6th REPORT OF THE

JOINT SELECT COMMITTEE ON

SOCIAL SERVICES AND PUBLIC ADMINISTRATION

ON AN

INQUIRY INTO MENTAL HEALTH AND WELLNESS SERVICES AND FACILITIES IN TRINIDAD AND TOBAGO

SIXTH REPORT

Of the

JOINT SELECT COMMITTEE ON SOCIAL SERVICES AND PUBLIC ADMINISTRATION

ON AN

INQUIRY INTO MENTAL HEALTH AND WELLNESS SERVICES AND FACILITIES IN TRINIDAD AND TOBAGO

Date Laid: HoR: 23.11.18 Senate: 20.11.18


The Joint Select Committee on Social Services and Public Administration

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THE COMMITTEE

CHAIRMAN

Mr. Esmond Forde, MP
VICE-CHAIRMAN

Mrs. Glenda Jennings-Smith, MP
MEMBER

Brig. Gen. (Ret.) Ancil Antoine, MP
MEMBER

Mrs. Christine Newallo-Hosein, MP
MEMBER

Mr. Rohan Sinanan
MEMBER

Ms. Khadijah Ameen
MEMBER

Ms. Allyson West
MEMBER

1 Former Senator Dr. Dhanayshar Mahabir served as chairman of the Committee from December 2015 to September 2018
Committee Mandate and Establishment

1.1 Section 66 of the Constitution of Trinidad and Tobago declares, that not later than three months after the first meeting of the House of Representatives, the Parliament shall appoint Joint Select Committees to inquire into and report to both Houses in respect of Government Ministries, Municipal Corporations, Statutory Authorities, State Enterprises and Service Commissions, in relation to their administration, the manner of exercise of their powers, their methods of functioning and any criteria adopted by them in the exercise of their powers and functions.

1.2 Motions related to this purpose were passed in the House of Representatives and Senate on November 13th, and 17th, 2015, respectively, and thereby established, inter alia, the Joint Select Committee on Social Services and Public Administration.

1.3 Standing Order 91 of the Senate and 101 of the House of Representatives outline the general functions of a Committee of this nature. They are as follows:

a) “To examine Bills and review all legislation relating to the relevant Ministries, departments or bodies or as may be referred to it by the House;

b) To investigate, inquire into, and report on all matters relating to the mandate, management, activities, administration and operations of the assigned Ministries, departments or bodies;

c) To study the programme and policy objectives of Ministries, departments or bodies and the effectiveness of the implementation of such programmes and policy objectives;

d) To assess and monitor the performance of Ministries, Departments and bodies and the manner of the exercise of their powers;

e) To investigate and inquire into all matters relating to the assigned Ministries, Departments and bodies as they may deem necessary, or as may be referred to them by the House or a Minister; and
f) To make reports and recommendations to the House as often as possible, including recommendations for proposed legislation.”

Powers of the Joint Select Committee

1.4 Standing Orders 101 of the Senate and 111 of the House of Representatives outline the core powers of the Committee which include *inter alia*:

- to send for persons, papers and records;
- to sit notwithstanding any adjournment of the Senate;
- to adjourn from place to place;
- to report from time to time;
- to appoint specialist advisers either to supply information which is not otherwise readily available, or to elucidate matters of complexity within the Committee's or Sub-Committee's order of reference;
- to communicate with any Committee of Parliament on matters of common interest; and
- to meet concurrently with any other Committee for the purpose of deliberating, taking evidence or considering draft reports.

Membership

1.5 The Committee comprises the following members:

1. Dr. Dhanayshar Mahabir\(^2\) Chairman
2. Mr. Esmond Forde, MP Member
3. Mrs. Glenda Jennings-Smith, MP Member
4. Brig. Gen. (Ret.) Ancil Antoine, MP Member
5. Mrs. Christine Newallo-Hosein, MP Member
6. Mr. Rohan Sinanan Member
7. Ms. Khadijah Ameen Member
8. Ms. Allyson West Member

\(^2\) Former Senator Dr. Dhanayshar Mahabir served as chairman of the Committee from December 2015 to September 2018
Secretariat Support

1.6 The following officers were assigned to assist the Committee:

1. Mr. Julien Ogilvie - Secretary
2. Mr. Johnson Greenidge - Assistant Secretary
3. Ms. Ashaki Alexis - Graduate Research Assistant
# TABLE OF CONTENTS

Committee Mandate and Establishment ........................................................................... iv
Powers of the Joint Select Committee ............................................................................ v
Membership ................................................................................................................ v
Secretariat Support ........................................................................................................ vi
TABLE OF CONTENTS ................................................................................................... vii
ABBREVIATIONS .......................................................................................................... ix
LIST OF TABLES AND FIGURES .................................................................................... 10
TABLE OF APPENDICES ................................................................................................ 111
EXECUTIVE SUMMARY ............................................................................................... 122
SUMMARY OF RECOMMENDATIONS ........................................................................... 155
INTRODUCTION ............................................................................................................ 19
Background .................................................................................................................. 19
Conduct of the Inquiry ................................................................................................. 244
KEY ISSUES, FINDINGS, AND RECOMMENDATIONS ................................................ 266

**OBJECTIVE 1:** To determine the prevalence of mental illness and abnormalities in Trinidad and Tobago ........................................................................................................ 266

FINDINGS AND RECOMMENDATIONS ........................................................................ 333
Findings ....................................................................................................................... 333
Recommendations ....................................................................................................... 344

**OBJECTIVE 2:** To assess the adequacy of services and facilities available to support mental health and well-being. .................................................................................. 377

FINDINGS AND RECOMMENDATIONS ........................................................................ 544
Findings ....................................................................................................................... 544
Recommendations ....................................................................................................... 577

**OBJECTIVE 3:** To determine the adequacy of the medical practitioners who specialize in mental health care and wellness .................................................................................. 609

FINDINGS AND RECOMMENDATIONS ........................................................................ 69
Findings ....................................................................................................................... 69
Recommendations ....................................................................................................... 702
OBJECTIVE 4: To assess the adequacy of the legislative framework that governs mental health

FINDINGS AND RECOMMENDATIONS

Findings

Recommendations

Appendix I

Appendix II

Appendix III

Appendix IV

Appendix V

Appendix VI

Appendix VII

Appendix VIII

Appendix IX

Appendix X

Appendix XI

Appendix XII

Appendix XIII

Appendix XIV

Appendix XV

Appendix XVI

Appendix XVII

Appendix XVIII
## ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
</tr>
<tr>
<td>CARPHA</td>
<td>Caribbean Public Health Agency</td>
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<tr>
<td>CDAP</td>
<td>Chronic Disease Assistance Programme</td>
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<tr>
<td>CMO</td>
<td>Chief Medical Officer</td>
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<tr>
<td>MH</td>
<td>Mental Health</td>
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<tr>
<td>MHGAP</td>
<td>Mental Health Gap Action Programme</td>
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<td>MHIS</td>
<td>Mental Health Institutional Services</td>
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<td>MHP</td>
<td>Mental Health Programme</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>NCPD</td>
<td>National Centre for Persons with Disabilities</td>
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<td>NWRHA</td>
<td>North-West Regional Health Authority</td>
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<tr>
<td>OCD</td>
<td>Obsessive Compulsive Disorder</td>
</tr>
<tr>
<td>OPPA</td>
<td>Offences Against the Person Act</td>
</tr>
<tr>
<td>RHA</td>
<td>Regional Health Authority</td>
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<tr>
<td>SAMHSA</td>
<td>Substance Abuse and Mental Health Services Administration</td>
</tr>
<tr>
<td>SFGH</td>
<td>San Fernando General Hospital</td>
</tr>
<tr>
<td>SMO</td>
<td>Specialist Medical Officer</td>
</tr>
<tr>
<td>SWRHA</td>
<td>South-West Regional Health Authority</td>
</tr>
<tr>
<td>T&amp;TAMH</td>
<td>T&amp;T Association for Mental Health</td>
</tr>
<tr>
<td>TRHA</td>
<td>Tobago Regional Health Authority</td>
</tr>
<tr>
<td>TTAP</td>
<td>Trinidad and Tobago Association of Psychologists</td>
</tr>
<tr>
<td>TTRNA</td>
<td>Trinidad and Tobago Registered Nurses Association</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
LIST OF TABLES AND FIGURES

Table 1: Main types of mental illness to which children and adolescents are pre-disposed ........................................ 30
Table 2: DSM-5 Clinical Primary Diagnoses of New Patients At Child Guidance Clinic (South) Jan-Dec 2016 .................................................................................................................... 31
Table 5: Aggregate information on staffing at the St Ann’s Psychiatric Hospital .......................................................... 38
Table 8: Number of patients’ admissions regions outside of NWRHA for the period 2015-2016 ..................................... 40
Figure 1: School-based system of referral .................................................................................................................. 45
Table 10: Doctor-to-patient ratio in mental health wards located in public hospitals (i.e. not including the St. Ann’s Psychiatric Hospital) ........................................................................... 62
Table 12: The “qualified persons” that were engaged to design the training programme ............................................. 68
Table 3: Age group of children recorded by the Children’s Authority with mental disorders/illnesses .................. 315
Table 4: Disaggregated data provide by the Children’s Authority on prevalence of mental illnesses amongst children and adolescents ........................................................................................................ 315
Table 6: Admission to Mental Health Facilities for 2016 ................................................................................................. 317
Table 7: Psychiatric Outpatient Clinic Attendance for the period 2016 .................................................................... 317
Figure 2: THE process to be followed by all parties involved in the student re-integration process ......................... 322
Table 9: BREAKDOWN OF STAFF AT ST. ANN’S HOSPITAL .................................................................................. 326
Table 11: COSTAATT’s intake and the graduating figure for Psychiatric Nursing for the period 2014-2016 ............... 333
Table 13: Placement of Children with Mental Illness in Alternative Care ................................................................. 343
Table 14: Placement of Children with Mental Illness in Non-Alternative Care ............................................................. 344
# TABLE OF APPENDICES

<table>
<thead>
<tr>
<th>APPENDICES</th>
<th>Page #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix I: list of names and positions of persons who appeared before the Committee</td>
<td>79-82</td>
</tr>
<tr>
<td>Appendix II: Site Visit Report to the St. Ann’s Psychiatric Hospital</td>
<td>83-102</td>
</tr>
<tr>
<td>Appendix III: Minutes of the Fourteenth Meeting of the Joint Select Committee on Social Services and Public Administration</td>
<td>103-119</td>
</tr>
<tr>
<td>Appendix IV: Minutes of the Fifteenth Meeting of the Joint Select Committee on Social Services and Public Administration</td>
<td>120-134</td>
</tr>
<tr>
<td>Appendix V: Minutes of the Eighteenth Meeting of the Joint Select Committee on Social Services and Public Administration</td>
<td>135-149</td>
</tr>
<tr>
<td>Appendix VI: Excerpt of Verbatim Notes of the Fourteenth Meeting of the Joint Select Committee on Social Services and Public Administration</td>
<td>150-194</td>
</tr>
<tr>
<td>Appendix VII: Excerpt of Verbatim Notes of the Fifteenth Meeting of the Joint Select Committee on Social Services and Public Administration</td>
<td>195-256</td>
</tr>
<tr>
<td>Appendix VIII: Excerpt of Verbatim Notes of the Eighteenth Meeting of the Joint Select Committee on Social Services And Public Administration</td>
<td>257-313</td>
</tr>
<tr>
<td>Appendix IX: Disaggregated data on children recorded by the Children’s Authority with mental disorders/illnesses</td>
<td>314-315</td>
</tr>
<tr>
<td>Appendix X: Total number of patients admitted at St. Ann’s Hospital for 2015-2016</td>
<td>316-318</td>
</tr>
<tr>
<td>Appendix XI: The organisational chart of the Psychiatric Unit of the Scarborough General Hospital</td>
<td>319-320</td>
</tr>
<tr>
<td>Appendix XII: The process to be followed by all parties involved in the student re-integration process</td>
<td>321-324</td>
</tr>
<tr>
<td>Appendix XIII: Breakdown of staff at the St. Ann’s Psychiatric Hospital</td>
<td>325-328</td>
</tr>
<tr>
<td>Appendix XIV: Costaatt intake and the graduating figure for Psychiatric Nursing within the last three years</td>
<td>329-331</td>
</tr>
<tr>
<td>Appendix XV: Training offered by the Student Support Services Department</td>
<td>332-333</td>
</tr>
<tr>
<td>Appendix XVI: Interventions provided by the Children’s Authority for children for whom placement into mental health facilities is not required</td>
<td>334-335</td>
</tr>
<tr>
<td>Appendix XVII: Placement of Children with Mental Illness by the Children’s Authority</td>
<td>336-341</td>
</tr>
<tr>
<td>Appendix XVIII: Placement of Children with Mental Illness by the Children’s Authority</td>
<td>342-345</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

2.1 At its ninth meeting held on Wednesday 19 April 2017, the Committee resolved to inquire into mental health and wellness services and facilities in Trinidad and Tobago.

The Committee agreed on the following inquiry objectives:

1. To determine the prevalence of mental illness and abnormalities in Trinidad and Tobago;

2. To assess the adequacy of services and facilities available to support mental health and well-being;

3. To determine the adequacy of the medical practitioners who specialize in mental health care and wellness; and

4. To assess the adequacy of the legislative framework which governs mental health.

2.2 The Committee acquired both oral and written evidence based on the above objectives. Oral evidence was received during three public hearings held with various stakeholders on Wednesday 15 May, 2017, Wednesday 07 June, 2017 and Wednesday 15 November, 2017 respectively. A site visit was also paid to the St. Ann’s Psychiatric Hospital on June 28th 2017.

Among the significant issues that are addressed in this report are:

a. Trinidad and Tobago is ranked the third highest in the Caribbean with respect to the prevalence of mental illness;

b. The detection of mental illnesses/disorder and the availability/accessibility of services and treatment are the two major issues concerning mental health in Trinidad and Tobago;

c. The adverse effects of the prevailing stigma associated with seeking and utilising mental health services;

d. Depression as one of the most prevalent types of mental illness amongst children/adolescents and adults;

e. The increased susceptibility of victims of childhood sexual abuse to developing and experiencing mental disorders and illnesses;

f. The high probability of an increase in mental illness in Trinidad and Tobago due to social stressors;
g. The hereditary nature of some Mental illnesses and disorders;

h. Lack of data and statistics on the prevalence and type of mental illnesses and disorders in Trinidad and Tobago;

i. The need for additional psychiatrists and psychologists in medical institutions and the shortage of psychiatric nurses employed within various medical health facilities;

j. Lack of sensitization programmes on mental health illnesses;

k. Lack of training offered to police officers to appropriately deal with persons who are mentally-ill;

l. The need for greater collaboration between Community Police and Mental Health Officers with reference to section 15 (1) of the Mental Health Act;

m. The need for the establishment of decanting facilities for out-patients;

n. The absence of Extended Care Centres (ECC) in the North-West Region to supplement the 2 ECCs under the SWRHA;

o. The paucity of drugs available under the Chronic Disease Assistance Programme (CDAP) for treating mental illnesses;

p. The reliance on medication and the absence of therapeutic methods in the treatment of persons with mental illnesses and disorders at mental health facilities;

q. The need for the implementation of a monitoring mechanism for mentally-ill patients outside mental health facilities;

r. The inadequacy of the current nurse-to-patient ratio in mental health care facilities, which has resulted in the need for an increase in nursing positions/posts;

s. The absence of a fully operational 24 hour suicide prevention hotline;

t. Limited specialized training in psychological nursing care;

u. The absence of
   
   o a children/adolescent ward at the St Ann’s Psychiatric Hospital
   
   o facilities for the daily treatment of children and adolescents with mental disorders and illnesses;

v. The need for more preventative interventions in schools in relation to mental health;

w. The low level of enrolment in mental health nursing programmes;

x. The need for the establishment and implementation of a proper discharge plan for mentally-ill patients;
y. The large number of patients (1000) currently residing and undergoing treatment at the St. Ann’s Psychiatric Hospital;
z. The lack of job opportunities available to psychologists;

aa. The absence of a register of practicing psychologists;

bb. The need for more awareness programmes and initiatives concerning Alzheimer's disease in order to facilitate early assessment and treatment;

cc. The challenge faced by the MoH with inadequate data as a result of privacy restrictions and the unwillingness of parents to report children who display symptoms of mental illness;

dd. The persisting need for additional resources for the improvement of mental health services offered to children and adolescents;

ee. The need to specifically identify the various types of mental illness which confront the student population and to address the inappropriate labelling of mentally challenged children;

ff. Bullying and preparations for examinations as contributing factors to stress and other mental health challenges confronting students;

gg. The need to review the providers of the various forms of clinical interventions delivered to children and adolescents;

hh. The need to better understand the dynamics and underlying challenges encountered by the parents and caregivers of children faced with mental challenges; and

ii. The inability to adequately manage and treat the number of children living with mental illnesses.

