigns to address mental health promotion activities targeting children, adolescents and their families. There is a role also for prevention of mental health problems and mental issues; however there are limited resources to address this issue for children and adolescents. This sector is implementing special supports programmes to vulnerable groups and a programme called 'second step' to address social and emotional development of students.

There is no role for planning for national mental health services. There is no formal intersectoral collaboration but there has been some irregular collaboration between the education/pupil support services sector and the ministry of health. The benefits of collaboration would be implementing national standards/guidelines/protocols for child and adolescent mental health services. Collaboration can also prevent the duplication of efforts and improve the effectiveness of services and efficient use of resources. There is current collaboration with the Wellness Centre to discuss child mental health services at the hospital. The barrier to intersectoral collaboration for mental health is the lack of established national guidelines/protocols for intersectoral collaboration.

#### **4.3.5 Human Services**

The mandate of the Human Services sector is *"to enhance the psychosocial functioning of children, families, older persons, individuals, and other vulnerable groups"*; therefore there is a strong relationship between this mandate and mental health services. The mental health issues seen here are psychotic issues, suicide, self-harming behavior, depressive disorders, substance

abuse, behavioural disorders in children and adolescents. These issues are addressed through *“advocacy, research, counseling and other social work therapeutic intervention strategies, which focus on family preservation and the provision of skills for self-empowerment”*. There are no written national strategies. Cases are dealt with on an individual basis and referrals made to the SLNMC on a needs basis; and capable staff professionals deliver some elements of psychosocial interventions at times. These services were developed through policy based on an increase in national suicides.

Mental health promotion takes place through addressing social and economic factors that impact individuals, using parenting programmes, conflict resolution, and anger management programmes. Mental health prevention takes place by identifying and targeting vulnerable groups such as the elderly, single parents, communities in poverty, children from families with mental health illnesses and the disabled. In terms of having a mandate for planning, *“absolutely, one important area is that of research. My department has over decades kept case notes on all clients, which record important information. Extracting and collating information from files can be an important source of data for predicting trends, for identifying causation factors, for identifying geographical distribution of cases etc.”*

There is a role for and should be collaboration between the Human Services sector and the mental health department and other sectors as this sector is in the same Ministry. The benefits include avoidance of duplication, streamlining of service where needed and proper coordination of individual client services. There has been collaboration in the past but the activities are

undermined due to stigmatization. This sector has inadequate financial allocation for mental health and social services. In addition, there is general understanding that mental health issues are to be addressed by the Ministry of Health.

#### **4.3.6 Correctional Facility**

The mandate of the Bordelais Correctional facility states *“A prison/correctional facility for the confinement and detention of individuals convicted of a crime or awaiting sentencing for a crime”*. There is no direct mention of mental health issues in this mandate. The facility, however, does separate adult offenders with mental disorders. *“The vast majority of prisoners with mental disorders (over 90%) have a diagnosable psychotic disorder. Some have a primary or comorbid seizure or behavioral disorder and many have comorbid substance abuse disorder”*. Notably this facility mentions that there is staff performing dispensing of medications with no training in mental health. The current services to address these issues include two therapeutic quiet rooms used to provide low stimulus environments for agitated patients; specialist mental health care is provided by the primary mental health care team and psychiatrists from the National Mental Wellness Center, they do not participate in rehabilitation or other therapies for mental health inmates. Planned initiatives include the implementation of national strategic planning for the health sector by the Ministry of Health. All mental health policies at this facility are developed internally by the Ministry of Health.

Promotion and prevention of mental health is done through special programmes that are aimed at incarcerated individuals. The Bordelais correctional facility sees a role in their mandate for

planning for national mental health services as they recognize that the needs of persons with serious mental illnesses are different than the needs of other inmates. They suggest that their contribution can come from documentation of issues faced and sharing of information with service planners.

Although there is no intersectoral collaboration with the facility they suggest that research on the mental health needs of the rest of the prison population can also be assessed and used to inform service and programme planning, resulting in programmes that are more responsive to the population, seamless transitions for inmates back into their communities after serving their sentences, and overall better outcomes for the mentally ill. The barriers to intersectoral collaboration suggested by this facility are the *“perception that mental health policies and programmes should be developed by the Ministry of Health only; every sector is preoccupied by their own mandate; competition for scarce resources; the practice of intersectoral collaboration is not a common practice; lack of understanding of mental health issues amongst policy makers and the general public”*.

#### **4.3.7 Mental Health Issues Addressed and Current Services**

The mandates of the organizations that were interviewed vary. The mandates presented are mostly targeting adults, adolescents, and social transformation, youth and sports and education/pupil services directly mention children and/or students and/or adolescents.

While all the organizations consider mental health to have a positive relationship with their mandate, not all mandates directly have mental health as a priority or initiative. The private sector mandate directly engages with mental health issues and describes the relationship as a “bi-directional relationship between my business and mental health services”. Education/pupil support services and Human Services sectors both have clear mandates that relate to addressing mental health issues. The youth and sports sector specifically stands out with a mandate that does not mention mental health directly, but does indicate that ‘wellness’ is a part of their mandate.