2.3 Based on these foregoing issues which emanated from the Committee’s examination of the subject, the Committee has offered recommendations which we believe will address the issues highlighted. A summary of these recommendations follows this Executive Summary.

2.4 The Committee looks forward to reviewing the Minister’s response to this Report, which becomes due sixty (60) days after the Report is presented to the Houses of Parliament.
SUMMARY OF RECOMMENDATIONS

RECOMMENDATIONS FOR IMPLEMENTATION IN THE SHORT-TERM

(To be implemented within 3 to 6 months of the presentation of the report)

A. That the MoH’s response to this report include an update on the implementation of a suicide surveillance system;

B. That MoH’s Mental Health Unit and TTRNA provide an outline of their respective proposals which aim to counteract or alleviate the apparent increase in mental illness/disorders. The Committee requests that these proposals should include details on the roles of each Ministry and the professionals in the field in this collaborative effort;

C. To augment the components of the MoH’s undocumented “Mental Health Plan”, the Committee requests that a policy document on the dispensation of mental health services to minors and adolescents be formulated within the first quarter of 2019. It is recommended that this policy document should inter alia:
   - Inform amendments to the Mental Health Act, the Children Act, Children’s Authority Act and any other relevant law;
   - Guide the development and expansion of facilities to provide mental health care to this cohort;
   - Guide the strategy for the development of human resources necessary for the treatment of minors and adolescents;
   - Promote the application of internationally accepted standards in the administration and dispensing of mental health care services for the cohort; and
   - Guide the collection of data by the relevant stakeholders on mental health issues pertaining to children and adolescents.

D. Through the application of ICT systems, the patient records at all facilities which provide mental health care services should be recorded electronically. A report on the critical requirements for the successful execution of such a project should be included in the Ministerial Response of the MoH;
E. That an objective assessment of the performance of the Mental Health Unit of the Ministry of Health must be undertaken. In the Ministerial Response to this report, the MoH should provide the Parliament with details on the short and medium-term objectives of this unit;

F. A system/method to record the activities of Mental Health Officers in relation to Section 15 (1) of the Mental Health Act must be instituted within fourth (4) months of the presentation of this report;

G. An action plan for attending to the shortcomings at the St. Ann’s Hospital which were identified by the Committee during its site should be produced by the Ministry of Health within three months of the presentation of this report to the Houses of Parliament;

H. That written guidelines and protocols be developed in relation to the tracking and monitoring of mentally-ill patients who were discharged from mental health care facilities;

I. That the MoH engages the Ministry of National Security and the Regional Corporations in establishing programmes to train emergency and first responders to handle the mentally-ill persons in the event of a disaster;

J. That the MoH provide the Parliament with an update on the implantation of the “New model of Mental Health Care” that the MoH anticipated to implement by the end of fiscal year 2018;

K. In the Ministerial Response, the MoH must advise the Parliament on the number of post-graduate government scholarships that were awarded in the areas of psychiatry and psychology in fiscal 2017/2018 and the number of scholarships proposed to be awarded in the next fiscal;

L. That an incentive scheme be developed to induce persons to select this specialist area of Nursing as a career;

M. That the TTAP collaborate with the MoH with a view to developing a framework for the partial or complete regulation of practicing Psychologists;

N. That there be a better multidisciplinary integration of treatment to create established protocols for care. The roles and relationships between professionals within the mental health field must be recognized and standardized i.e. nurses, mental health officers, social workers, occupational therapists, speech pathologists, psychiatrists, psychologists etc. The MoH must produce a single brochure or suitable publication to enlighten the public about the distinction in the roles of these professionals. This should be completed within 60 days of the publication of this report; and
O. Section 30 (2) of the Children’s Authority Act (Chapter 46:10) should be amended to include a stipulated timeframe for the submission of “reports of the child’s mental status”.

RECOMMENDATIONS FOR IMPLEMENTATION IN THE MEDIUM-TERM
(To be implemented within 7 months to 12 months of the presentation of the report)

I. That the MoH collaborate with the network of public and private mental health care establishments (including the RHAs and outpatient care centres) to develop a robust system to collect data/statistics on the mentally-ill and mental illnesses in Trinidad and Tobago;

II. The existing curriculum or course content for the MSc Clinical Psychology programme offered by the University of the West Indies (St. Augustine) should be assessed to ensure that the knowledge and training that is being provided to students are aligned with the needs of the society;

III. That the training of School Guidance Counsellors and Social Workers be augmented to assist in the early detection of at-risk children;

IV. That the Ministry of Education and the MoH collaborate to design a digital manual/guidebook for teaching staff to aide them to effectively identify and provide a basic response to children and adolescents with mental illnesses;

V. That patient records at the St. Ann’s Psychiatric Hospital be digitized;

VI. That consideration be given to establishing separate units/wards at public hospitals dedicated for the treatment of children/minors with mental disorders;

VII. That a CCTV Camera system be installed at the St Ann’s Hospital as a means of bolstering the security surveillance system at the hospital;

VIII. The Committee recommends that a review of the existing suite of children’s legislation and the Mental Health Act be conducted to ensure that adequate provisions are made to treat with the complex legal issues which arise out of the diagnosis, treatment and accommodation of children who are mentally-ill or subnormal; and

IX. That consultations with stakeholders on the proposed amendments to the Mental Health Act be initiated and the final amendments be submitted for the consideration of the Parliament by the second quarter of 2019.
RECOMMENDATIONS FOR IMPLEMENTATION IN THE LONG-TERM
(To be implemented within 2 years of the presentation of the report)

I. That the MoH sustain and enhance its public awareness initiatives/programmes which have assisted in educating the population on matters associated with mental health;

II. That MoE place greater focus on enlightening the school population on some of the negative stereotypes that are associated with mental health and how they can be dismantled;

III. Information on the process involved in accessing treatment at the various public health care facilities should be widely circulated and easily accessible.

IV. The MoH should collaborate with the Ministry of Social Development and Family Services to support the work of the NGOs that are involved in providing care and support to persons with mental illnesses/disorders;

V. That therapy be practiced more extensively in the treatment of the mental ill as a means of complementing pharmacological interventions;

VI. To reduce the probability of replication of efforts and/or the inefficient allocation of resources, the management of the Student Support Services Division (MoE) and the managers of Child Guidance Clinics should collaborate on a continuous basis with respect to delivering mental health services to children in a more expeditious manner;

VII. That persons over the age of 65 years undergo periodic screening for Alzheimer’s disease and dementia as allegedly occurs in the UK;

VIII. Support to women who may be experiencing post-partum depression and other maternity-related mental illnesses should be incorporated within the ambit of post-natal care provided at public health care facilities; and

IX. That professional medical treatment for the mentally-ill should be supplemented by alternative treatments including art therapy, music and drama therapy, and animal therapy.
INTRODUCTION

Background

Mental Health

3.1. Mental health includes our emotional, psychological and social well-being. It affects how we think, feel and act as we cope with life’s challenges. Furthermore, it helps determine how we handle stress, relate to others, and make choices. Mental health is a level of psychological well-being, or an absence of mental illness. It is the "psychological state of someone who is functioning at a satisfactory level of emotional and behavioural adjustment". According to the World Health Organization (WHO), mental health includes:

- subjective well-being;
- perceived self-efficacy;
- autonomy;
- competence;
- inter-generational dependence; and
- Self-actualization of one's intellectual and emotional potential.

3.2. The WHO further states that the well-being of an individual is encompassed in the realization of their abilities, coping with normal stresses of life, productive work and contribution to their community. According to the U.S. Surgeon General (1999), mental health is the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and cope with adversity. The term mental illness refers collectively to all diagnosable mental disorders—health conditions characterized by alterations in thinking, mood, or behaviour associated with distress or impaired functioning.

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3 http://wordnetweb.princeton.edu/perl/webwn?s=mental+health&sub=Search+WordNet
Mental Illness

3.3. According to the *Britannica Concise Encyclopaedia*, 'mental illness' refers to "any illness with a psychological origin, manifested either in symptoms of emotional distress or abnormal behaviour. Most mental disorders can be broadly classified as either psychoses or neuroses. Psychoses (e.g., schizophrenia and bipolar disorder) are major mental illnesses characterized by severe symptoms such as delusions, hallucinations, and an inability to evaluate reality in an objective manner. Neuroses are less severe and more treatable illnesses, including depression, anxiety, and paranoia as well as obsessive-compulsive disorders and post-traumatic stress disorders. Schizophrenia appears to be partly caused by inherited genetic factors. Neuroses often appear to be caused by psychological factors such as emotional deprivation, frustration, or abuse during childhood, and they may be treated through psychotherapy."

3.4. A person struggling with his or her mental health may experience stress, depression, anxiety, relationship problems, grief, addiction, ADHD or learning disabilities, mood disorders, or other mental illnesses of varying degrees. Mental health problems are a growing public health concern and is becoming prevalent around the world.

Mental health and illnesses in Trinidad and Tobago

3.5. Section 2 of the Mental Health Act 1975 defines “mental disorder” as mental illness, arrested or incomplete development of mind and “mentally disordered” shall be construed accordingly.

3.6. The Act also includes the following interpretations:

- “mental illness” means the condition of mind of a mentally-ill person;

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7 Accessed on April 18, 2017. [https://psicovalero.files.wordpress.com/2014/06/dsm-v-manual-diagn3bstico-y-estadc3adstico-de-los-trastornos-mentales.pdf](https://psicovalero.files.wordpress.com/2014/06/dsm-v-manual-diagn3bstico-y-estadc3adstico-de-los-trastornos-mentales.pdf)

8 ADHD, or attention deficit hyperactivity disorder, is a medical condition that affects how well someone can sit still, focus, and pay attention. People with ADHD have differences in the parts of their brains that control attention and activity. This means that they may have trouble focusing on some tasks and subjects.


“mentally-ill” or “mentally-ill person” means a person who is suffering from such a disorder of mind that he requires care, supervision, treatment and control, or any of them, for his own protection or welfare or for the protection or welfare of others; and

“mentally subnormal” or “mentally subnormal person” means a person in whom there is a condition of arrested or incomplete development of mind whether such condition arises from inherent causes or is induced by disease or injury before such person attains the age of eighteen years and includes a person who requires care, supervision, treatment and control, or any of them, for his own protection or welfare or for the protection or welfare of others.

3.7. In 2012, the then Minister of Health issued a statement in observance of World Mental Health Day. The statement indicated that “approximately one quarter of our population, or 1 in 4 persons, is afflicted by mental illness. Mood disorders such as depression account for 30% of the reported cases of mental illness in Trinidad and Tobago. The last Global School Health Survey (2007) conducted in Trinidad and Tobago revealed that 21.5% of students felt sad or hopeless almost every day to the extent that they stopped participating in their usual activities. Moreover, the survey also indicated that female students were more likely than males to be affected by mental health issues, with 21.5% of females and 14.1% of males reporting that they seriously considered committing suicide during the 12 months before the survey.13"

3.8. The country’s main mental health issues have been identified as schizophrenia, mood/affective disorders (e.g., depression), mental and behavioural disorders (e.g., suicides), and substance abuse. Furthermore, high rates of depression have been reported in studies on adolescents and some communities.14

Policy and legislative framework

3.9. The Mental Health Act15 is the primary legislation which treats with mental health care. This legislation focuses on the following components:

1. Access to mental health care including access to the least restrictive care;
2. Organization of services: developing community mental health services;
3. Organization of services: downsizing the large mental hospital;
4. Organization of services: reforming mental hospitals to provide more Comprehensive care;
5. Human resources;
6. Involvement of users and families;
7. Advocacy and promotion;
8. Human rights protection of users;
9. Equity of access to mental health services across different groups;
10. Financing;
11. Quality improvement; and
12. Monitoring system.

**Mental health care systems in Trinidad and Tobago**

*Ministry of Health (MoH)*

3.10. Mental health services are governed by the Ministry of Health and organized in terms of catchments/service areas.

*Mental Health Unit*

3.11. The MoH’s Mental Health Programme is actually a focused intervention for achieving a specific, often short-term goal. An integral component of the MHP is the ‘mental health plan’. This is a more detailed pre-formulated scheme for implementing strategic actions. The policies and plans within the programme are engineered to improve the quality of services, accessibility, community care, the participation of consumers and families and the mental health level of citizens of Trinidad and Tobago.

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Mental Hospitals

3.12. The **St Ann’s Psychiatric Hospital** is the only tertiary level psychiatric hospital in the country. It currently occupies 125 acres of land and has over 784 beds. The patients admitted to this mental hospital belong primarily to the following two (2) groups: schizophrenia (and related disorders) and mood disorders.

Day Treatment Facilities

3.13. There are three (3) day treatment facilities available in the following Regional Health Authorities (RHAs): NWRHA, SWRHA and TRHA.

Mental Health Outpatient Facilities

3.14. According to the WHO-AIMS Report on the Mental Health System of this country, there are thirty-one (31) outpatient mental health facilities in Trinidad and Tobago, of which one (1) facility is for children and adolescents only. Thirteen (13) out of the thirty-one (31) mental health facilities have beds for inpatient care\(^\text{19}\).

Community-Based Psychiatric Inpatients Units

3.15. There are two community-based psychiatric inpatients units (SWRHA and TRHA) available in the country for a total of 0.2 beds per 100,000 population. None of the beds in community-based inpatient units are reserved only for children or adolescents.

Community Residential Facilities

3.16. There are eight (8) community residential facilities available in the country for a total of fourteen point nine (14.9) beds/places per 100,000 population. Thirty (30) of the beds in community residential facilities are reserved for children or adolescents only. Four percent (4\%) of users treated in community residential facilities are children. In 2007 the number of users in community residential facilities were one hundred and sixty one (161). The community residential facilities are part of an NGO initiative.

Estimates for the amount allocated to the NWRHA in particular St. Ann’s Psychiatric Hospital

3.17. MoH provides a monthly subvention of $10,000.00 dollars to the Trinidad and Tobago Association for Mental Health to assist with its operations.\textsuperscript{20}

3.18. According to the Estimates of Expenditure 2017\textsuperscript{21}, the following was allocated to the North West Regional Health Authority (NWRHA) including St Ann’s Psychiatric Hospital:

- 2015- $780,000,000
- 2016 (revised estimate)- $912,862,468
- 2017 (estimate)- $1,045,000,000

Conduct of the Inquiry

3.19. At a meeting held on Wednesday April 19, 2017, the Committee agreed that its inquiry will be guided by the following objectives:

2. To determine the prevalence of mental illness and abnormalities in Trinidad and Tobago;

3. To assess the adequacy of services and facilities available to support mental health and well-being;

4. To determine the adequacy of the medical practitioners who specialize in mental health care and wellness; and

5. To assess the adequacy of the legislative framework that governs mental health.

3.20. On May 17, 2017 , June 07, 2017 and November 15 2017, the Committee convened public hearings with the following entities (See appendix I for the names and positions of persons who appeared):

- Ministry of Health (MoH);
- Ministry of Education (MoE);


Children’s Authority;
- Trinidad and Tobago Nurses Association;
- Lifeline (NGO);
- Trinidad and Tobago Nurses Council; and
- Trinidad and Tobago Association of Psychologists.

3.21. A site visit was also conducted to the St. Ann’s Psychiatric Hospital on June 28th 2017. (See appendix II to view report on the site visit).

3.22. Subsequent to the public hearings of March 15, 2017, April 19, 2017 and December 15, 2017, additional information requested from MoH, MoE, TTPA, TTRNA, TTPS, Lifeline and the Children’s Authority was provided.

3.23. The Minutes of the Meetings during which the public hearings were held are attached as Appendix III, IV and V and the Verbatim Notes as Appendix VI, VII and VIII.
KEY ISSUES, FINDINGS, AND RECOMMENDATIONS

OBJECTIVE 1: To determine the prevalence of mental illness and abnormalities in Trinidad and Tobago

Types of Mental Illness

4.1.1. According to the Trinidad and Tobago Association of Psychologists, mental illness is one of the greatest causes of disability worldwide and also in Trinidad and Tobago. The following are considered among the most prevalent mental illnesses locally:

- Depressive Disorders (e.g. Major Depressive disorder);
- Anxiety Disorders (e.g. Generalized Anxiety Disorder, Panic Disorder);
- Trauma-related and Stress disorders (e.g. Post-traumatic Stress Disorder);
- Schizophrenia;
- Personality Disorders (e.g. Borderline Personality Disorder);
- Substance Use Disorders (e.g. Alcohol Use Disorder); and
- Neurodevelopmental Disorders (e.g. Intellectual Disability, Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder)

4.1.2. Psychologists, psychiatrists and other health care professionals who appeared before the Committee confirmed that the following types of mental illness are prevalent in Trinidad and Tobago:

In children and adolescents

1. Developmental disorders;
2. Child depression;
3. Autism; and
4. Attention-deficit/hyperactivity disorder.

In adults

1. Anxiety disorder;
2. Mood disorder;
3. Depression;
4. Bipolar disorder;
5. Personality disorder;
6. Psychotic disorder;
7. Suicidal tendencies, and
8. Substance abuse.

Elderly persons
1. Neuropsychology disorders;
2. Dementia;
3. Epilepsy, and
4. Parkinson’s disease.

4.1.3. Mental Health professionals also advised the Committee that depression is possibly the most prevalent mental health illness, with prevalence rates similar to those of countries in the North Atlantic. In this regard, it was noted that Trinidad and Tobago’s health profile is that of a developed country. The Chief Medical Officer (Ag.) postulated that the prevalence of depression in Trinidad and Tobago may range from up to six (6) to ten (10) percent. However, for targeted populations, there will be different prevalence rates.

4.1.4. It was further indicated that the main diagnosis of patients at St. Ann’s Psychiatric Hospital is Schizophrenia followed by ‘deferred’ diagnoses, bipolar disorder, substance abuse disorders, depression, anxiety disorders and intellectual and developmental disorders.

Number of Persons with Mental Illnesses

4.1.5. According to a submission from MoH dated May 15, 2017, the 2014 Mental Health Atlas WHO22 Publication indicated that for Trinidad and Tobago, the total number of treated cases of severe mental disorders for the year 2014 was 5,826 and the total number of inpatients at St. Ann’s Psychiatric Hospital was 740 for the year 2014.

4.1.6. Furthermore, it was indicated that during the period October 2015- September 2016, the total number of patients admitted at St. Ann’s Hospital was 2,210 and the total number of patients attending its psychiatric outpatient clinics for the same period was 22,668.

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Persons living with an Undiagnosed Mental Health Issue

4.1.7. According to MoH, as of 2017, approximately twenty (20) percent of Trinidad and Tobago’s population may be living with some type of mental illness that can be treated but is not currently being treated.

Suicide

4.1.8. The Committee was informed by Lifeline that estimates done by PAHO in 2012\(^\text{23}\) suggest that 100,000 persons were at risk of attempting suicide in Trinidad and Tobago.

4.1.9. In the submission dated August 27, 2018 from Lifeline, it was indicated that the World Health estimated that 25% of the population of Trinidad and Tobago have a lifetime prevalence of mental issues. That translates to 325,000 persons.

4.1.10. According to a 2015 report by the Centre of Disease Control and Prevention in the United States on Suicide Trends Among Persons Aged 10–24 Years\(^\text{24}\), suicide is the second leading cause of death among persons aged 10–24 years in the United States and accounted for 5,178 deaths in this age group in 2012. In the submission dated June 2, 2017 from Lifeline, it was indicated that for 2012, 2-3 children aged 10-14 are officially classified as having died by suicide. A study conducted by Lifeline in 2012 showed that nearly 20% of adolescents were struggling with feelings of sadness and thoughts of suicide.

4.1.11. The Committee took note of statistics which were provided from a study conducted by the Trinidad and Tobago Association of Psychiatrists in 2016 using data collated from patients warded at the St Ann’s Psychiatric Hospital. The study that looked at a sample of 200 children/adolescents admitted to St Ann’s Psychiatric Hospital over a 5 year period revealed that there were approximately 121 admissions for attempted suicide. Of those admissions,


\(^{24}\) Centre of Disease Control and Prevent in United States. 2015 “Suicide Trends among Persons Aged 10–24 Years” accessed on July 23, 2018. [https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6408a1.htm](https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6408a1.htm)
between 80 to 90% were impulsive suicides attempts. The important at risk age group identified was 18 to 26 years.

**Children and Mental Illness**

4.1.12. The Children’s Authority’s multi-disciplinary assessments determined the main categories of diagnoses for children with mental illness. It revealed that several children were evaluated with multiple mental health diagnoses. These included listed in order of the highest number of presentations:

- Depression
- Conduct Disorder/Oppositional Defiant Disorders
- Anxiety
- Post-Traumatic Stress Disorder/Trauma/Stressor-Related Disorders
- Attention Deficit Hyperactivity Disorders
- Developmental Delays
- Borderline Personality Features
- Suicidal Ideations
- Self-Harm
- Substance Use Disorders
- Intermittent Explosive Disorders
- Antisocial Personality Features
- Psychoses

In addition, the TTAP further identified the main types of mental illness that are identified in children and adolescents categorized by developmental stage, which include:
### Table 1: Main Types of Mental Illness to Which Children and Adolescents Are Predisposed

<table>
<thead>
<tr>
<th>Developmental Stage</th>
<th>Types of Mental Illness</th>
</tr>
</thead>
</table>
| 1. Early childhood  | - Learning disorder (Dyslexia);  
                      - Attention deficit hyperactivity disorder (ADHD);  
                      - Trauma; and  
                      - Anxiety disorder |
| 2. Middle childhood | - Conduct and behavior disorder  
                      - Neurological disorders;  
                      - Impulse control;  
                      - Mood disorder;  
                      - Anxiety disorder; and  
                      - Trauma |
| 3. Late childhood   | - Depression;  
                      - Substance abuse;  
                      - Suicide;  
                      - Mood disorder;  
                      - Anxiety disorder; and  
                      - Trauma as a result of abuse and neglect |

4.1.13. The Committee was informed by TTAP that the percentage of children suffering from a disabling mental illness in Trinidad and Tobago may be significant. Since symptoms of mental illness are usually considered as part of the passing developmental phases of a child, mental illness frequently goes unnoticed.

4.1.14. During the public hearing dated November 15, 2017, TTAP indicated that for the period 2016-2017, 243 students were referred to the Student Support Services Division (SSSD) of the MoE by TTAP and are currently being treated for mental illness. Furthermore, it was indicated that a large percentage of those were diagnosed with ADHD. 54 students, from both primary and secondary schools were diagnosed with various emotional behavioural disorders. 476 other
Sixth Report of the Joint Select Committee on Social Services and Public Administration

students have been evaluated to have "home morbid disorders", which include ADHD and emotional, behavioural learning disabilities.

4.1.15. Furthermore, in relation to Child Guidance Clinics (CGCs), the total number of new patients registered in 2017 at the NWRHA was 284 and for SWRHA the new patients registered in 2016 were 238. All patients whether new and/or returning, are deemed to be 'registered patients'.

4.1.16. Further details on primary diagnosis and rate of occurrence for the SWRHA CGC are as outlined below in Table 2.

**Table 2: DSM-5 Clinical Primary Diagnoses of New Patients at Child Guidance Clinic (South) Jan-Dec 2016**

<table>
<thead>
<tr>
<th>Primary Diagnosis</th>
<th>Number (#) of New Patients</th>
<th>Percentage (%) of New Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention Deficit Hyperactivity Disorder</td>
<td>22</td>
<td>9</td>
</tr>
<tr>
<td>Behavioral Problems, ODD, Conduct Disorder</td>
<td>37</td>
<td>16</td>
</tr>
<tr>
<td>Intellectual Developmental Disorder</td>
<td>13</td>
<td>5</td>
</tr>
<tr>
<td>Depression</td>
<td>31</td>
<td>13</td>
</tr>
<tr>
<td>Anxiety / PTSD / Panic Disorder</td>
<td>24</td>
<td>10</td>
</tr>
<tr>
<td>Schizophrenia and Psychosis</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Learning Disorder</td>
<td>21</td>
<td>9</td>
</tr>
<tr>
<td>Autism Spectrum Disorder</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Combined Diagnoses</td>
<td>73</td>
<td>31</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>238</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

4.1.17. In a submission dated September 28, 2018 it was specified that in 2017, the total number of new registered patients at SWRHA’s Child Guidance Clinic was 234 (118 males, 116 females).
4.1.18. In the submission from the Children’s Authority, it was indicated that for the period May 2015 to October 2017, 471 multidisciplinary assessments were conducted at the Assessment Centres of the Children’s Authority of Trinidad and Tobago. From these, 360 treatment plans were completed. (Please see appendix IX).

**Children displaying beyond control behaviour and acute mental illness**

4.1.19. The Chairman, Children's Authority noted that there are unfavorable labels attached to children/adolescents living with mental illness such as "bad child", "delinquent" or "beyond control".

4.1.20. The Committee was informed by the Children’s Authority that:

i. The label "**beyond control**" is used by the Court in situations where a parent cannot cope and would therefore, bring the child before a court at which time the label is deemed appropriate. These children are now referred to as "**children in need of supervision**" as defined in **Section 61** of the Family and Children Division Act, 2016;

ii. A child who may be experiencing a mental episode/breakdown that is determined to be a type of behavioral instability or emotional dysregulation is deemed to be in need of acute care for mental illness;

iii. A part of the stigma associated with mental illness is the assumption that children presenting uncontrollable behavior suffer from mental illness. Uncontrollable behavior and mental illness are not synonymous as deemed by the health care professionals.

iv. In accordance with **Section 61** of the **Family and Children Division Act 2016**25, the reasons for uncontrollable behavior are determined by the assessment of the Authority, after which the child is referred for treatment at an appropriate facility.

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25 Family and Children Division Act 2016
4.1.21. By Submission dated June 05, 2017, the TTAP indicated that in one local study, diagnoses of mental illness were made in 70% of cases of beyond control behavior in children and adolescents admitted to St Ann’s Psychiatric Facility.

Children and adolescents displaying self-harming behaviors

4.1.22. In an appearance before the Committee on Wednesday November 15, 2017 MoE revealed that for the period 2012 to 2017, the Student Support Services Division (SSSD) received 563 referrals of students displaying self-harming behaviors. The statistics are categorized by educational district and types of behavior such as; self-mutilation, suicide ideation and suicide by stress. Upon analysis, it was discovered that a greater percentage of the data represented students experiencing suicidal tendencies.

Identifying children at risk of Mental Illness/disorder

4.1.23. During the November 15, 2017 public hearing, TTAP indicated to the Committee that at a recent national suicide prevention mission held in partnership with PAHO on March 29, 2017 it was revealed that there are currently over 400 students on suicide watch across the country’s Primary and Secondary System. However, a breakdown of the age groups was not provided but it was stated that these students are as young as seven (7) years old.

FINDINGS AND RECOMMENDATIONS

Findings

6.1 Based on the preceding evidence/information, the Committee concluded as follows:

   i. That the negative stereotyping of mental illnesses may contribute to the under-reporting and low-diagnosing of mental illnesses within our population. Mental health professionals confirmed that this phenomenon was evident from the avoidance of the health system, the lack of awareness of mental health services available, and an inability to recognize associated symptoms;
A combination of societal and personal circumstances, such as the current economic downturn and trauma such as sexual abuse, produce stressors which are major contributing factors to mental health problems;

ii. That there are unfavorable labels attached to children/adolescents living with mental illness/disorders such as "bad child", "delinquent" or "beyond control";

iii. The State has provided basic support for young people/minors with mental issues through the education system via the SSSD. However, accessibility to mental health care for students at the Early Childhood level appears to be in need of further development;

iv. There is a lack of training programmes in the area of child therapy and child therapy psychology;

v. Due to the anonymity maintained during calls, Lifeline cannot link calls to incidents of suicide or murder/suicide and prevention of such incidents cannot be confirmed; and

vi. That there is the need for the establishment of a system of programmes at schools with the aim of guiding children/adolescents on healthy choices and risk prevention methods to decrease their susceptibility to mental illness.

Recommendations

In light of the foregoing, the Committee recommends the following:

A. That the MoH sustain and enhance its public awareness initiatives/programmes which have assisted in educating the population on matters associated with mental health;

B. That MoE place greater focus on enlightening the school population on some of the negative stereotypes that are associated with mental health and how they can be dismantled. Consideration should be given to incorporating this type of content in the Health and Family Life Education curriculum of the Primary School System;
C. Information on the process involved in accessing treatment at the various public health care facilities should be widely circulated and easily accessible. In particular, such information should be disseminated in a strategic and methodical manner including via Social Media on the Notice Boards of all Constituency Offices, Regional Corporations and public health facilities;

D. That the MoH collaborate with the network of public and private mental health care establishments (including the RHAs and outpatient care centres) to develop a robust system to collect data/statistics on the mentally-ill and mental illnesses in Trinidad and Tobago. A Concept Note on this initiative be included in the Ministerial Response to this Report;

E. The existing curriculum or course content for the MSc Clinical Psychology programme offered by the University of the West Indies (St. Augustine) should be assessed to ensure that the knowledge and training that is being provided to students are aligned with the needs of the society. Should major gaps be identified, a strategy should be developed to modify the programme to include additional training in areas such as Child Therapy in child therapy and Child Therapy Psychology. Alternatively, post-graduate scholarships may be awarded by the State for persons to pursue subspecialties at foreign universities on the condition that they return and work in the public health system;

F. That the MoH’s response to this report include an update on the implementation of a suicide surveillance system;

G. That MoH’s Mental Health Unit and TTRNA provide an outline of their respective proposals which aim to counteract or alleviate the apparent increase in mental illness/disorders. The Committee requests that these proposals should include details on the roles of each Ministry and the professionals in the field in this collaborative effort;

H. The MoH should collaborate with the Ministry of Social Development and Family Services to support the work of the NGOs that are involved in providing care and
support to persons with mental illnesses/disorders. In this regard, we further recommend that a Register of such agencies be created and published on the websites or appropriate internet platform of both Ministries;

I. That the training of School Guidance Counsellors and Social Workers be augmented to assist in the early detection of at-risk children;

J. That the Ministry of Education and the MoH collaborate to design a digital manual/guidebook for teaching staff to aide them to effectively identify and provide a basic response to children and adolescents with mental illnesses. A digitalized manual/guidebook narrated by an appropriate mental health professional along with instructive videos would allow teachers to acquire the necessary knowledge (and perhaps skills) without having to host formal seminars or workshops; and

K. To augment the components of the MoH’s undocumented “Mental Health Plan”, the Committee requests that a policy document on the dispensation of mental health services to minors and adolescents be formulated within the first quarter of 2019. It is recommended that this policy document should inter alia:

i. Inform amendments to the Mental Health Act, the Children Act, Children’s Authority Act and any other relevant law;

ii. Guide the development and expansion of facilities to provide mental health care to this cohort;

iii. Guide the strategy for the development of human resources necessary for the treatment of minors and adolescents;

iv. Promote the application of internationally accepted standards in the administration and dispensing of mental health care services for the cohort; and

v. Guide the collection of data by the relevant stakeholders on mental health issues pertaining to children and adolescents.
OBJECTIVE 2: To assess the adequacy of services and facilities available to support mental health and well-being.

MoH’s Mental Health Unit

4.2.1. The MoH’s Mental Health Programme is actually a focused intervention for achieving a specific, often short-term goal. There are three main goals of the MHP:
   a. To encourage the development and maintenance of the highest level of mental health in the population of Trinidad and Tobago;
   b. To provide an adequate level of individualized care for those who have mental and substance abuse disorders, or who are at risk from suffering from such disorders;
   c. To eradicate the discrimination and negative stigmatization of persons who suffer from mental disorders.

Role / Functions of the Mental Health Unit

4.2.2. The Unit directs and co-ordinates the implementation of the activities of the MHP in the MoH’s annual action plan. As part of its other major functions, the Unit:
   i. The operationalization of the MH Policies, which includes making provisions for children and adolescents.
   ii. Co-ordinating the process of updating the MH legislation in accordance to the MH Policy.
   iii. Developing guidelines for quality assurance in mental health care, as part of the delivery of relevant services at the regional level.
   iv. Monitoring and evaluating programme performance at the regional and national level.

St Ann’s Psychiatric Hospital (SAPH)

4.2.3. In a submission dated May 16, 2017 by MoH it was indicated that the St. Ann’s Psychiatric Hospital (SAPH) remains the main public health institution which provides tertiary level mental health services. With over 780 beds, this facility has 14 chronic wards, 9 acute wards, and 2 forensic wards. Services offered at SAPH are national in scope and include inpatient psychiatry services, child guidance services, forensic psychiatry services, medical internship,
occupational therapy, psychology, physical education, psychiatric social work, psychiatric outpatient clinics, psychosocial rehabilitation, substance abuse prevention, and treatment.

4.2.4. As of 2017, there is a total of 1,520 persons employed at the St Ann’s Psychiatric Hospital (SAPH). The table below shows the aggregate information on staffing at the hospital.

**Table 5: Aggregate information on staffing at the St Ann’s Psychiatric Hospital**

<table>
<thead>
<tr>
<th>POSITION TITLE</th>
<th>NO. OF POSITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical doctors</td>
<td>57</td>
</tr>
<tr>
<td>Nurses</td>
<td>1088</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>87</td>
</tr>
<tr>
<td>Administrative Staff</td>
<td>7</td>
</tr>
<tr>
<td>Patient Support staff</td>
<td>43</td>
</tr>
<tr>
<td>Technical staff</td>
<td>7</td>
</tr>
<tr>
<td>other staff members</td>
<td>231</td>
</tr>
</tbody>
</table>

**Psychiatric Treatment and services at other public health institutions**

**San Fernando General Hospital (SFGH)**

4.2.5. At the San Fernando General Hospital (SFGH), acute inpatient mental health services are provided at ward 1 which currently has 28 beds. This ward consists of two (2), fourteen (14) bed dormitories for male and female patients respectively, with two (2) seclusion rooms in each dormitory.