The social transformation sector and the Bordelais correctional facility have no mental health purposes indicated in their mandate; this is notable because this sector still identifies mental health as a significant challenge faced by their various clients. The sectors here all see the benefit of participating in mental health initiatives even though some of them do not have direct mandates. It is clear that mental health issues are being presented in all the clients who use the services provided by all the sectors here.

There are a myriad of presenting mental health issues impacting on the target group/service recipients across these sectors. The major issues are depression and anxiety; chronic pain management; substance use/abuse; suicide attempts and suicides; and psychotic disorders. Additional issues noted are developmental disorders, behavioural disorders, self-harming behaviour and stress. Noticeable is the education/pupil services mention of early onset psychotic disorders; pointing to the need for prevention measures as well as monitoring of family history of mental health issues. The private sector mentions the history of sexual abuse as a complicating

factor in current mental health status of some clients as well as an increase in chronic pain and other psychosomatic complaints. The social transformation is the only sector that brings up issues of homelessness and apathy as issues presented by or affecting their various clients. Overall this may suggest that a multi-pronged approach to wellness may enhance the individual as well as the community; by taking information from each sector and applying it to any initiative designed by the Ministry (policy driven) or developed by the sectors based on client needs.

There are six sectors; for five out of the six sectors, any programming that has been developed or implemented – whether planned or current – have been policy driven. The private sector is the only one out of the six that has client based programmes and activities. The private sector has client based initiatives with direct referral and knowledge building from experts and direct client services are provided. The social transformation sector has services that are policy driven with strengthening of existing programmes in the Ministry. They participate in initiatives that provide contribution to poverty reduction and vulnerability, building community resilience. Mental health falls within this so they provide indirect service delivery to people via communities.

Direct client services provided through Ministry programming. The youth and sports sector has policy driven initiatives but currently has no programmes. The education/pupil services has policy driven programming and direct client services using individual and group counselling, parent education and referrals to the hospital for assessment and management. The human services sector uses policy driven initiatives emphasizing collaboration with other Ministries.

They have direct individual services through referrals. The Bordelais correctional facility has direct patient services provided through programming from the Ministry of Health.

The services addressing mental health issues provided by non-health sectors can fall into a few categories – education (public seminars); counselling (individual and group); advocacy and research; and media promotion (print, radio and television interviews).

#### **4.3.8 Roles played within the overall mental health service delivery system (Promotion, Prevention and Planning)**

The private sector plays a very limited/small scale role within the mental health services delivery system. This sector is waiting for a national mandate to proceed so they are presently not involved a lot of prevention or planning. However, they do consider mental health promotion as an important part of their work, empowering on an individual level and educating on a group/community level. The social transformation sector does not participate in the prevention of mental health problems and mental illnesses. Their mandate addresses promotion and protection. They contribute to the mental health services delivery system using advanced training for their officers/staff which will affect their monitoring of clients. This Ministry can promote but cannot intervene directly. It does however, serve on the Mental Health Committee of the Ministry of Health and therefore this gives a greater opportunity to share concerns and to implement decisions taken in the area of planning. The youth and sport sector participates by promoting relevant programmes as they believe high level performance in sport cannot be attained without positive mental health. They see their mandate for prevention played out in the “fitness and wellness for nation building” section. However there is no active planning initiative from the youth and sports sector in the Ministry.

Although there is a role for promotion there are no programmes designed for the education/pupil support sector. There is a role for prevention such as special programmes for vulnerable groups, teaching children and youth to cope with stressful situations can help prevent some mental health issues. Social emotional development of students using a programme called second step is being introduced in schools. This programme deals with emotional regulation, anti- bullying drug use etc. They do not see themselves having any role in planning for mental health.

The human services sector plays a role in the overall mental health service system with such promotional activities as parenting programmes, conflict resolution, and anger management programme. These programmes could be specifically targeted to special groups e.g. the elderly, children from families with substance abuse/mental illnesses etc. to help with prevention. In terms of having a mandate for planning, “absolutely, one important area is that of research. My department has over decades kept case notes on all clients, which record important information. Extracting and collating information from files can be an important source of data for predicting trends, for identifying causation factors, for identifying geographical distribution of cases etc.”

The Bordelais correctional facility participates in the promotion and prevention of mental health issues through special programmes aimed at incarcerated individuals. This sector recognizes that persons with mental illnesses have very different needs from those of the general prison population. Therefore they suggest that they can contribute to national mental health service planning through documentation and the sharing of information with service planners.

#### **4.3.9 Intersectoral collaboration for the planning and delivery of mental health services**

The private sector suggests that” mental health is global and affects every aspect of daily living. It is integral to physical, social, educational, spiritual and legal well-being. Therefore conceptually it makes sense that any well-designed and effective mental health services, must be intersectoral by its very nature. It makes sense to have services that are integrated and seamless between one sector and the other. Services must ‘speak’ to each other in a way that benefits clients and reduces frustration”. There is no collaboration in a systemic manner.