**Other Public Mental Health Institution within the RHA System**

4.2.6. There has been an expansion of community-based mental health services which in total have 130 beds, in the following units:

- Three (3) Acute Inpatient Psychiatric Units/Wards;
- Two (2) Extended Care Centres;
- Three (3) Child and Adolescent Outpatient Clinics;
- Twenty-seven (27) Adult Outpatient Clinics; and
• Three (3) Mental Health and Wellness Centres.

4.2.7. The Committee was informed by MoH during a public hearing convened on November 15, 2017 that a new model of mental health care is being developed and should be implemented by the end of the fiscal year 2018. This model will consider evidence-based protocols and practices for mental health such as early intervention, respect for human rights and the integration of mental health into the general health care system.

Extended Care Centres (ECCs)

4.2.8. Under the South-West Regional Health Authority there are two (2) Extended Care Centres namely; the Couva Extended Care Centre and the Point Fortin Extended Care Centre. The ECC at Couva is located at Grant Street, Couva and was opened on the 1st of July, 1982 and the one at Point Fortin is located at Warden Road, Point Fortin and was opened on the 4th of October, 1984. These Centres provide care for psychiatric patients with a capacity of forty (40) and thirty-five (35) patients respectively. Both Centers together, currently have eighty (80) patients, the majority of whom were brought from the St. Ann’s Hospital and some from Ward I (in San Fernando General).

Patients Admissions and attendance to Mental Health Facilities

4.2.9. In a submission dated from May 16, 2018 by MoH it was indicated that during the period October 2015 - September 2016, the total number of patients admitted at St. Ann’s Hospital was 2,210, of which 68% of these admissions were from regions outside of NWRHA and approximately 80% to 90% of patients assessed are admitted. (Please refer to Appendix X, table 6).

4.2.10. The table below illustrate the number of patients that received assessments and treatment from mental health facilities in regions outside of NWRHA during the period 2015-2016. A total of 22,688 patients were seen at psychiatric out-patient clinics. (Please refer to Appendix X, table 7).
TABLE 8: NUMBER OF PATIENTS’ ADMISSIONS REGIONS OUTSIDE OF NWRHA FOR THE PERIOD 2015-2016

<table>
<thead>
<tr>
<th>Mental Health Facility</th>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCRHA</td>
<td>8,604</td>
</tr>
<tr>
<td>ERHA</td>
<td>5,880</td>
</tr>
<tr>
<td>NWRHA</td>
<td>8,184</td>
</tr>
<tr>
<td>San Fernando General Hospital (SFGH) Ward 1</td>
<td>836</td>
</tr>
</tbody>
</table>

4.2.11. Furthermore, in the submission from MoH dated May 16, 2017 it was indicated that for the year 2016, the ERHA had an outpatient attendance of five thousand eight hundred and eighty (5880). This number is a representation of one RHA. (ERHA 2017). Admission from the ERHA to St Ann’s Hospital for the same year was recorded as two hundred and sixty-nine (269).

Mental Health Facilities available in Tobago

4.2.12. During a public hearing on Wednesday May 17, 2017, the committee was informed by MoH that the Tobago RHA is responsible for the delivery of mental health services in Tobago. There is a psychiatric unit at the Scarborough General Hospital which is staffed by two psychiatric nurses, social workers, and mental health nurses. According to the MoH as at September 2018, the current staffing complement of the psychiatric unit at the Scarborough General Hospital was 55. (Please refer to Appendix XI for the staff structure of the Unit.) The Committee was further advised that there are also outpatient clinics in the areas of Scarborough and Roxborough.

Protocols and procedures associate with Patients admitted to the forensic ward of St Ann’s Hospital

4.2.13. By submission dated July 27, 2017 the MoH indicated that as of 2017, the ward statistics were as follows:

- Court Order (Magistrates’ Courts): 28
• Court Order (High Court): 1 – receiving treatment
  9 – President’s Pleasure sentence
  4 – Court’s Pleasure sentence

4.2.14. The Committee was further advised that patients are not generally kept on the forensic ward awaiting trial due to outstanding (psychiatric evaluation) reports. Reports are generally prepared within fourteen (14) days of the patient’s admission to the St. Ann’s Hospital by Court Order. When additional time is required in order to properly complete the evaluation, a written request for additional time is made to the court.

4.2.15. Additional time is requested when prisoners sent for evaluation are found to be mentally-ill and in need of in-patient care and treatment beyond the return date of the hearing (remand date) that is specified on their Remand Order.

4.2.16. In some cases, a patient’s needs are communicated in writing to the relevant court and the court is advised of the additional time needed to administer treatment. These requests are usually granted and a new deadline for receipt of the report from the St. Ann’s Hospital by the court is set accordingly.

Mental Health Facilities and Services available for Children and Adolescents

Ministry of Health (MoH)

4.2.17. During a public hearing dated November 15, 2017 it was indicated that the St. Ann's Psychiatric Hospital (SAPH) does not normally admit children unless it is by way of Court Order or in exceptional circumstances through a child psychiatrist. In accordance with international best practice, children/adolescents should be treated in general hospital settings. Therefore, in the first instance, children/adolescents would be referred to the pediatric ward at EWMSC.

4.2.18. Mental health services for children/adolescents are provided via three (3) Child Guidance Clinics (CGC). They are:

- Under the NWRHA, located at Pembroke Street, Port of Spain. This clinic also serves both NCRHA and ERHA;
- Under the SWRHA, located in Pleasantville, San Fernando;
- Under the TRHA, located in Scarborough, Tobago.

**Tobago Regional Health Authority (TRHA)**

4.2.19. In 2008, the Child and Adolescent Centre (CAC) was established in Scarborough, Tobago providing many therapeutic modalities, e.g., individual and group therapy, family therapy, school visits, play, speech, and language therapy. A social worker, a part-time psychologist, a speech therapist, an occupational therapist, and a mental health officer provide services at this centre; however, there is no resident child psychiatrist in this facility.

4.2.20. In a MoH submission dated September 14, 2018 it was indicated that the CAC in Tobago is currently operational. It was further indicated that there are currently five (5) persons employed at this facility including one (1) Psychologist, one (1) Psychiatric Social Worker, one (1) Speech and Language Therapist, one (1) Mental Health Officer and one (1) Clerk.

4.2.21. With regard to the number of children and adolescents that have benefited from treatment at this facility over the period of 2016 and 2017, the Child and Adolescent Centre has provided services to 181 new clients (90 males and 91 females) and 1,085 revisits (506 males and 579 females).

**Services provided for children/adolescents at these facilities**

4.2.22. The services provided include mechanisms to deal with relationship problems, emotional, different behavioral and/or developmental difficulties. These categories of issues encountered by children and adolescents are taken into account when arriving at a diagnosis in accordance with the Diagnostic Statistical Manual of Mental Disorders including:

- Disruptive, Impulse-control and Conduct Disorders (including conduct disorders and oppositional defiant disorders);
- Neuro-developmental disorders including:
  - Attention Deficit Hyperactivity Disorder
  - Autism Spectrum Disorder
  - Specific Learning Disabilities
  - Intellectual Disabilities
  - Mood disorders (Depression);
  - Anxiety Disorders; and
  - Trauma and Stressor related disorders.

4.2.23. Informal estimates at the NWRHA and SWRHA indicate that 2,400 patients have been tested and treated at public healthcare facilities for mental illnesses over the last five (5) years.

4.2.24. Furthermore, the total number of persons between the ages of 9-17 who accessed services over the past five (5) years was 373. Disaggregated by gender: 122 were males and 251 females.

**Child Guidance Clinic**

4.2.25. In 2017, the Child Guidance Clinics received 386 referrals. 284 of children referred for a preliminary interview returned for psychiatric evaluation. It was noted that a parent had the right to refuse the treatment intended for his/her child. The 386 referrals included children with significant mental health needs who are unable to attend public school for the following reasons:
  - they are underage;
  - they are living with disabilities;
  - they are forced to stay at home or attend private schools because of developmental difficulties that the general education system does not provide for.

4.2.26. The Child Guidance Clinic and the SSSD utilize a collaborative system to evaluate and treat children commencing from the Primary school level. It was noted that not every child who is identified with a psychological difficulty is in need of a full psychiatric evaluation.
Dedicated inpatient psychiatric care facilities for the treatment of children

4.2.27. The interim arrangements identified for children/adolescents evaluated by a Psychiatrist and assessed as requiring admission to a health facility, are as follow:

- Children under the age of 16 displaying mild behavior may be accommodated on a ward at the Pediatric Hospital;
- Children over 16 may be admitted either to the Psychiatric Unit at the Mount Hope Hospital or the LFE Lewis Unit at the St. Ann’s Hospital. This Unit is dedicated to acute care; and
- In relation to San Fernando and environs, children may be admitted to the San Fernando General Hospital.

Support services, protocols and procedures: students with mental disorders/illnesses

Ministry of Education (MoE)

4.2.28. The Ministry of Education (MoE) through the Student Support Services Department (SSSD) implements a school-based system of referral. The diagram below illustrate the school-based system of referral.
Assessment of Students

4.2.29. By submission dated November 17, 2017, the MoE advised the Committee that the length of time for assessing students with psychological issues is dependent on the severity of the need. There are two mechanisms in which Psychoeducational Assessments are provided:

(a) Out-sourcing to private practitioners; and

(b) Internal Assessment Services.

4.2.30. Funding constraints and limited personnel to conduct Psychoeducational Assessments have also contributed to delays in meeting the demands for Psychoeducational Assessments. There are currently five (5) Clinical Psychologists employed with the MoE on a full-time basis. These Psychologists each hold a Master’s Degree in Clinical Psychology from an accredited university.

4.2.31. The Ministry further indicated that it is in the process of outsourcing these cases to expedite the current backlog of approximately 225 psychoeducation assessments.
4.2.32. In a submission dated September 21, 2018, the MoE confirmed that an evaluation was undertaken to determine the cost of outsourcing the psychoeducational assessments. It was indicated that based on an average market rate of $4,500.00 per assessment, the cost of outsourcing the current backlog of psychoeducational assessments was $1,012,500.00.

4.2.33. The estimated cost to the MoE to employ the requisite six (6) Clinical Psychologists at an annual cost of $178,800.00 per person is $1,072,800.00. It appears that the Ministry was inclined to pursue the hiring of the additional Psychologists. It was proposed that each officer will be assigned to six (6) cases per month to complete the current backlog and any future psychoeducational assessments. The Ministry submitted that interviews for these positions were expected to be completed by October 30, 2018. The Ministry further submitted that subject to the availability of funds in fiscal 2018/2019, the Ministry intends to outsource psychoeducational assessments if necessary, to minimize the wait time for students requiring psychoeducational evaluation.

The re-integration of students into schools

4.2.34. For re-admission, the parent has three (3) means of redress:

i. To approach the Education District’s School Supervisor III (SSI) for secondary schools or School Supervisor II (SSII) for primary schools, to outline his/her grievance. The SSIII or SSII will then contact the relevant principal to determine the background to the parent’s claim.

ii. To approach the Student Support Services Division (SSSD) staff within the relevant Education District for intervention for the re-integration of the student back into school. Either the Guidance Officer II (GOII) or Senior School Social Worker (SSSW) will conduct the necessary background checks to confirm the reason for the student absence from school and readiness for re-integration.

iii. Once it is confirmed through various interviews, relevant documentary and medical evidence or otherwise that the student is in fact fit and able to return to school, the
SSSD personnel will make contact with the relevant School Supervisor for the Education District and inform of the need for a Case Conference to reinstate the student to school.

iv. Upon the student's return to school, especially after lengthy absences, the student is provided with academic support by the resident guidance personnel to ensure that there are minimal learning gaps and to develop a study time table with the student. If the student is on any medication, the student is monitored by the teachers and SSSD staff to ensure that there are no negative side effects while the child is on the school compound. If there are, contact is made with the medical doctor or facility to adjust the medication.

4.2.35. In a submission dated January 15, 2018, the MoE presented the Committee with a diagram (please refer to Appendix XII) which illustrated the process to be followed by all parties involved in the student re-integration programme. This diagram depicts the courses of action to be adhered to in the following scenarios:

- School Principal permits the reintegration of the student; and
- School Principal rejects the reintegration of the student.

Children/adolescents referred for mental health care by the Courts

4.2.36. The Committee was informed that the age group usually referred for care by the Courts are adolescents over the age of 16. Children are usually referred to the Child Guidance Clinic and outpatient services in San Fernando and Tobago for evaluation and report to the Court.

4.2.37. Prior to 2016, adolescents were remanded for psychiatric evaluation at the Forensic Unit, SAPH and were admitted together with adults due to the absence of a dedicated children's ward for forensics or general psychiatry. In 2016, a decision was taken that no children/adolescents who are referred by the Courts will be housed at the SAPH.

4.2.38. It was noted that the Forensic Unit houses potentially violent patients. In a site visit to the St Ann's Psychiatric Hospital conducted on June 28th 2017, the Committee was informed that
this ward accommodates mentally-ill patients who have committed a crime or a violent offence and were ordered by the Court to be admitted to the facility. As a consequence, children/adolescents are now evaluated at the Forensic Unit and are sent to less threatening locations for treatment;

4.2.39. It was later indicated that children admitted to the SAPH may be housed for approximately 2 weeks until they can be evaluated by a Forensic Psychologist. This is owing to the fact that the stipulated working hours of the Forensic Psychologist is 8:00 a.m. to 4:00 p.m.

4.2.40. The MoH indicated that discussions have commenced to include four beds for children and adolescents with mental illness at the Wendy Fitzwilliam Paediatric Hospital, Mt. Hope as a first initiative. The Ministry proposed June 2018 as the deadline for implementation of this initiative.

**Students with learning disabilities within the spectrum of special needs**

4.2.41. Intervention for all students with diagnosed disabilities includes the development of Individual Education Plans (IEP’s). For students with diagnosed mental health disorders, a range of approaches are applied, including:

- Medication Management;
- Behaviour Management;
- Environmental Modification;
- Replacement Strategy;
- Curriculum Modification e.g., Pre-arranged frequent breaks, the extension on assignments; and
- Support of a Student Aide where available.

In all cases, advocacy is the guiding principle to promote inclusivity and education for all.
Special schools designated for the care of students who have been diagnosed with a mental illness or disorder

4.2.42. In a submission dated November 17, 2017, the MoE indicated that Wharton Patrick which is located at 2A Sydenham Avenue, St Ann's is the only Special School which specifically caters for students with emotional and behavioural disorders. The programme at this institution facilitates students referred from primary schools, SSSD, Children's Authority, Child Guidance Clinics and the St. Ann's Hospital, and walk-in referrals from parents of students who are out of school due to their challenging behaviours. The school has a capacity for thirty-five students at any given time. Students benefitting from this programme may be transitioned back into their regular school, when possible.

Treatment available for Alzheimer’s patients

4.2.43. The President, TTAP stated that persons suffering from Alzheimer’s tend to present themselves at health care facilities when they are already at a moderate to severe stage of the disease at which point little can be done. Increased public awareness of the signs and symptoms of the disease may encourage persons to present at an earlier stage which will allow for better treatment and management.

The Role of the TTPS in relating to the Mentally-Ill

4.2.44. Section 15, subsections (1) and (6) of the Mental Health Act, prescribes the circumstances in which a police officer may become involved in interfacing with a mentally-ill person.

(1) ‘A person found wandering at large on a highway or in any public place and who by reason of his appearance, conduct or conversation, a mental health officer has reason to believe is mentally-ill and in need of care and treatment in a psychiatric hospital or ward may be taken into custody and conveyed to such hospital or ward for admission for observation in accordance with this section.’

(6) ‘A Police Officer shall render such assistance as may be necessary for the apprehension and safe conveyance to a psychiatric hospital or ward of a person referred to in subsection (1).’
4.2.45. The provisions quoted underscore that members of the TTPS are mandated to play a supportive role in facilitating the admission of the mentally-ill to an appropriate health facility.

4.2.46. Furthermore, the following steps are taken when admitting mentally-ill persons to St. Ann’s Psychiatric Hospital:

- the caretaker of the mental health patient contacts the Police Officer;
- the Police Officer then responds and if the Mental Officer is present, an Apprehension Order is issued by the authorized Mental Health Officer; and
- where possible the Police Officer facilitates the transportation to the St. Ann’s Hospital.

4.2.47. The assistance rendered by members of the TTPS in respect of public encounters with the mentally-ill is guided by Standing Order No.33 of the Trinidad and Tobago Police Service.

4.2.48. The Committee was informed that the SSSD works collaboratively with the Community Police to address the needs of children displaying anti-social or unacceptable behaviour. An officer of the SSSD and if necessary the Community Police will be first on-site to handle situations in this regard.

**Decanting of Mentally-Ill Patients**

*Decanting Process*

4.2.49. During an appearance before the Committee on May 17, 2017 the Medical Chief of Staff, St. Ann’s Hospital informed the Committee that the decanting process for the St. Ann’s Hospital is difficult since there are no longer any extended care centres for ex-patients as is the case in the SWRHA. It was revealed that the only options that were available were the Arima Rehabilitation Centre and in Sangre Grande, which housed 24 patients and one patient respectively and at which such persons could undergo rehabilitation of life and social skills. However, these have been closed.
Decanting Centres for outpatients of the St. Ann’s Hospital and the use of geriatric homes as Decanting Centres

4.2.50. The MoH reported that there are two (2) extended care centres which fall under the SWRHA, one is located in Point Fortin and the other in Couva. One centre has a fifty (50) bed capacity while the other has forty (40). During an appearance before the Committee on May 17, 2017, MoH advised that both centers together currently have eighty (80) patients, the majority of whom were brought from the St. Ann’s Hospital and some from Ward I (of the San Fernando General). These are long stay facilities in which patients remain for the rest of their lives, with a few exceptions who were able to go home. However, the rate of admissions to these centres are very low as it is dependent on the death of patients to free up bed space. The Committee was advised that in 2017 there were six (6) admissions to those facilities.

4.2.51. It was indicated that mentally-ill persons found at geriatric facilities would be as a result of private arrangements made by families.

Support to deal with post-partum depression and other maternity-related mental illnesses

4.2.52. The Head, Psychiatry, NCRHA stated that there are no formal and/or specific arrangements in place to treat persons with post-partum depression in the public health care system. However, persons who display symptoms during pregnancy or after delivery, are referred to the mental health services.

4.2.53. As part of the post-maternity treatment, it is recommended that mothers be screened both during the pregnancy and after the delivery. Based on the results of the screening, the mothers can then be referred. However, there needs to be a dedicated team in place to respond to the referrals.

Suicide Prevention and risk mitigation

The MoH National Suicide Prevention Action Plan.

4.2.54. During an appearance before the Committee on June 07, 2017 it was indicated by MoH that they are in the process of implementing a Suicide Surveillance System that is a part of the
National Suicide Prevention Action Plan. It was further indicated that operating a 24 hour hotline is an essential component of an effective anti-suicide intervention. However there is no State instituted or funded 24 hour suicide hotline. There is however, a hotline run by an NGO called Lifeline.

4.2.55. The Ministry further reported that as part of its suicide prevention plan, it will either collaborate with Lifeline to supplement its existing services or establish an alternative that can be funded and supported by the State.

4.2.56. In a MoH submission dated September 14, 2018, the Committee was provided with the list of members of the implementation committee for the National Suicide Prevention Action Plan and the designations of the members (please see appendix XIII)

4.2.57. It was further indicated by the MoH that this implementing committee convened on March 29th 2017 coming out of a national suicide prevention mission held in collaboration with PAHO from March 6th to 10th 2017. The mandate of this group is to develop and implement a national suicide prevention strategy. To date this strategy is still in draft. However, one component of the strategy has been operationalized namely; the development of national media guidelines for responsible reporting on suicide. These guidelines were launched on September 10th 2018.

4.2.58. The National Suicide Surveillance System, another component of the strategy, is being developed in tandem with the Non Communicable Disease (NCD) plan as mental health indicators including suicide are integrated into routine NCD surveillance at the hospitals.

**Involvement of the Non-Governmental Sector in Mental Health and wellness**

**Lifeline**

4.2.59. Lifeline, which was founded by Chad Varah, commenced its operations in 1977. During the organization’s appearance before the Committee on June 07, 2017, the Committee was advised that the organization’s hotline receives an average of 10 calls per day. Those who operate the
organization’s hotline are called “listeners” who are trained to dispense emotional support to callers as opposed to providing psychiatric assessments or treatments. Should a caller request professional help, “listeners” may refer the person to a psychologist, psychiatrist or consultant.

4.2.60. At present, the organization does not possess the capacity to track how many lives it has been able to save as a result of its operations. Undertaking such data gathering would be inherently difficult as calls made to lifeline are anonymous.

The working relationship between Lifeline and Government Ministries

4.2.61. The Chairperson of Lifeline indicated that the organization has received a regular subvention from the Ministry of Social Development and Family Services since 1990. In 2016, Lifeline received a one-time grant of $50,000 and the subventions received as at June 07, 2017 were estimated to be $20,000.

4.2.62. During the organization’s appearance before the Committee on June 07, 2017, it was indicated that the organization has a working relationship with the South-West Regional Health Authority. However the Committee was informed in a submission dated August 27, 2018 that the organization’s intention was to strengthen this relationship with the Regional Health Authority. However, the SWRHA had not made a corresponding commitment. Lifeline also submitted that efforts by the MoH to assist with reducing incidents of suicides also appeared to have stalled from 2017 to present.

Availability of medication under the CDAP Programme

4.2.63. The Committee was informed that a small number of mental health drugs are available under CDAP. The generic form of Prozac and Amitriptyline, anti-depressants, are available under CDAP. An antipsychotic (Chlorpromazine) along with a few others, are also available under CDAP. The Medical Chief of Staff, St. Ann’s Hospital indicated that she believed the list of mental health drugs under CDAP can be expanded.

4.2.64. It was also indicated that there are some drugs that are in short supply at the St. Ann’s Hospital and psychiatric departments of various hospitals throughout Trinidad and Tobago.
FINDINGS AND RECOMMENDATIONS

Findings

4.2.65. In this regard the Committee has made the following observations:

Facilities and treatment for Adults

i. Based on the evidence received it may be reasonable to conclude that the Mental Health Unit, Ministry of Health has under-performed, at least in the fulfilment of its obligation to “Co-ordinate the process of updating the MH legislation according to the MH Policy” as no substantial amendments have been made to the Mental Health Act Chapter 28:02 since 1999. There was also minuscule evidence to suggest that this Unit has achieved any notable success in the execution of its other obligations;

ii. The St. Ann’s Psychiatric Hospital is the main centre where mental health care services are disbursed, to the adult population. However the Committee, based on evidence received and further to its site visit on June 28th 2017, took particular note of the following challenges confronting the operations of the hospital:
   a. A strong focus on treatment by administering medicine and very limited dispensing of psychotherapy/counseling;
   b. It is questionable whether the ergonomics and layout of some of the wards are configured to encourage or nurture mental health and wellness;
   c. The records management system at the hospital requires urgent updating and should be digitized;
   d. The facility has no control over the intake of patients ordered by the court to be admitted to the forensic ward at the St. Ann’s Psychiatric Hospital; and
   e. Some wards are overcrowded as the number of patients is greater than the number of beds available.

(See Report on site visit at Appendix II for further details on the observations made by the Committee)

iii. Some decentralization of public mental health care has occurred through the establishment of outpatient clinics, Extended Care Centres, Mental Health and
Wellness Centres and Child Guidance Clinics. These satellite facilities have certainly made mental health services more accessible to a wider cross section of the population.

iv. The system used to record the activities of Mental Health Officers in relation to Section 15 (1) of the Mental Health Act is haphazard and needs to be properly streamlined;

v. There are no formal systems in place to provide support to women who suffer from post-partum depression and other maternity-related mental illnesses;

vi. Given that the Arima Rehabilitation Centre appears to be the only state supported centre for the decanting of outpatients of the St. Ann’s Hospital, it would be reasonable to conclude that current arrangements to provide for the continuous care of outpatients in need of shelter/accommodation are inadequate;

vii. There are serious shortcomings in data collection and analysis as it concerns the mentally-ill in Trinidad and Tobago. The Committee considers this an area which may be improved in the short-term through the use of ICT and an enhanced records management system.

**Children and adolescents**

B. The waiting period (minimum six (6) month) for a child/adolescent to be assessed or treated at one of the Child Guidance Clinics is protracted. Although the excessive waiting time is a factor of demand and supply, this is clearly an area that requires improvement.

C. In-patient mental health care facilities for children is woefully lacking. The Committee noted that the Ministry of Health has only recently started to take action to improve this situation by adding four (4) beds to the Mt. Hope or Couva Hospital for use by children;
D. That the advance or acute mental health needs of children and adolescents are not adequately treated in the current service delivery model as there remains no suitable in-patient service for children and adolescents experiencing severe acute psychiatric symptoms. Fortunately the education sector mainly via the Student Support Services Division provides some mental health screening and support to primary and secondary school students;

E. Given that mental illnesses and disorders may compromise one’s psychological development, it may be counterproductive to admit patients to mental health facilities simply based on their age. Arguably, the resulting assessment of a patient’s mental state should be the main determinant of his/her placement. Notwithstanding, we are cognizant that there would be legal considerations involved in the placement of persons in certain public institutions especially children.

Persons with Alzheimer’s disease
i. It appears that there is a need for services and facilities dedicated for the early screening and treatment of Alzheimer’s patients, given the aging of our population.

Other matters
i. Further to the site visit to the St Ann’s Psychiatric Hospital on June 28, 2017, the Committee has concluded that the forensic ward is not adequate to accommodate the mentally-ill convicted persons. The inhuman conditions and lack of security was a cause for concern.

ii. The Committee also noted during the site visit that there are a number of issues that are in need of urgent attention by the MoH as it relates to overcrowding, lack of security, infrastructural needs and the inhuman/unsanitary conditions of wards with seclusion rooms;
iii. The committee noted that there are some drugs that are in short supply at the St. Ann’s Hospital and psychiatric departments of various hospitals throughout Trinidad and Tobago;

iv. There are no legislative provisions to facilitate the tracking and monitoring of mentally-ill patients outside mental health care facilities; and

v. It appears that there are no services available to provide psychological support to mentally-ill persons during disasters.

Recommendations

In light of the foregoing, the Committee recommends the following:

A. That patient records at the St. Ann’s Psychiatric Hospital be digitized. Consideration should be given to achieving this objective via a public-private partnership. In the interest of pragmatism, a decision should be taken as to how dated the retroactive digitization should be;

B. Further, through the application of ICT systems, the patient records at all facilities which provide mental health care services should be recorded electronically. A report on the critical requirements for the successful execution of such a project should be included in the Ministerial Response of the MoH;

C. That consideration be given to establishing separate units/wards at public hospitals dedicated for the treatment of children/minors with mental disorders;

D. That therapy be practiced more extensively in the treatment of the mentally ill as a means of complementing pharmacological interventions;

E. To reduce the probability of replication of efforts and/or the inefficient allocation of resources, the management of the Student Support Services Division (MoE) and the
managers of Child Guidance Clinics should collaborate on a continuous basis with respect to delivering mental health services to children in a more expeditious manner;

F. That persons over the age of 65 years undergo periodic screening for Alzheimer’s disease and dementia as allegedly occurs in the UK;

G. That an objective assessment of the performance of the Mental Health Unit of the Ministry of Health must be undertaken. In the Ministerial Response to this report, the MoH should provide the Parliament with details on the short and medium-term objectives of this unit;

H. That a CCTV Camera system be installed at the St Ann’s Hospital as a means of bolstering the security surveillance system at the hospital;

I. A system/method to record the activities of Mental Health Officers in relation to Section 15 (1) of the Mental Health Act must be instituted within fourth (4) months of the presentation of this report;

J. Support to women who may be experiencing post-partum depression and other maternity-related mental illnesses should be incorporated within the ambit of post-natal care provided at public health care facilities;

K. An action plan for attending to the shortcomings at the St. Ann’s Hospital which were identified by the Committee during its site should be produced by the Ministry of Health within three months of the presentation of this report to the Houses of Parliament;

L. That written guidelines and protocols be developed in relation to the tracking and monitoring of mentally-ill patients who were discharged from mental health care facilities;
M. That the MoH engages the Ministry of National Security and the Regional Corporations in establishing programmes to train emergency and first responders to handle the mentally-ill persons in the event of a disaster; and

N. Provide the Parliament with an update on the implementation of the “New model of Mental Health Care” that the MoH anticipated would be implement by the end of fiscal year 2018.
OBJECTIVE 3: To determine the adequacy of the medical practitioners who specialize in mental health care and wellness

The various types of psychologists that operate in this country

4.3.1. According to TTAP, the various types of psychologists that practice in Trinidad and Tobago are as followed:

- Clinical Psychologists;
- Neuropsychologists (a sub-specialization of Clinical Psychologists);
- Counseling Psychologists;
- School/Educational Psychologists;

(These are the three professions within psychology that offer professional services to clients/persons for a cost).

4.3.2. There are other psychologists who work in different settings—health, educational, research, corporate, human resources etc. They are:

- Forensic Psychologists;
- Work/organizational psychologists;
- Health psychologists;
- Developmental psychologists; and
- Social Psychologists.

Mental health care professionals available to treat children/adolescents

4.3.3. The Committee was informed by MoH that the number of mental health care professionals employed by the MoH is inadequate to effectively treat children. The Ministry reported that there are shortages in Child Psychiatrists, Clinical Psychologists, Speech and Language Therapists, Occupational Therapists and other professionals in public health. It was noted that there is a global shortage of professionals in the field of Child Psychiatry. In view of this, the MoH advised that it has identified Child Psychiatry as an area of priority and has conveyed this to the National Scholarship Programme, Ministry of Public Administration. The Ministry expects the scholarship awards to attract more persons to the field in the near future. It was
further indicated in the submission from MoH that plans are in place for Registered Mental Nurses assigned to children’s homes throughout Trinidad and Tobago.

The estimated number of qualified psychologists and psychiatrist in Trinidad and Tobago

4.3.4. In a submission from the TTAP, it was indicated that the best estimate at this time of the number of qualified psychologists in Trinidad and Tobago is between 200-300 persons who hold at least a Master's Degree in Psychology. Unfortunately, due to the absence of a register of practicing psychologists, the TTAP was incapable of providing an actual number. However, this is currently being addressed by the Association.

4.3.5. Notwithstanding the lack of statistical data to confirm the actual number of practicing psychologists, the TTAP estimated that there is an adequate number of “Masters’ level clinical and counseling psychologists”. However, the Association advised the Committee that the number of Doctoral level psychologists is still inadequate and as such Masters Level Psychologists have been operating in a number of roles throughout the country. In order to ensure appropriate, competent and ethical delivery of psychological services, the Committee was advised that it is essential that frameworks exist whereby junior and inexperienced Masters' level psychologists are supervised by qualified doctoral-level psychologists.

4.3.6. According to MoH’s submission dated May 16, 2017, the St. Ann's Psychiatric Hospital is currently staffed with 8 full-time Specialist Medical Officers (SMOs), 5 full-time Registrars (only two of which have completed post-graduate training in psychiatry), 25 House Officers and 3 part-time SMOs. The current ratios for the St. Ann’s Hospital are 17 patients per doctor and 56 patients per fully trained psychiatrist (please see appendix XIV for more details).

4.3.7. In a MoH submission dated September 28, 2018 it was revealed that as at September 01st, 2018, the doctor-to-patient ratio in mental health wards located in the other public hospitals (i.e. not including the St. Ann’s Hospital) was as stated in table 10 below.
### TABLE 10: DOCTOR-TO-PATIENT RATIO IN MENTAL HEALTH WARDS LOCATED IN PUBLIC HOSPITALS (I.E. NOT INCLUDING THE ST. ANN’S PSYCHIATRIC HOSPITAL)

<table>
<thead>
<tr>
<th>RHA</th>
<th>Location of Psychiatric Ward</th>
<th>Doctor to Patient ratio</th>
<th>Psychiatrist to Patient ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCRHA</td>
<td>Eric Williams Medical Sciences Complex</td>
<td>1:4</td>
<td>1:7</td>
</tr>
<tr>
<td>SWRHA</td>
<td>San Fernando General Hospital</td>
<td>1:4</td>
<td>1:6</td>
</tr>
<tr>
<td>TRHA</td>
<td>Scarborough General Hospital</td>
<td>1:3</td>
<td>1:12</td>
</tr>
</tbody>
</table>

4.3.8. During an appearance before the Committee on June 07, 2017, officials of the TTRNA reflected on the findings of the Welch Committee Report (2016) which suggested that fifty-seven (57) vacancies exist for Registered Mental Health Nurses within the NWRHA. However, there are 32 Mental Health Nurses employed with the NWRHA.

4.3.9. The Committee was informed by MoH that House Officers are encouraged to take advantage of the DM Programme in psychiatry at UWI since it is easier to access training locally than abroad in the post-specialist disciplines.

4.3.10. Furthermore, the programme costs TT $30,000 per annum and is partially funded by GATE as a postgraduate programme. Doctors pursuing the programme have to pay TT $15,000 per year for four (4) years of training. It was suggested that scholarships be offered for sub-specialties such as child, substance abuse related, forensic or geriatric psychiatry since those are not offered in Trinidad and Tobago.