One of the biggest benefits of intersectoral planning and service implementation is to allow services that are multitier - that speak to prevention, early detection and intervention. For example, schools have an important role in education, prevention and early detection. Therefore there needs to be a strong relationship between mental health services and the education system. Also a strengthening of the relationship between mental health services and physical health services will help with early detection and brief interventions that may mitigate against more serious mental health disorders later.

One of the biggest benefits in the local context may be a reduction in stigma and mental health issues, diagnosis and treatment. Intersectoral collaboration also means that there is a seamless path to receiving services so that clients can be followed through the system at all levels. There are potential benefits of avoiding wastage of resources through duplication of efforts. Also, more efforts at prevention may have long term benefits for reducing the health bill overall”

The challenge to collaboration revolves around the need for attitudinal change across the entire society and agencies where there is a built in stigmatization and discrimination of those with mental illnesses as well as a lack of sustainable frameworks for these collaborations; lack of understanding of the importance of good mental health to national development.

There is definitely a place for intersectoral collaboration for the social transformation sector. They have a seat on the Mental Health Committee of the Ministry of Health and they have the Integrated Development Planning which permits it to be added to national planning. The benefits include monitoring of client behaviours, improved health statistics. This unit collaborates closely with the Ministry of Health. The main set back is how community development is ranked in the process of prioritization of Ministry interventions.

The youth and sports sector see themselves collaborating with the Ministry of Health as it would complement the mandate of gaining wellness and fitness. There are no programmes right now as there is a lack of cohesive coherent planning, a lack of multi-sectoral approaches to the planning and delivery of mental health services.

There is no role for planning for national mental health services for the education/pupil support sector. There is limited informal intersectoral collaboration. Benefits are limited as there are no protocols or standards as to mental health services; however, collaboration would prevent duplication of services. A recent collaboration took place with the Wellness Centre having meetings to discuss child mental health services at the hospital – basically to ensure that they

cater for children and adolescents. In general they see the barriers as: lack of leadership in mental health and lack of policy and established national guidelines for intersectoral collaboration. This sector suggests that there needs to be a policy so that education is guided by established procedures.

The human services sector feels that there should be collaboration between mental health department and other sectors especially as this sector is in the same Ministry. The benefits include avoidance of duplication, streamlining of service where needed and proper coordination of individual client services. They have tried collaboration in the past but the activities are undermined due to stigmatization. The department has inadequate financial allocation. In addition, they feel that there is general understanding and acceptance that mental health issues are to be addressed by the Ministry of Health (solely).

The Bordelais correctional facility sees a role for planning, even though they have no collaboration initiatives in place. They see collaboration as a positive activity using research on mental health needs of the prison population to inform service programming and planning with benefits such as enhanced programmes and programme delivery, increased seamless transitions of inmates back into their communities after release. The barriers to intersectoral collaboration suggested by this facility are the “perception that mental health policies and programs should be developed by the Ministry of Health only; every sector is preoccupied by their own mandate; competition for scarce resources; the practice of intersectoral collaboration is not a common practice; lack of understanding of mental health issues amongst policy makers and the general

public”. This facility brings out clearly the range of barriers currently affecting intersectoral collaboration.

## **5 DISCUSSION**

### **5.1 Introduction**

Mental health problems and mental illness very rarely occur in isolation from other medical problems and from related psycho-social problems. This often results in the probability that many people having their issues identified and/or addresses in a non-health sector setting such as education, human services, child protection, social welfare and the criminal justice system amongst others. It therefore stands to reason that improving outcomes for the mentally ill and improving the general wellbeing and quality of life calls for a multi-sector approach to service design and delivery.

This study attempted to highlight that despite the acknowledgement of the benefits of and the need for intersectoral collaboration for better mental health outcomes, very little of this was evident in the mental health service delivery system in Saint Lucia. The results indicate that the stated intent for intersectoral collaboration for mental health service delivery through policy declarations did not necessarily lead to the desired action.

The findings of the three areas of the investigation will now be discussed.

### **5.2 Policy Evaluation**

The directorate of the Ministry of Health recognizing the need to improve the health sector identified mental health as a priority area for action in the national strategic plan. This

necessitated the establishment of a mental health office and the appointment of a national focal person in 2006 for the first time in the country's history. The national mental health policy 2007 was an output of this initiative. This policy document clearly articulated intersectoral collaboration as both a guiding principle/value and a priority are for action.

It is clear that the policy document was a comprehensive one which followed the guidelines set out by the WHO and included all the relevant information and expected policy pronouncements. However an implementation framework which should have clearly spelt out the expected roles and functions of each sector, the leadership and coordination mechanisms, resource identification and allocation was not identified.

The literature on intersectoral collaboration for positive health outcomes identify some critical success factors which were absent in the Saint Lucian context. These include:

- 1) Strong and visionary leadership,
- 2) A clearly articulated vision, shared goals and objectives, and indicators for monitoring progress;
- 3) Permanent and adequately funded organizational structures—ideally situated at the chief executive level, with resources and organizational capacity for collaboration
- 4) Legal mandates and legislated support;
- 5) Robust and resourced community and stakeholder engagement; and

- 6) Conscientious and explicit prioritization of human well-being and development, health, equity, and sustainability as core responsibilities and goals of government (St. Pierre, 2009).

Despite the fact that the process of policy formulation included multi-sector consultations, there is no evidence of the contribution of the different sectors to the final product. The content and tone of the policy document leaves the reader to conclude that the actual writing was facilitated by the mental health directorate and presented to stakeholders, for discussion and possibly validation. This set the stage for the resulting failure to implement any meaningful intersectoral collaborative action.

Even more significant was the fact that the document never established a working definition for the term collaboration such as the one advanced by Mattessich et al that “Collaboration is a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals. The relationship includes a commitment to the relationship and goals; a jointly developed structure and shared responsibility; mutual authority and accountability for success; and sharing of resources and rewards (Mattessich, Murray-Close, & Monsey, 2001). 2001). Collaboration can be further elaborated as “increased trust and decreased turf protection among members who work together to improve each other’s efforts to support and deliver prevention services” (Hays, Hays, & DeVille, 2000).

The adoption of a working definition such as those advanced above could have set the foundation for establishing the required systems and resources for intersectoral collaboration for mental health, which should have commenced at the policy formulation phase, then through to the planning and design of programs and services and ending in successful implementation.

### **5.3 Application of the WHO-AIMS Tool.**

The absence of a sound foundation for intersectoral collaboration through a rigorous policy and implementation framework led to a number of service gaps identified in the results of the application of the WHO-AIMS tool. The findings provides a snapshot of the landscape of the areas considered to be important to intersectoral action by the designers of the tool and thus worthy of measurement. The picture is one in which the formal mental health sector plays a dominant role in service provision, with very little collaborative support from other sectors.

- Legislative and financial provisions

No legislation or financial provisions exist concerning legal obligation for employers to hire a certain percentage of employees with a disability. Neither is there legislation for protection from discrimination solely on the account of mental disorder.

The legislative provisions for housing measured in the tool does not apply to Saint Lucia since the country has no state housing or subsidized housing schemes. A review of the national housing policy for Saint Lucia reveal very little provision for private housing for people with disabilities. The document makes reference to “Institutional and Special Needs Housing” which includes include special education centers; homes for the elderly;

orphanages; poor/relief houses and correctional facilities (Government of Saint Lucia 2008).

The 1978 Constitution of Saint Lucia explicitly states that every person in Saint Lucia is entitled to fundamental rights and freedoms and make provisions for the protection of individuals from discrimination based on sex, race, place of origin, political opinions, colour or creed, however, individuals with “physical or mental disability” are omitted from the definition of “discriminatory” and thereby denied this express protection.

The country has an existing body of legislation which contains some provisions for safeguarding the interest of persons with disabilities. However, they do not specifically address or promote the needs of the mentally ill. Language used in existing legislation that implies inclusion of the mentally ill such as: mental disability, mental incapacity, mental disablement, mental handicap and infirmity of mind are ambiguous and left open to interpretation.

- Formal collaborative programs with other health and non-health agencies/departments. Collaborative programs existed only with health sectors departments. These are all health departments under the prevue of the Ministry of Health, with existing referral systems between mental health and other services. In addition agencies within the Ministry share resources for public education and there are opportunities for joint planning. For example a Health Fair planned by the Ministry will have representation from all departments. The

substance abuse treatment facility is co-located on the same compound as the psychiatric treatment facility and share services and personnel with the mental health facility.

- Links with other sectors: activities.

There is no provision for people with severe mental disorders, through activities outside the mental health facility.

The assessment showed that 0% of schools have designated specialist mental health professionals, however all secondary school employ a Guidance and Counselling Officer, who perform some mental health and social work functions. At the primary school level there are Guidance and Counselling Officers at the district level. No data was provided for the existence of school-based activities to promote mental health and prevent mental disorders.

Within the last five (5) years 0% of judges and lawyers participated in mental health training, however training was conducted for members of the police force.

Mental health services, predominantly medical management for persons with diagnosed mental disorders which is approximately between 11 – 15% of the total prison population. These services are delivered by the primary care mental health personnel. In addition the services of psychiatrists are available to the prison.

People with mental health problems receive welfare benefits available to the rest of the population, through the Ministry of Social Transformation. Receipt of these benefits are

not dependent on people's mental status, but on the department's own means testing procedures.

In 2009 the total WHO-AIMS instrument was applied to Saint Lucia and the findings were submitted in a report. It is worth noting that the findings from this current study and those of the 2009 assessment showed very little difference in the area of intersectoral collaboration. Of significance also is that this report covered the period immediately following the drafting and launch of the first national mental health policy.

In the category of *Legislative and financial provisions for people with mental disorders*, the 2009 report stated that "In the reference year, there were no legislative provisions concerning: a) a legal obligation for employers to hire a certain percentage of employees that are disabled; b) protection from discrimination (dismissal, lower wages) solely on account of mental disorder; c) priority in state housing and in subsidized housing schemes for people with severe mental disorders; and d) protection from discrimination in allocation of housing for people with severe mental disorder."

And under the sub category of *Links with other sectors*, there were no formal collaborative programs that addressed the needs of people with mental health issues between the Ministry of Health and any other department or agency. The 2009 report also concurred with the findings of this new study in the areas of school mental health and mental health in the criminal justice system.