**Registration and licensing for Clinical Psychologists**

4.3.11. The President, TTAP indicated that the Association is the only representative body for Clinical Psychologists in Trinidad and Tobago but the legal provisions/parameters for the Registration and licensing of this cohort of professionals are currently not available.
4.3.12. The Association is currently deliberating on whether it should establish itself as an independent organization or seek incorporation by Act of Parliament. This is the main reason for the delay in the establishment of the TTAP as the official licensing body and registrar for psychologists in the country. The President of the Association indicated that stakeholder consultations on this matter was expected to commence by September 2017 to assist in advancing this process.

4.3.13. In the absence of an official Register for Psychologists in the country, the Association collates the number of graduates from the Clinical Psychology programs at UWI and USC and maintains a record of its historical membership to remain aware of the number of practicing Psychologists in Trinidad and Tobago. The Association also advised that it is in the process of drafting a Scope of Practice and a Code of Ethics for the Clinical Psychologist profession.

Training and Programmes offered in Mental Health Care and Wellness

MoH

4.3.14. In an appearance before the Committee on May 17, 2017 the MoH advised the Committee that general practitioners/primary care physicians receive training which involves a mental health component so that there is a level of awareness, especially as it concerns persons presenting with Non-communicable Diseases (NCDs). Furthermore, pediatricians are equipped to identify developmental disorders and refer patients for additional assistance.

4.3.15. The Ministry further advised that the type of compulsory and optional training for staff employed at public health facilities are as follows:

- Customer Service (all staff)
- Patient Restraint & Lifting for Attendants
- Health & Safety (all staff)
- Infection Control (all staff)
- Supervisory Management (Nursing and supervisory staff)
Trinidad and Tobago Registered Nurses Association

Registered Mental Health Nurses Programme

4.3.16. According to the TTRNA, there are two nursing schools that prepare Registered Mental Nurses in Trinidad and Tobago – 1) These are the MoH and MoE Apprentice Programme, which awards a Diploma qualification, and 2) the College of Science, Technology and Applied Arts of Trinidad and Tobago (COSTAATT) which offers a Bachelor of Nursing in Psychiatric Nursing Programme.

4.3.17. According to the Office of the Director of Nursing Education, MoE, the Registered Mental Nurses Programme is not as popular as the other programmes offered by MoE such as the Registered Nurse Programme. It was reported that the school often struggles to convene a cohort/batch of Psychiatric Nursing students.

4.3.18. In the submission from TTRNA dated June 7, 2017, it was indicated that currently, COSTAATT, MoE and MoH via the Apprentice Programme, train Psychiatric Nurses. For the last 27 years, mental health nurses have been trained and graduates are produced at least twice a year.

4.3.19. The Committee obtained the statistics on the enrollment output of the Psychiatric Nursing Programme for the period 2014-2017. (the details are at appendix XV)

4.3.20. A gap analysis is performed by the St. Ann’s Psychiatric Hospital to determine the need for Registered Mental Nurses. It was indicated that as of 2017, there exists a 25% shortage of Resident Nurses and a 55% shortage of Enrolled Nursing Assistants at the Hospital.

Student Support Services Department (SSSD)

4.3.21. In the submission from MoE, it was indicated that some of the Teachers, Deans, and Principals are adequately trained to identify and recognize the various forms of mental illnesses which may affect children. However, the MOE is working on building capacity through targeted training based on needs. Training for school personnel include:

- Response protocol with respect to the referral process to SSSD;
• Identification of risk and protective factors associated with mental health disorders at the level of individual, family, and community; and

• Psychological First Aid - through CREDI - training began in the Port of Spain Education District for Teachers, School Safety Officers, Social Workers, Guidance Officers and Special Education Officers;

4.3.22. Guidance Officers, Guidance Counsellors, and School Social Workers are trained to recognize various forms of mental illness and are required to sensitize school staff. The Ministry of Education is also organizing in-house and external training of SSSD Staff. (Please see appendix XVI).

**The Children’s Authority**

4.3.23. The Children’s Authority indicated in its submission that all Clinical Psychologists employed by the Authority are trained in the administration, scoring and interpretation of psycho-educational assessments which may be required to ascertain the intellectual functioning, achievement levels, and neurodevelopmental functioning of children in need of care and protection. These aid in identifying any neurodevelopmental conditions that may warrant intervention.

4.3.24. Additionally, all Psychologists employed by the Authority have received several rounds of training, arranged by the Authority, in the administration, scoring and interpretation of the standard psychological tests.

4.3.25. Furthermore, the Authority’s Psychologists and Social Workers, particularly those within the Assessment and Child and Family Services Units that focus on evaluations and treatment, also benefit from in-house clinical supervision. This in-house clinical supervision allows staff to discuss and receive guidance on assessments and the management of the presenting conditions, including mental illness. This facilitates efficient detection, diagnosis, and treatment.

4.3.26. In order to build the skillsets of caregivers across the nation’s community residences, the Office of the Prime Minister (Gender and Child Affairs) partnered with the Children's
Authority to conduct a training programme for staff of the Community Residences from December 2016 to August 2017 (8 months). Some of the courses completed by caregivers include:

- Children’s Psychological Health (Trauma)
- Crisis Management & De-Escalation
- Control and Restraint for Children
- Child Protection and Behavior Management
- Children/adolescents with mental disorders referred to Children's Community Residences, Foster Care by the Authority.

Training offered to employees at Children's Community Residences, Foster Care, and Nurseries

4.3.27. In the submission of the Children’s Authority dated November 30, 2017 it was indicated that in order to care for children living with mental illness, caregivers need to be sufficiently trained to treat with the challenging behaviors that result from mental illness. Of equal importance is the need for specialist staff in the form of trained nurses and medical practitioners to manage the child’s mental and physical health. While some staff employed at the various children’s homes across Trinidad and Tobago possess qualifications and training in childcare, the Authority has not seen evidence that the staff of the CRs are trained to treat with children living with mental illness.

The involvement of the Trinidad and Tobago Police Service (TTPS) in treating with the mentally-ill.

4.3.28. In the TTPS submission27, we were informed that a component of the Police Academy’s Induction Training Programme includes the training of officers to handle situations involving mentally-ill persons. The training is dispensed through Module 15 of the Behavioral Sciences course, entitled “Dealing with the Mentally-Ill- Special Needs”.

4.3.29. It was indicated in the TTPS’s submission that relevant training module is encompassing the issue of dealing with mentally-ill persons is provided at least once per year during in the

27 By letter dated July 25, 2017
induction programme. Additionally, standard operating procedures which guide officers on how to treat with persons who are mentally-ill, are contained in the **TTPS Standing Order No 33: “Mentally-Ill Persons”**.

4.3.30. The relevant sections of the Standing Orders comprise the following sub headings:

- Mentally-Ill Persons;
- Mental Health Officers;
- Detained Mentally-Ill Persons;
- Assistance by Police Officer;
- Breach of the Peace committed by Mentally-Ill Persons;
- Request for a written statement;
- Obtaining a Remand Warrant and Conveyance;
- Report to be submitted on committal; and
- The responsibility of the Officer in charge.

4.3.31. The Standing Orders of the TTPS provides guidance to officers on how to “manage” mentally-ill persons who have breached the law and have been detained into police custody. Furthermore, the Standing Order prescribes when and how the police shall render assistance in apprehending a person for transfer to an appropriate Medical Institution or to a Police Station (whichever is applicable).

4.3.32. The TTPS, reported that the Police Academy has established Course and Programme Committees with the aim of developing training courses and programmes to be offered at the Police Academy. These Committees are expected to comprise members of the TTPS and external stakeholders.

4.3.33. By written submission dated August 23, 2018, the TTPS indicated that two meetings were held on Friday 28th July 2017 and Monday 27th November 2017 with stakeholders’ regarding the development of training to improve police officers’ dealings with special interest groups in society. The meeting held on Friday 28th July 2017 comprised of 26 persons from the TTPS, MoH, MoSDFS, UWI, NGOs and Governmental Organizations. Furthermore, in the meeting
Sixth Report of the Joint Select Committee on Social Services and Public Administration

held on Monday 27th November 2017 a total of 22 person were in attendance which included officials from TTPS, MoSDFS, NGOs and Governmental Organizations.

4.3.34. In a correspondence dated August 23, 2018, the TTPS provide a list of qualified person that were engaged to design a training programme geared specifically to sensitize officers about mental illness and enhance their ability to effectively address situations that involve persons who are mentally-ill. The table below shows the “qualified persons” that were engaged to design the training programme:

**TABLE 12: THE “QUALIFIED PERSONS” THAT WERE ENGAGED TO DESIGN THE TRAINING PROGRAMME**

<table>
<thead>
<tr>
<th>No.</th>
<th>NAME</th>
<th>RANK/POSITION</th>
<th>UNIT/ORGANISATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Arlene Layne</td>
<td>Assistant Superintendent of Police</td>
<td>Community Policing Secretariat</td>
</tr>
<tr>
<td>2.</td>
<td>Carl Ryan</td>
<td>Mental Health Consultant</td>
<td>NICER Foundation (NGO)</td>
</tr>
<tr>
<td>3.</td>
<td>Ian C McLean Jr.</td>
<td>Mental Health Officer</td>
<td>NWRHA</td>
</tr>
<tr>
<td>4.</td>
<td>Katija Khan</td>
<td>Association of Psychologists, UWI Lecturer</td>
<td>UWI HAP</td>
</tr>
<tr>
<td>5.</td>
<td>Kevon Maynard</td>
<td>Mental Health Officer</td>
<td>NWRHA</td>
</tr>
<tr>
<td>6.</td>
<td>Livingston Mayers</td>
<td>Victim &amp; Witness Support Officer</td>
<td>POS Division /West End</td>
</tr>
<tr>
<td>7.</td>
<td>Michael Reid</td>
<td>Director</td>
<td>Social Planning Ministry of Social Development and Family Services</td>
</tr>
<tr>
<td>8.</td>
<td>Ronald Auguste</td>
<td>Social Work Officer</td>
<td>Social Work Unit, UPS</td>
</tr>
<tr>
<td>9.</td>
<td>Samuel Shafe</td>
<td>Psychiatrist</td>
<td>UWI and NWHRA</td>
</tr>
</tbody>
</table>

4.3.35. With regard to any training programme that has been launched to sensitize police officers about mental illness and enhance their ability to effectively address situations that involve persons who are mentally-ill, by correspondence dated August 23, 2018, the TTPS indicated that no training programme has since been launched via the Advanced Programmes and Services Training Unit to sensitize in-service officers about mental illness. This is largely due
Sixth Report of the Joint Select Committee on Social Services and Public Administration

to human and financial resource constraints presently being experienced at the Trinidad and Tobago Police Service Police Academy. While the training is available through external service providers, the Trinidad and Tobago Police Service does not have the financial resources to pay for the training.

FINDINGS AND RECOMMENDATIONS

Findings

4.3.36. In this regard the Committee has made the following observations:

i. Based on the data received regarding the human resources at the “flagship” mental health facility (St. Ann’s) we concluded that additional nursing staff is required to augment the standard of service delivery at the hospital. However, the inadequate number of mental health nurses may be connected to the relatively low level of interest of aspiring nurses in specializing in the area of mental health care;

ii. Evidence received also revealed a shortage of specialist medical practitioners within the network of public mental health care. As a result, the Committee is concerned that the few Psychiatrists and Psychologists who operate within the public sector may be dispensing treatment for mental issues for which they do not hold the requisite post-graduate qualifications. Should this be the case, we anticipate adverse effects on the quality of the services provided and the retention of said persons because they are likely to be overworked;

iii. In the absence of a formal/statutory arrangements for registering psychologists, it was difficult for the Committee to verify the number of practicing psychologists in this country. Notwithstanding, we gleaned that there is a shortage of psychologists with doctoral qualifications. Neuropsychology (pediatrics) was one of the specialty areas identified by stakeholders for human resource development;

iv. The fact that the Registered Mental Nurses Programme is not as popular as the other programmes offered by the two nursing schools suggests that there will continue to be shortages of nursing staff in mental health care facilities at least within the short to medium-
term. As such, we may continue to observe vacancies at the St. Ann’s Hospital in the positions of:

- Nursing Supervisor
- Head Nurse
- Registered Mental Nurse
- Enrolled Nursing Assistant
- Patient Care Assistant
- Nurses Aide
- Nursing Instructor

v. The Committee took particular note of the human resource shortages within the public sector in the positions of Child Psychiatrists, Clinical Psychologists, Speech and Language Therapists and Occupational Therapists and other professionals;

vi. The Committee noted that financial constraints in the State sector has thwarted the efforts of the authorities to fill vacant posts throughout the public health care facilities;

vii. The student support services division is responsible for coordinating support services to students via an amalgamation of professionals including Guidance Counsellors and Psychologists. Undoubtedly, this Division of the MOE plays an essential role in dispensing special or additional support to students. However, the disparity in the ratio of students to professionals is extremely high and as such brings into question the quality of service the Division is able to dispense; and

viii. The Committee questioned to what extent teachers are equipped to detect mental abnormalities within the classroom (besides the obvious). In this regard, a system of basic continuous training for teachers is required.

**Recommendations**

In light of the foregoing, the Committee recommends the following:
A. The Committee is cognisant that there is a shortage of specialist medical doctors in various aspects of medicine within the public health care system, including psychiatry. The award of scholarships through collaboration between the MoH, the MoE and the Ministry of Public Administration appears to be the most potent method of filling these human resource gaps. In the Ministerial Response, the MoH must advise the Parliament on the number of post-graduate government scholarships that were awarded in the areas of psychiatry and psychology in fiscal 2017/2018 and the number of scholarships proposed to be awarded in the next fiscal;

B. Given the relatively low enrolment rate into the Mental Health Nurse programmes, the Committee recommends that an incentive scheme be developed to induce persons to select this specialist area of Nursing as a career;

C. In the interest of accountability and the well-being of the public, every cohort of professionals engaged in dispensing medical, psychological or therapeutic treatment to patients should be regulated either voluntarily and/or by statute. We recommend that the TTAP collaborate with the MoH with a view to developing a framework for the partial or complete regulation of practicing Psychologists. In this regard, the experiences and lessons learned by existing regulatory bodies such the Medical Council and the Dental Council should be taken into consideration;

D. That there be a better multidisciplinary integration of treatment to create established protocols for care. The roles and relationships between professionals within the mental health field must be recognized and standardized i.e. nurses, mental health officers, social workers, occupational therapists, speech pathologists, psychiatrists, psychologists etc. The MoH must produce a single brochure or suitable publication to enlighten the public about the distinction in the roles of these professionals. This should be completed within 60 days of the publication of this report; and

E. That professional medical treatment for the mentally-ill should be supplemented by alternative treatments including art therapy, music and drama therapy, and animal therapy.
OBJECTIVE 4: To assess the adequacy of the legislative framework that governs mental health

Mental Health Act 1975 Chap. 28:02

4.4.1. The Mental Health Act 1975 Chap. 28:02 is the primary legislation which provides for the administration of mental health services in Trinidad and Tobago. Enacted over 43 years ago, this law has not undergone substantial amendments since 2014. Some of the main sections of the Act make provisions for *inter alia*:

- a) admission and detention in psychiatric hospitals or wards;
- b) the establishment and operations of certain Tribunals; and
- c) protection of property of patients.

4.4.2. Section 15 of the Act empowers a Mental Health Officer in the course of his/her duties, to take a person from a public place who may be displaying symptoms of a mental disorder, to an appropriate mental health care facility.

Mental Health Review Tribunal and Psychiatric Hospital Tribunal

4.4.3. By submission dated September 14, 2018, the MoH informed the Committee that the Psychiatric Hospital Tribunal was convened in September 2017 and its last meeting was held on December 12th 2017. It was reported that the Mental Health Review Tribunal was never convened.

4.4.4. With respect to inspections conducted by the Psychiatric Hospital Tribunal in accordance with Section 18(1) (c) of the Mental Health Act, the MoH advised that the last inspection was conducted on December 12th 2017.

*Deficiencies within the Mental Health Act 1975 Chap. 28:02*

4.4.5. The Committee noted that there are no provisions within the Mental Health Act Chap. 28:02 which treat specifically with the dispensing of mental health care to children. Perhaps the most
relevant section of the Act which may be pertinent to children is Section 28 which provides that the Minister may issue a certificate approving the use of any house as an approved home for the reception of persons who are mentally-ill and in need of care and treatment. This provision may be extrapolated to include Community Residents, Children Homes and Homes for the Elderly. Notwithstanding this specialised accommodation and care to children with mental illness was not included in the legislation.