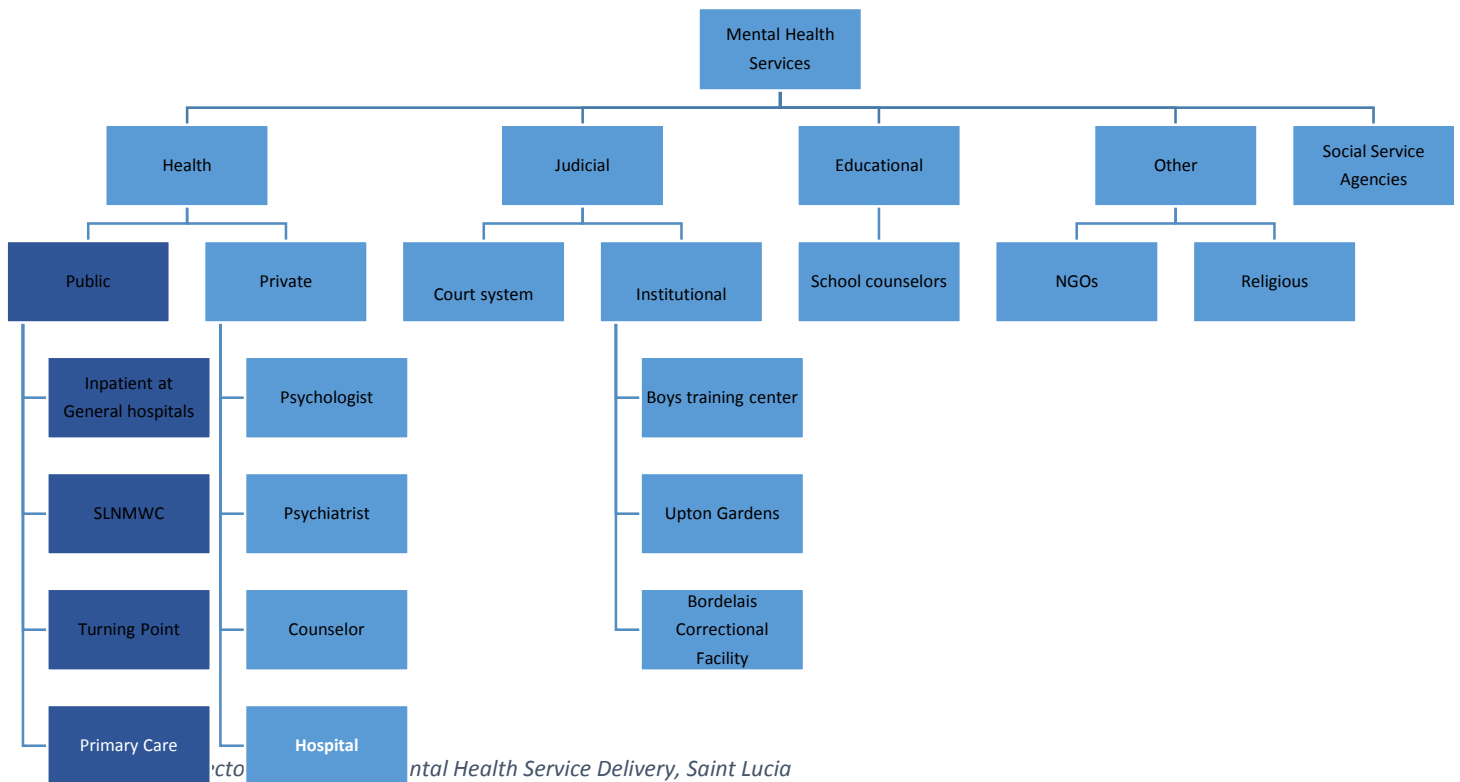
*“None of the primary or secondary schools had either a part-time or full time mental health counsellor. Guidance counsellors were assigned to secondary schools and education districts. There were no school-based activities to promote mental health and prevent mental disorders. The proportion of prisoners with psychosis was estimated at 14%; less than 2% had mental retardation. The single prison had at least one prisoner per month in treatment contact with a mental health professional within the prison. Some police officers (21-50%) and no judges and lawyers participated in educational activities in the last five years” (World Health Organization, 2009).*

The only significant differences in the findings of the two assessments are that in 2009 the report found that persons with serious mental disorders had access to programs which provided employment opportunities outside the mental hospital and there was data on the % of recipients of welfare benefits who qualified solely because of a disability as a result of having a mental disorder. The figure quoted was 2.6%. (World Health Organization, 2009).

#### **5.4 Interviews with Sector Representatives**

There is a general consensus and awareness of increased mental health issues affecting individuals, families and communities in general. This increase is also seen alongside a lack of a comprehensive national mental health system for the nation. The interviews show that the various sectors are developing and implementing policies and programmes that address the mental health issues relevant to their specific mandate. The question still remains as to how much collaboration actually exists between ministries and agencies, and whether there is coordinated strategy to address these issues.