4.4.6. According to MoH, the under mentioned are the current deficiencies of the Act:

i. Primarily, the Act does not adequately protect and promote the rights of patients with mental illness. Consequently, provision needs to be made for the recognition of inter alia, the right to be informed of any proposed treatment, right to education, right to work, the right to the exercise of civil, political, economic, social, and cultural beliefs, the right to be treated with humanity and respect for the inherent dignity of the human person, and the right to be protected from sexual and other forms of exploitation, physical or other form of abuse and degrading treatment.

ii. It does not adequately address patient care in the community.

iii. The current fines are too low for offences committed under the Act and as such they need to be increased to a level which will cause them to act as deterrents.

iv. Section 9(2) and (4) of the Act, should refer to persons under the age of eighteen (18) who are unmarried. Further, a voluntary patient should not be held for up to 7 days after he/she gives notice of his intent to leave the Hospital. Such a patient should be allowed to leave at his will, provided that his status was not changed to involuntary patient.

v. The framework does not mandate the Attending Practitioner to get informed consent from the patient before treatment of the patient.

vi. It does not provide for procedural safeguards such as the right of the patient to choose and appoint counsel to represent him/her including representation in any complaint procedure or appeal.

vii. It is relatively easy under this Act to detain a person and restrict his/her liberty and autonomy on the basis of mental illness. An assessment by a medical practitioner of a person’s needs is given more importance than that of the patient’s own views about whether he needs care or not.
viii. With respect to Section 8 of the Act, the review period should be reduced to within 24 hours, for an assessment to be made. The present period is too long and is onerous on the patient.

ix. With respect to Section 15 of the Act, same ought to be amended to read “any person found wandering at large on a highway, road or in any public place and who by reason of his appearance, conduct and conversation…” As such, the three conditions must be present before the Mental Health Officer proceeds to consider the mental state of the individual.

4.4.7. In the MoH’s submission dated May 16, 2017, it was reported that there is a draft revised Mental Health Act that requires further review and refinement. The Ministry suggested that the draft revised Act seeks to address some of the discrepancies and shortfalls in the existing legislation and its focus will be a community based approach. This will therefore necessitate infrastructure, training and stakeholder consultation. The MoH reported that revisions to the Act should be completed and considered by Parliament by 2020. The Mental Health Policy is being finalized and consultations with key stakeholders should be completed in 2019.

The Children’s Authority Act 2000 Chap 46:10

4.4.8. At present, Section 30 of the Children’s Authority Act, Chap 46:10 is the only provision in the existing suite of legislation which treats with children certifiable as mental patients as follows:

30.3[1] (1) Where a child has been received into the care of the Authority and subsequently that child is determined to be mentally-ill, under the Mental Health Act, and such determination results in the admission of the child to a psychiatric hospital, if there is no one willing and able to assume responsibility for the child, the Authority shall continue to exercise responsibility and rights in respect of that child notwithstanding the fact that the Authority does not have physical control of the child.

The above provision relates to children already received into the Authority's care and thereafter certified as mentally-ill under the Mental Health Act.
Laws, Policies and international agreements which guide the Ministry of Education as it relates to the education of children with mental illnesses

4.4.9. The Ministry of Education is guided by the following laws/policies:

- Trinidad and Tobago Mental Health Act, Chapter 28:02 – This is the primary legislation that guides the intervention of the Ministry of Education with respect to mental health;
- Education Act Chapter 39:01 of 1966;
- Ministry of Education National Policy on Student Support Services, 2004;
- Equal Opportunity Act, Chapter 22:03;
- Inclusive Education Policy 2009;
- Preventing Suicide a Resource for Teachers and School Staff; Mental and Behavioural Disorders; the World Health Organization, Geneva, 2000;
- Dakar Framework for Action; World Education Forum, Senegal, 26-28 April 2000;
- Draft Education Policy Paper 2017-2022; and

FINDINGS AND RECOMMENDATIONS

Findings

4.4.10. In this regard the Committee has made the following findings:

i. There are no specific provisions within the Mental Health Act (Chap. 28:02) for the treatment of children with mental illness;

ii. Given the “lacunas” in the current act as it relates to the absence of certain safeguards to protect the rights and freedoms of a mentally-ill or mentally subnormal person, we
anticipate that the legal counsel guiding the Ministry of Health would aim to strike an acceptable balance between the public interest and individual rights and liberties; and

iii. It is imperative that the Ministry of Health and the Regional Health Authorities develop the capacity to implement the provisions contained in the existing legislation. The Committee intends to monitor the adherence of existing provisions of the Mental Health Act pending the amendment of same by the Parliament.

**Recommendations**

In light of the foregoing, the Committee recommends the following:

A. That consultations with stakeholders on the proposed amendments to the Mental Health Act be initiated and the final amendments be submitted for the consideration of the Parliament by the second quarter of 2019;

B. Section 30 (2) of the Children’s Authority Act (Chapter 46:10) should be amended to include a stipulated timeframe for the submission of “reports of the child’s mental status”; and

C. The Committee recommends that a review of the existing suite of children’s legislation and the Mental Health Act be conducted to ensure that adequate provisions are made to treat with the complex legal issues which arise out of the diagnosis, treatment and accommodation of children who are mentally-ill or mentally subnormal.
Your Committee respectfully submits this Report for the consideration of the Parliament.

Mr. Esmond Forde, MP
Vice-Chairman

Mrs. Glenda Jennings-Smith, MP
Member

Brig. Gen. (Ret.) Ancil Antoine, MP
Member

Mrs. Christine Newallo-Hosein, MP
Member

Ms. Khadijah Ameen
Member

Ms. Allyson West
Member

Mr. Rohan Sinanan
Member

November 07, 2018
APPENDICES
Appendix I

Persons who appeared and provided oral Evidence
<table>
<thead>
<tr>
<th>Name of Official</th>
<th>Portfolio</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public Hearing Held on May 17, 2017</strong></td>
<td></td>
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<tr>
<td>Mr. Richard Madray</td>
<td>Permanent Secretary</td>
<td>Ministry of Health (MoH)</td>
</tr>
<tr>
<td>Dr. Vishwanath Partapsingh</td>
<td>Chief Medical Officer</td>
<td></td>
</tr>
<tr>
<td>Prof. Gerard Hutchinson</td>
<td>Head, Psychiatry, NCRHA</td>
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<tr>
<td>Dr. Hazel Ann Othello</td>
<td>Medical Chief of Staff, St Ann’s Hospital</td>
<td></td>
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<tr>
<td>Dr. Celia Ramcharan</td>
<td>Specialist Medical Officer, Psychiatry, SWRHA</td>
<td></td>
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<tr>
<td>Ms. Mala Kowlessar</td>
<td>State Counsel III</td>
<td></td>
</tr>
<tr>
<td>Mr. Lawrence Jaisingh</td>
<td>Director, Health Policy, Research and Planning</td>
<td></td>
</tr>
<tr>
<td>Mr. Asif Ali</td>
<td>Health Sector Advisor</td>
<td></td>
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<tr>
<td><strong>Public Hearing Held on June 07, 2017</strong></td>
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<tr>
<td>Mr. Idi Stewart</td>
<td>President</td>
<td>Trinidad and Tobago Nurses Association</td>
</tr>
<tr>
<td>Ms. Letitia D. Cox</td>
<td>Social Marketing Officer</td>
<td></td>
</tr>
<tr>
<td>Mr. Walt Murphy</td>
<td>Mental Health Officer</td>
<td></td>
</tr>
<tr>
<td>Dr. Lucretia Gabriel</td>
<td>Chairman</td>
<td>Lifeline</td>
</tr>
<tr>
<td>Mr. David Murphy</td>
<td>Council Member</td>
<td>Trinidad and Tobago Nurses Council</td>
</tr>
<tr>
<td>Dr. Katija Khan, PHD</td>
<td>Coordinator, MSC Clinical Psychologist, Programme/Lecturer in Clinical Psychology</td>
<td>Trinidad and Tobago Veterinary Association (TTVA)</td>
</tr>
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</table>
### Site Visit to St. Ann’s Psychiatric Hospital conducted on June 28, 2017

<table>
<thead>
<tr>
<th>Name of Official</th>
<th>Portfolio</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. Lawrence Jaisingh</td>
<td>Director, Health Policy, Research and Planning,</td>
<td>Ministry of Health (MoH)</td>
</tr>
<tr>
<td>Ms. Ashvini Baball</td>
<td>Mental Health Officer, Ministry of Health</td>
<td></td>
</tr>
<tr>
<td>Mr. Sheldon Cyrus</td>
<td>Chief Executive Officer, NWRHA</td>
<td></td>
</tr>
<tr>
<td>Dr. Hazel Othello</td>
<td>Medical Chief of Staff, St. Ann's Hospital, NWRHA</td>
<td></td>
</tr>
<tr>
<td>Mrs. Norma Harewood</td>
<td>Nursing Administrator, St. Ann's Hospital, NWRHA</td>
<td></td>
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<tr>
<td>Mrs. Keisha Lewis</td>
<td>General Manager, Mental Health Services, St. Ann's Hospital, NWRHA</td>
<td></td>
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<tr>
<td>Mr. Terron Gilchrist</td>
<td>Hospital Administrator, St. Ann's Hospital, NWRHA</td>
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</tr>
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### Public Hearing Held on November 15, 2017

<table>
<thead>
<tr>
<th>Name of Official</th>
<th>Portfolio</th>
<th>Organization</th>
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<tbody>
<tr>
<td>Mrs. Lenor Baptiste-Simmons</td>
<td>Permanent Secretary</td>
<td>Ministry of Education (MoE)</td>
</tr>
<tr>
<td>Mr. Harrilal Seecharan</td>
<td>Chief Education Officer</td>
<td></td>
</tr>
<tr>
<td>Ms. Amanda Pedro</td>
<td>Guidance Officer II</td>
<td></td>
</tr>
<tr>
<td>Mrs. Leticia Rodriguez-Cupid</td>
<td>Special Education Teacher II</td>
<td></td>
</tr>
<tr>
<td>Mrs. Sharon Francis-Gaines</td>
<td>Social Work Specialist</td>
<td></td>
</tr>
<tr>
<td>Name of Official</td>
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</tr>
<tr>
<td>Mr. Richard Madray</td>
<td>Permanent Secretary</td>
<td>Ministry of Health (MoH)</td>
</tr>
<tr>
<td>Dr. Roshan Parasram</td>
<td>Chief Medical Officer</td>
<td></td>
</tr>
<tr>
<td>Dr. Indar Ramtahal</td>
<td>Medical Chief of Staff, St Ann’s Hospital (Ag.)</td>
<td></td>
</tr>
<tr>
<td>Dr. Jacqueline Sharpe</td>
<td>SMO, Child and Adolescent Psychiatrist</td>
<td></td>
</tr>
<tr>
<td>Prof. Gerard Hutchinson</td>
<td>Head of Psychiatry, UWI</td>
<td></td>
</tr>
<tr>
<td>Ms. Ashvini Nath</td>
<td>Manager, Mental Health Unit</td>
<td></td>
</tr>
<tr>
<td>Mr. Hanif E.A. Benjamin</td>
<td>Chairman, Board of Management</td>
<td>Children’s Authority</td>
</tr>
<tr>
<td>Ms. Safiya Noel</td>
<td>Director</td>
<td></td>
</tr>
<tr>
<td>Ms. Christalle Gemon</td>
<td>Deputy Director- Care, Legal and Regulatory</td>
<td></td>
</tr>
<tr>
<td>Dr. Margaret Nakhid-Chatoor</td>
<td>President</td>
<td>Trinidad and Tobago</td>
</tr>
<tr>
<td>Dr. Krishma Maharaj</td>
<td>Senior Clinical Psychologist and Health Administrator</td>
<td>Association of Psychiatrist</td>
</tr>
</tbody>
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Appendix II

Report on Site Visit to the St. Ann’s Psychiatric Hospital
Joint Select Committee on Social Services and Public Administrations

Report on Site Visit to the St. Ann’s Psychiatric Hospital

on June 28th 2017

St. Ann’s Psychiatric Hospital, St. Ann’s
Contents

Introduction ........................................................................................................................................... 86

Visit to St. Ann’s Psychiatric Hospital, St. Ann’s .................................................................................. 87

  Background information on the facility ............................................................................................. 87
  Visit to the Forensic Ward (wards 15 and 16) .................................................................................. 90
  Visit to the LFE Lewis Ward (ward 1) ............................................................................................... 94
  Visit to Ward 24 (female long stay ward) .......................................................................................... 97
  Visit to the Evaluation room (ward 9) ................................................................................................. 99
  Visit to Ward 17 (male long stay ward) ............................................................................................ 100

Recommendations .................................................................................................................................. 102
Report on a site visit to the St. Ann’s Psychiatric Hospital held on Wednesday
June 28th 2017, from 10:02 am to 11:45pm

Introduction

On Wednesday May 17, 2017, the Committee convened a public hearing with a team of officials of the Ministry of Health (MoH) pursuant to its inquiry into the state of Mental Health Services and Facilities in Trinidad and Tobago. Prior to this meeting, the Committee requested a written submission on the subject from the Ministry of Health (MoH). Written and oral submissions were also received from Lifeline, the Trinidad and Tobago Association of Psychologists (TTAP), the Trinidad and Tobago Registered Nurses Association (TTRNA), and the Nursing Council of Trinidad and Tobago.

Following the meeting with officials of the line ministry, the Committee decided that it would be beneficial to acquire a first-hand perspective of the state and condition of the primary Mental Health Facility in Trinidad and Tobago. As such, it was decided that the Committee would undertake a site visit to the St. Ann’s Psychiatric Hospital, which is the only mental hospital in the country that facilitates the assessment, treatment and admission of mentally-ill persons.

Ultimately, the Committee hoped that by conducting the site visit to the St. Ann’s Psychiatric Hospital it will:

a) Acquire a realistic perspective of the issues/challenges which may be impacting the operations of the hospital; and
b) Verify evidence received in writing or during the public hearing with officials of the Ministry of Health and the Trinidad and Tobago Nurses Association.
Visit to St. Ann’s Psychiatric Hospital, St. Ann’s

Background information on the facility

1. The St. Ann’s Psychiatric Hospital currently occupies 125 Acres of land and is the only mental hospital in the country. The institution provides 69 beds per capita (100,000) and comprises 27 wards, which include 14 chronic wards, 9 acute wards and 2 forensic wards. Services offered at SAPH are national in scope and include:
   i. inpatient psychiatry services;
   ii. child guidance services;
   iii. forensic psychiatry services;
   iv. medical internship;
   v. occupational therapy;
   vi. psychology;
   vii. physical education;
   viii. psychiatric social work;
   ix. psychiatric outpatient clinics;
   x. psychosocial rehabilitation; and

2. Currently there are 820 patients warded at the facility. Patients are admitted based on area of residence which comprises 5 Sectors, for example Sector 5 comprises persons who reside in Port of Spain and Tobago.

Members who visited the St. Ann’s Psychiatric Hospital

i. Dr. Dhanayshar Mahabir - Chairman
ii. Mr. Esmond Forde, MP - Member
iii. Mrs. Glenda Jennings-Smith, MP - Member
iv. Mr. Rohan Sinanan - Member
The Committee was accompanied by the following Parliamentary officials:

i. Ms. Kimberly Mitchell - Assistant Secretary to the Committee
ii. Ms. Ashaki Alexis - Parliamentary Intern
iii. Mr. Mark Peterson - Communications Officer
iv. Mrs. Lucinda Leston-Raymond - Clerk Stenographer II
v. 2 Parliament Police Officers
vi. 3 Chauffeur/Drivers

Officials from the Ministry of Health who were during the site visit

i. Mr. Lawrence Jaisingh - Director, Health Policy, Research and Planning, Ministry of Health
ii. Ms. Ashvini Baball - Mental Health Officer, Ministry of Health
iii. Mr. Sheldon Cyrus - Chief Executive Officer, NWRHA
iv. Dr. Hazel Othello - Medical Chief of Staff, St. Ann's Hospital, NWRHA
v. Mrs. Norma Harewood-Clarke - Nursing Administrator, St. Ann's Hospital, NWRHA
vi. Mrs. Keisha Lewis - General Manager, Mental Health Services, St. Ann's Hospital, NWRHA
vii. Mr. Terron Gilchrist - Hospital Administrator, St. Ann's Hospital, NWRHA

3. Members arrived at the facility at 10:02 a.m. and was greeted by Dr. Hazel Othello, Medical Chief of Staff at the St. Ann's Psychiatric Hospital.
4. A brief meeting was held with officials of the Ministry of Health and the St. Ann’s Psychiatric Hospital in the Admission building before the commencement of the tour of the facility. During this meeting, a multimedia presentation on the history and operations of the facility was presented. Thereafter, Members of the Committee posed questions to the Hospital’s Medical Chief of Staff and the line Ministry.