Mental health services in Saint Lucia is delivered through a number of agencies and organizations, both public and private sector. Services range from highly intensive acute inpatient care to less intensive community-based psychosocial interventions and behavioural and psychological interventions.



(Please note, that this not a hierarchical representation of relationships between agencies)

The persons interviewed as part of this study represented the private sector mental health service provider, the Department of Youth and Sports, the Social Services Department, the department of Social Transformation, Corrections and Education. The involvement of non-health sector service providers often necessitates some level of coordination of care which may be difficult, due to multiple bureaucracies and in agencies with sometimes conflicting mandates and priorities.

A number of national sector policies have been developed in recent times and they all subscribe to the principle of multi sector action to meet their mission e.g. “ External agencies, Ministries, national associations.....private sector are all partners in the youth development and sport process” (Ministry of Youth Development and Sports, Saint Lucia, 2012). The exact sentiment in similar language was expressed in the Education Sector Development Plan 2009 -2014. The national housing and resettlement policy used the term “partnering “ and states that *“The mobilisation and harnessing of the combined resources, efforts and initiatives of; public and private sectors, community organizations, civil society and the international community, is essential to housing all citizens. The contribution and commitment of the skills, labour, creativity, knowledge, financial and other resources of all these stakeholders is critical to facilitate an enabling environment to house all citizens”* (Ministry of Housing, Urban Renewal and Local Government, 2008)

A key sector whose mandate includes reducing social inequalities, community development and poverty alleviation falls within the Ministry of Social Transformation. In the ministerial forward to the Social Protection Policy developed in 2015 it was stated that

*“The Government of Saint Lucia recognizes that poverty is a multi- dimensional concept comprising of social, economic and environmental deprivation. Increasing environmental scarcities, risks and vulnerabilities, growing economic uncertainty and inequalities, and the continued existence of high rates of unemployment, are important factors for understanding and addressing poverty in Saint Lucia. Indeed, those who are in need of equitable and integrated*

*Social Protection services include those who are already marginalized through poverty, indigence and lack of access to natural and financial capital, as well as those who are economically and socially vulnerable to marginalization. It is against this backdrop that the Government of Saint Lucia initiated this process to develop a policy that combines Preventative, Protective, Promotive and Transformative measures. A combination of social policy measures and green economy principals can offer an integrated approach for achieving short- and medium-term poverty reduction strategies and long-term sustainable development with multiple benefits in social, economic and environmental spheres”* (Ministry of Social Transformation, Local Government and Community Empowerment, 2015). A lengthy quotation, but very important in articulating the role which intersectoral can play in overall national development.

While all the sectors interviewed seem to understand that there is a need for collaboration, they also identify significant barriers to intersectoral collaboration. Current intersectoral collaborations are limited to failed multi-sector committees (especially with regards to mental health concerns for children/adolescents), and periodical education and training for the case workers. The collaboration has always taken place between the sector and the Ministry of Health, but no sector to sector collaboration. Noticeably the collaboration seems to be driven by national crises such as the spate of increased suicides, and possibly the incidences of youth violence and this collaboration is expected to come from top down policy driven implementations from the Ministry of Health. Two of the persons interviewed indicated their involvement in a mental health committee, however the operational details of this committee were not available.

The challenge to collaboration revolves around the need for attitudinal change across the entire society and agencies where there is a built in stigmatization and discrimination of those with

mental illnesses as well as a lack of sustainable frameworks for these collaborations; lack of understanding of the importance of good mental health to national development amongst policy makers and the general public; preoccupation with singular mandates/unwillingness to expand mandates to address mental health directly . The main factors that would facilitate intersectoral collaboration seem to be buried in the need for attitudinal change, increased financial resources, and successful examples to follow and an overall understanding of the national picture and the roles that even non-health sectors can play in the effective management of mental health.

The perceptions of policy makers affect their understanding of mental health issues and in turn there is an impact, whether positive or negative, on the social and economic situation of the country. The information indicates that a multi-pronged approach to wellness may enhance the individual as well as the community; that by sharing information and creating two-way communication opportunities among the sectors and applying this knowledge to any initiative designed by the Ministry (policy driven) or developed by the sectors (based on client needs), would provide an enhanced national policy that would benefit and promote mental wellness. The analysis shows that both private and public sectors view mental health as an important part of national development. However, there is still a general understanding that mental health problems should be policy driven and directed by the Ministry of Health.

A national approach to the development of mental health policies, programmes and planning would need to have a buy in by all stakeholders as well as an established set of protocols to ensure that sectors know and understand the national picture and their role in achieving the

national standards required or set. The interviews show that most of the sectors believe that there are significant barriers to intersectoral collaboration, which in turn would hinder a national approach. A national approach cannot be achieved without multi-sectoral collaboration. Intersectoral collaboration is not possible if sectors themselves are waiting on top-down driven policy implementation or if the general atmosphere is clouded by stigmatization of mental health illnesses.

## **5.5 Conclusions**

The Declaration of the Alma, the Ottawa Charter for Health Promotion and the Jakarta Declaration all subscribe to an intersectoral approach to public health (and by extension mental health). This approach is based on the premise that good health (physical and mental) is fundamental for a strong economy and vibrant society. Further the relationship between mental health and social and economic factors calls for action from a number of sectors (education, criminal justice, labour etc.). In addition in most instances the health sector does not have the mandate or capacity to make the required policy, systems and environmental actions, which fall within the mandate of other agencies.

Health in all policies is an emerging 21<sup>st</sup> century approach to health care which calls for the collaboration of initiatives across sectors. This approach promotes achieving improvements in the health of a population by incorporating health considerations into decision making, policy formulation and actions across sectors (Rudolph et al 2013). The World Health Organization concludes that “health in all policies emphasizes the consequences of public policies on health determinants” (organization, 2013).

A key element of a population health approach is the recognition that improving health is a shared responsibility. "Intersectoral collaboration" is the joint action among health and other groups to improve health outcomes. A population health approach calls for shared responsibility and accountability for health outcomes with health groups and groups not normally associated with health, but whose activities may have an impact on health or the factors known to influence it. Intersectoral collaboration in a population health approach includes the horizontal management of health issues. Horizontal management identifies common goals among sectoral partners. It then ensures coordinated planning, development and implementation of their related policies, programs and services.

Another key element of a population health approach is the participation of all representative groups in developing strategies to improve health. The approach ensures appropriate opportunities for non-health sector players to have meaningful input into the development of health priorities, strategies and the review of outcomes.

**At the National level,** the goal is to create a climate for improving health by providing coordination and leadership; encouraging collaboration; providing the public and other stakeholders with the information and tools they need; collaborating on an international level to share information; and developing the infrastructure to institutionalize the population health approach

**The role of the Ministry of Health** includes collaborating across ministries and levels of government to develop healthy public policies; developing health goals and accountability frameworks that reflect the population health approach; balancing investments across the health system; and providing regular information to members of the public about health status

**The private sector** can do its part by ensuring that it provides a safe and healthy working environment that has opportunities for continuous learning; that it takes into account its responsibilities for protecting the environment; and that it contributes to the overall well-being of the community,

**At the local level**, communities can focus their energies on developing partnerships that address the determinants of health; planning and providing high-quality services; sharing information and resources designed to maximize health impacts; and involving citizens in setting priorities and implementing programs,

**Civil Society Organizations** usually play an important role in health care by advocating for better services, by forming supportive networks for their membership, by providing complementary services and educating the public on health care issue.

**Individuals**, contribute by taking responsibility for their own health and well-being; actively seeking out the information needed to make informed health decisions; building supportive communities; and participating in community activities that have an impact on health (WHO, 1997).

The principles of intersectoral collaboration in general health is also being applied specifically to the mental health sub-sector in initiatives such as “Mental Health in All Policies” (MhiAP)

Examples of effective interventions to promote population mental health include interventions in local communities, parenting support and home visiting programmes as well as school based programmes. Lessons learned from the promotion of physical health indicate that the road to improved mental health among populations lies less in the investment in late-coming mental health services, but more in a coordinated public mental health programme to implement large-scale promotion and prevention activities (Parkkonen, Campion, & Wahlbeck, 2015).

There is no doubt that the government of Saint Lucia or more specifically the drafters of the 2007 national mental health policy subscribed to the principles outlined for intersectoral collaboration and by extension the modern day principles of MhiAP. However the study reveals a gap between policy pronouncement and action. This suggests that the conditions which facilitate intersectoral collaboration for mental health does not exist in the country.

## **5.6 Recommendations**

Based on the findings of this study it is recommended that the health directorate in Saint Lucia

- Conduct a comprehensive population survey to determine the prevalence of mental health problems and mental disorders and plan appropriate services to match findings.

- Research and address identified barriers to intersectoral collaboration for mental health in order to gain momentum and facilitate planning for national mental health services.
- Create bi-directional/multi-directional communication channels to address learning and education about the mandates, initiatives and programmes/services offered by sectors under the Ministry of Mental Health.
- Educate policy-makers across sectors on the importance of mental health and well-being to overall national development.
- Research and implement where possible the MHiAP approach in non-health sectors, as it seems that this may benefit the development of a comprehensive national mental health system.
- Introduce and integrate small scale intersectoral collaboration at the agency level to make collaboration become a “common practice”, and therefore increase the potential for successful examples of intersectoral collaboration.
- Mental health advocates or the Ministry’s directorate can investigate whether the process of the ongoing constitutional review is still open and recommend that provisions are made that clearly protect the rights and promote the interests and needs of the mentally ill.

- The drafting and revision of existing legislation or in some cases introduce new legislation which will facilitate and support the introduction of mental health initiatives across sectors.

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## **7 APPENDICES**

## 7.1 APPENDIX I - GENERAL INTERVIEW GUIDE

### INTERVIEW GUIDE

1. What is the mandate of your Organization?
2. In your opinion is there a relationship between your organization's mandate and mental health services?
3. If yes what are the mental health issues impacting on the target group/service recipients?
4. What are the current or planned initiatives/services to address those issues?
5. How were these developed?
6. Is there a role in your organization's portfolio for mental health promotion?
7. Is there a role in your organization's mandate for prevention of mental health problems and mental illnesses?
8. Is there a role in your organization's mandate for planning for national MH services?
9. Is there a place for intersectoral collaboration for the planning and delivery of mental health services?
10. What would be the benefits?
11. Has there been any collaboration between your organization and any other agencies to address mental health?
12. What are the possible barriers to intersectoral collaboration for mental health?

### DEFINITIONS

**Mental Health** - A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. (World Health Organization)

**Mental Health Promotion** - Mental health promotion is defined by the World Health Organization as the creation of living conditions and environments that support mental health and allow people to adopt and maintain healthy lifestyles

**Mental Health Prevention** - Mental disorder prevention activities aims at "reducing incidence, prevalence, recurrence of mental disorders, the time spent with symptoms, or the risk condition for a mental illness, preventing or delaying recurrences and also decreasing the impact of illness in the affected person, their families and the society" (Mrazek & Haggerty, 1994).

**Mental Health Problem** - Clinically significant patterns of behaviour or emotions that are associated with some level of distress, suffering or impairment in one or more areas such as school, work, social and family interaction, or the ability to live independently.

**Mental Health Service Delivery System** - All activities whose primary purpose is to promote, restore or maintain mental health and includes all organizations and resources. (WHO).

**Mental Illness** - A medical condition that significantly interferes with an individual's cognitive, emotional and/or social abilities. The diagnosis of mental illness is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD).

**Intersectoral Collaboration** - A recognized relationship between part or parts of different sectors of society which has been formed to take action on an issue to achieve health outcomes or intermediate health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector ...(<http://www.whp-training.eu/?i=whp.en.glossary>)

Formal collaboration in the form of laws, administration, and programmes with (other) health and non-health sectors aimed at improving mental health. (WHO)

## **7.2 APPENDIX II - INVITED GUESTS – NATIONAL POLICY CONSULTATION 2007**

Governor General

Ministers (All Ministries)

Permanent Secretaries (All Ministries)

Aids Action Foundation

Universal Health Care

Bureau of Health Promotion

Chief Medical Officer

Chief Planner

Department Heads

Government Information Service

Principal Information Officer

Members of the Senate

Speaker of the House

Leader and Members of the Opposition

University of the West Indies

School Counsellors

Social Workers

Welfare Officers

Friends of Golden Hope

Golden Hope Staff

Mental Health Association

Help Age International

Probation Officers

St. Lucia Teachers Union

National Youth Council

CAFRA

Red Cross  
National Development Foundation  
Turning Point Staff  
St. Lucia Chamber of Commerce  
Fellowship of Gospel Preaching Churches  
Salvation Army  
St. Lucia Mission of Seventh Day Adventist  
Archbishop Kelvin Felix  
Archbishop Cannon Evelyn (Anglican Church)  
Methodist Church  
Back on Track Ministry  
St. Lucia Civil Service Association  
St. Lucia Bar Association  
St. Lucia Dental and Medical Association  
Private Mental Health Care Providers  
St. Lucia Blind Welfare Association  
National Council of and for Persons with Disabilities  
National Council of and for Older Persons  
Organization of Eastern Caribbean States  
Sir Arthur Lewis Community College  
General Nursing Council of St. Lucia  
National Farmers' Association

## 7.3 APPENDIX III - MENTAL HEALTH COMMITTEE

### Membership/Representation

Mental Wellness Centre  
Ministry of health  
Community Nursing  
Bureau of Health  
Human Services  
Gender Relations  
Substance Abuse Secretariat  
Turning Point  
Social Transformation  
Police  
Min of Education

### **TERMS OF REFERENCE**

The Mental Health Committee will oversee Mental Health Service plans, risks, performance (including financial) & evaluation frameworks.

#### **Purpose**

1. To represent the interests of all persons providing mental health care, including those for whom this is part of their broad scope of practice and those with a special interest or focused practice;
2. To ensure discussion and communication among practitioners and related Associations (Medical and Dental, Nursing);
3. To advocate for sustainable, high quality mental health care provided by physicians, social workers, psychotherapists, occupational therapists, counsellors, policy makers, training programs, and relevant professional organizations.

#### **Responsibilities**

1. To carry out discussions and make recommendations to the Permanent Secretary/Minister on the following areas:
  - a. Communications and networking among members involved in mental health care;
  - b. Development/review of policies and/or positions related to patient care and the practice needs/environment of members involved in mental health care;
  - c. Advocacy on behalf of the members involved in mental health care
  - d. Identification of area in need of accredited programs related to mental health care;
  - e. Review and implementation of Model of Care;
  - f. Review of Mental Health Bills and other related policy documents;
2. To be a resource to medical students, interested groups and family members and recipients of care in the mental health services;

## 8 LIST OF ABBREVIATIONS

GDP	Gross Domestic Product
GOSL	Government of Saint Lucia
MHiAP	Mental Health in All Policies
PAHO	Pan American Health Organization
SLNMWC	Saint Lucia National Mental Wellness Center
UNDP	United Nations Development Program
WHO	World Health Organization
XCD	Eastern Caribbean Dollar