Figure 1: Presentation being done by Dr. Hazel Othello, Medical Chief of Staff at the St. Ann's Psychiatric Hospital

Figure 2: Brief meeting with Dr. Dhanayshar Mahabir (Chairman), Mrs. Glenda Jennings-Smith, MP (Member), Mr. Esmond Forde MP (Member), Mr. Rohan Sinanan (Member) and officials of the Ministry of Health
5. The tour of the facility commenced at 10:30 a.m. and was guided by Dr. Othello and Mrs. Harewood-Clarke.

6. The tour began at the Admission building and then moved on to the facility’s male and female forensic wards.

**Visit to the Forensic Ward (wards 15 and 16)**

7. This ward accommodates mentally-ill patients who have committed a crime or a violent offence and were ordered by the Court to be admitted to the facility.

8. The Members were shown the gardening area where the patients of this ward are allowed to plant fruits such as grapes and vegetables as a part of their treatment and therapy.
9. Members were introduced to the nurses assigned to both the male and female forensic wards and viewed the condition of the common and dormitory areas. Members were also informed that the ward has two categories of patients:

i. **President’s pleasure** - patients who were admitted to the facility before the legislative changes to the Mental Health Act were made; and

ii. **Court ordered** - patients ordered by the court to be admitted to the facility and are awaiting trial.
10. During the tour of the ward the following issues were highlighted:

i. Overcrowding

- The facility has no control over the intake of patients ordered by the court to be admitted to the ward;
- A number of patients are awaiting trial due to outstanding reports;
- There are patients who have been admitted to the forensic ward and remained there for over 10 years;
- The male forensic ward currently houses 46 patients with a capacity of 41 beds available;

Figure 5: Contingent gathered in the common area interacting with a staff member assigned to the male forensic ward.
Since the population on the female forensic ward is small, other female patients are also admitted and accommodated on that ward; and

There is no mechanism in place for the assessment and evaluation of patients ordered by the court to be conducted at outpatient clinics. The implementation of such a mechanism can assist in curbing the current issue of overcrowding at the St. Ann’s Psychiatric Hospital.

ii. Conditions

- Unsanitary and inhuman conditions;
- There is no designated visitor’s area. Currently the common area is used to host family members whenever they visit patients;
- Lack of accommodation for adolescents;
- The male and female forensic patients are housed in the same building;
- There is an urgent need for infrastructural and other maintenance work such as electrical to be done on the ward; and
- The need to maintain overall cleanliness of the ward.

iii. Staff

- There are 15 nurses assigned to the ward;
- The current staff to patient ratio on this ward is 1 to 7;
- Lack of male nurses assigned to the male forensic ward; and
- No designated personnel for the female forensic ward.

iv. Safety and care of patients

- It was observed that there were no fire extinguishers on both wards;
• It also appeared that there were no smoke alarms installed on the wards;
• Lack of a proper monitoring system. Currently the CCTV system is experiencing technical difficulties. Furthermore, the facility currently has one CCTV camera system which is located in the male forensic ward of the facility. However, the MoH has embarked on a tendering process to install CCTV cameras on that ward of the facility;
• There is a response time of 30 minutes by security personnel to any incident that may occur on the ward;
• Nurses assigned to the ward have only basic training in the restraint of patients; and
• No security personnel stationed inside the facility.

11. The tour then proceeded to the LFE Lewis Ward (ward 1).

Visit to the LFE Lewis Ward (ward 1)

Figure 6: The LFE Lewis Ward (ward 1)
12. LFE Lewis Ward (ward 1) is a ward which accommodates short-term patients (3 to 4 weeks) who have been brought into the facility to be assessed and evaluated. Staff assigned to this ward observed that during the carnival period there is an increase in admissions to this ward. The ward accommodates all diagnoses of mental illness.

13. The contingent arrived at the ward and was greeted by nurses and other staff. Members held a brief meeting with the nurses assigned to the ward before the start of the tour.

14. The tour of the ward was guided by Dr. Othello and Mrs. Harewood-Clarke. It initiated at the common area of the facility, where members interacted with the patients.
15. The contingent then proceeded to the dormitory area of the ward. The Members were able to view the conditions of the dormitories and asked questions about the patients residing at the ward.

16. During the visit the following issues were highlighted:

i. Overcrowding
   - It was observed that this ward was overcrowded. In addition to short-stay patients, other patients are also relocated to this ward in the event other wards are unable to accommodate them; and
   - Patients overstay the time period due to abandonment by relatives. In most cases, staff members are unable to make contact with the relatives of the ‘abandoned’ patient.

ii. Conditions
   - The condition of seclusion rooms appeared to be unsanitary. Patients are required to sleep on a sponge on the floor of the room; and
   - Each dormitory has a capacity of 3 beds.

![Figure 8: Seclusion room](image)
iii. Staff

- There is currently one psychiatrist assigned to this ward.

iv. Safety and care of patients

- No fire extinguishers on the ward;
- No smoke alarms installed on the ward;
- Absence of a security surveillance system;
- Lack of a proper patient monitoring system; and
- No security personnel inside the facility.

17. Members then proceeded to Ward 24.

Visit to Ward 24 (female long-stay ward)

18. This newly renovated open ward accommodates female long-stay patients. On arrival, the contingent was greeted by nurses assigned to the ward and the tour of the facility was guided by Dr. Othello and Mrs. Harewood-Clarke.

19. The tour of the facility began at the Nurses Station, then proceeded to the dormitory area. The Members were allowed to view the dormitory area and interact with the patients.
20. During the visit the following issues were highlighted:

   i. **Maintenance of records**
      
      - The need for the implementation of a computerized system for the recording and maintenance of patients’ records. There have been instances where records, which are currently maintained through a file system have been lost and/or damaged. However, Members were informed that the Ministry of Health is currently awaiting the implementation of the PAHO Computerized system for patient records to be implemented.

   ii. **Safety and care of patients**
      
      - No fire extinguishers or smoke alarms on the ward; and
• Absence of a security surveillance system.

21. The tour then proceeded to the facility’s Evaluation Room.

**Visit to the Evaluation room (ward 9)**

22. This room is assigned for the assessment and evaluation of patients (both adults and adolescents).

23. Members were informed that the evaluation and assessment of patients take approximately 30 minutes to 1 hour.

24. Members then viewed the room and interacted with the nurses and the assigned psychiatrist.

25. During the visit the following were discussed/highlighted:

   **i. Predominant mental illnesses**
   - Schizophrenia, bipolar disorder and depression were identified as the most predominant mental illnesses.

   **ii. Assessment of adolescents**
   - Most adolescents are assessed and treated at outpatient clinics; and
   - In instances where adolescents are admitted to the facility, they are warded at the L.F.E Lewis Ward (ward 1).

   **iii. Dealing with aggressive patients**
   - Patients who display aggressive behaviour during assessment are sedated before they are admitted.
26. Members then proceeded to the final ward of the tour, the male long-stay ward.

**Visit to Ward 17 (male long-stay ward)**

27. This ward accommodates male long-stay patients.

![Figure 10: Ward 17’s patient diet chart](image)

28. On arrival, the contingent was greeted by nurses assigned to the ward and the tour was guided by Dr. Othello.

29. The tour began in the dormitory area. Members were allowed to view the conditions of the facility and interact with the patients.

30. During the visit the following were discussed/highlighted:
i. Conditions

- Unpleasant smell;
- High maintenance cost;
- The need for electrical work and upgrades to be done not only on the ward but throughout the facility, and
- The unsanitary condition of the seclusion room.

ii. Safety and care of patients

- No fire extinguishers and smoke alarms;
- Absence of a security surveillance system;
- Reported incidents where nurses and staff have been attacked by patients;
- The need for training programmes to be implemented on safety and awareness; and
- Attempts by patients to leave the facility without being discharged.

iii. Staff

- Currently there are 4 nurses assigned to the ward.

iv. Duration of Shifts

- Nurses assigned to the ward currently carry out 8 hour shifts.

v. Evaluation of patients

- Patients are evaluated once per month by a medical doctor assigned to the facility.

vi. Funds

- Financial allocations are required to facilitate infrastructural works at this ward.
Recommendations

31. During the tour of the facility, the following recommendations were proposed by the Committee Members:
   i. The demolition and reconstruction of the forensic ward;
   ii. The implementation of a short-term database system for the maintenance of patients’ records until the PAHO Computerized can be fully implemented; and
   iii. That a CCTV Camera system be installed throughout the facility.

32. The contingent departed the facility at approximately 11:45 am.

Committees Unit
July 12, 2017
Appendix III

MINUTES OF THE
FOURTEENETH MEETING
OF THE JOINT SELECT
COMMITTEE ON SOCIAL
SERVICES AND PUBLIC
ADMINISTRATION
MINUTES OF THE FOURTEENTH MEETING OF THE JOINT SELECT COMMITTEE OF PARLIAMENT APPOINTED TO INQUIRE INTO AND REPORT ON SOCIAL SERVICES AND PUBLIC ADMINISTRATION, HELD IN THE ARNOLD THOMASOS ROOM (EAST), LEVEL 6, AND THE J. HAMILTON MAURICE ROOM, MEZZANINE FLOOR, OFFICE OF THE PARLIAMENT, TOWER D, #1A WRIGHTSON ROAD, PORT OF SPAIN, ON

WEDNESDAY MAY 17, 2017

PRESENT

Members
Dr. Dhanayshar Mahabir  Chairman
Brig. Gen. (Ret.) Ancil Antoine, MP  Member
Mrs. Christine Newallo-Hosein, MP  Member
Mrs. Glenda Jennings-Smith, MP  Member
Ms. Ayanna Lewis  Member
Ms. Khadijah Ameen  Member

Secretariat
Mr. Julien Ogilvie  Secretary
Ms. Kimberly Mitchell  Assistant Secretary
Ms. Ashaki Alexis  Research Assistant

ABSENT
Mr. Rohan Sinanan  Member
Mr. Esmond Forde, MP  Vice-Chairman (Excused)

CALL TO ORDER AND ANNOUNCEMENTS

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

1.2 Members were advised that Mr. Esmond Forde asked to be excused from the day’s proceedings.

CONFIRMATION OF MINUTES OF THE THIRTEENTH MEETING HELD ON APRIL 19, 2017

2.1 The Chairman invited Members to examine page-by-page, the Minutes of the Meeting held on February 15, 2017.
2.2 There being no omissions or corrections, the Minutes were confirmed on a motion moved by Mrs. Newallo-Hosein and seconded by Brig. Gen. (Ret.) Antoine.

MATTERS ARISING FROM THE MINUTES

3.1 With reference to:

a. Item 3.3 (on page 2), the lack of clarity regarding whose signature is on a license was raised. The Secretariat was requested to verify whether it is the Minister or the Permanent Secretary.

b. Item 3.4 (on page 2), Members were informed that the matter is still outstanding; however, as it concerned the legislation regarding the banning of scratch bombs, Members were informed by the Legal Officer assigned to the Committee that there is no specific law that bans the use of the particular device. The Legal Officer also indicated that it was not fair to state that the devices are legal. Both the Explosives Act and the Summary Offences Act outline definitions for explosives, which can be imported by a person with the requisite license, issued by the Commissioner of Police.

c. Item 3.5 (on page 2), the expert opinion of the Chemistry, Food and Drugs Division regarding the expiry date for gunpowder was outstanding. The Secretariat was requested to communicate with the Chemistry, Food and Drugs Division to determine whether the entity would be in a position to conduct the necessary tests.

d. Item 8.1 (on page 12), the response from the Ministry of Agriculture, Land and Fisheries was outstanding.

e. Item 8.1 (b) (on page 12), Members were informed that the EMA’s submission was received and circulated.

3.2 A discussion ensued concerning the ability of the Chemistry, Food and Drugs Division to conduct the tests, the cost of getting the tests done by CARIRI and the acquisition of samples of fireworks.

PRE-HEARING DISCUSSIONS

4.1 The Chairman expressed his dissatisfaction with the content and tardiness of the submission of the Ministry of Health.
4.2 A discussion then ensued on the approach to questioning that would be adopted during the hearing.

4.3 Members were invited to probe the officials of the Ministry of Health in order to get a full understanding of the manner in which mentally-ill patients are treated in Trinidad and Tobago.

OTHER BUSINESS

Submissions from fireworks importers

5.1 The issue of submissions from the other fireworks importers was raised and the Secretariat was requested to inform the importers that they were thwarting the finalization of the Committee’s Report on the matter. It was agreed that the importers would be given one (1) week to submit the information.

Inquiry into the adverse health effects of fireworks

5.2 The Chairman expressed his dissatisfaction with the responses received from the entities invited to the previous public hearing into the adverse health effects of fireworks.

5.3 Members indicated that more clarification was needed regarding the following:

- the location of the various storage units of fireworks across the country;
- the value of fireworks (in US dollars) imported over the last five (5) years;
- which authority provides security at the storage units; and
- the quantity of fireworks in the country.

5.4 It was indicated that the data concerning the value of the fireworks can be sourced from either the Ministry of Trade and Industry or the Customs and Excise Division.

5.5 Mrs. Jennings-Smith advised the Committee that there is a special unit within the Fire Services that deals with fireworks and fire explosives.

5.6 Members agreed to conduct a follow-up hearing regarding the issue of fireworks in the next session of Parliament. The possibility of inviting entities from the private sector was also discussed.

Draft Report on Geriatric Care Facilities

5.7 Members were reminded that the Draft Report on Geriatric Care Facilities was circulated and Members were requested to submit comments by the following Monday.

5.8 It was agreed that Brig. Gen. (Ret.) Antoine will present the Report in the House of Representatives and Ms. Ameen in the Senate.
**Agenda for the rest of the session**

5.9 It was agreed that the Committee’s second public hearing into the state of mental health services and facilities will be held on June 07, 2017 with the following stakeholders:

- Lifeline;
- The Department of Behavioural Sciences, University of the West Indies; and
- The Trinidad and Tobago Association of Psychologists.

5.10 Members also agreed to conduct site visits to the St. Ann’s Psychiatric Hospital and the Centre for Socially Displaced Persons at Riverside Plaza on June 21, 2017.

**SUSPENSION**

6.1 The Chairman suspended the meeting at 10:19 a.m.

**PUBLIC HEARING WITH OFFICIALS OF THE MINISTRY OF HEALTH**

7.1 The meeting resumed in public at 10:30 a.m. in the J. Hamilton Maurice Room, Mezzanine Floor.

7.2 The Chairman welcomed the officials and introductions were exchanged.

7.3 The Chairman informed those concerned of the objectives of the inquiry.

7.4 Detailed below are the issues/concerns raised and the responses which were proffered during the hearing:

i. **Major issues concerning mental health in Trinidad and Tobago**

   The Head, Psychiatry, NCRHA identified the following major issues:

   - the detection of mental illnesses;
   - the availability and accessibility of treatment; and
   - the stigma associated with seeking and utilizing mental health services.

ii. **The range of mental health issues medical practitioners treat with**

   a. The Head, Psychiatry, NCRHA revealed that there are a number of disorders in children and adolescents which include developmental disorders, intellectual handicap, childhood depression, conduct disorder, autism and attention deficit/hyperactivity disorder.

   b. The disorders in adults range from anxiety disorders (which include phobias), mood disorders, depression and bipolar disorder (manic-depressive illnesses), personality disorders, psychotic illnesses such as schizophrenia, self-harm and suicidal tendencies and substance abuse disorders.
c. Elderly persons experience mental disorders such as neuropsychiatric disorders, dementia such as Parkinson’s disease and epilepsy.

iii. Issues related to the early diagnosis of mental health disorders
The Medical Chief of Staff, St. Ann’s Hospital disclosed that persons do not access care as early as they should due to stigmatisation, lack of awareness of the mental health services available, and an inability to recognise symptoms.

iv. Whether pediatricians and general practitioners are trained to identify mental disorders in children and adults
a. The Medical Chief of Staff, St. Ann’s Hospital stated that all doctors are exposed to mental health training as part of their general training regardless of the specialty they may go on to pursue.

b. She further elaborated that during basic medical training, doctors are exposed to psychiatry as a specialty as well as practical work in a psychiatric service. Additional training in mental health is also provided for those who pursue psychiatry as a specialty.

c. As it concerns pediatricians, the Medical Chief of Staff, St. Ann’s Hospital indicated that pediatricians are equipped to identify developmental disorders and referring patients for additional assistance.

v. The extent to which diagnoses can be done at the Ministry of Health’s regional centres
a. The Chief Medical Officer (Ag.) supplemented the information provided by the Medical Chief of Staff, St. Ann’s Hospital. He indicated that general practitioners/primary care physicians do receive training which involves a mental health component so that there is a level of awareness, especially as it concerns persons presenting with Non-communicable Diseases (NCDs). He further elaborated that there is an association between NCDs and mental health which doctors have been oriented to look out for.

b. He further disclosed that whenever a patient has been identified as having a mental disorder/issue, the patient is referred to the mental health services.

vi. Percentage of the population living with an undiagnosed mental health issue
a. The Chief Medical Officer (Ag.) indicated that the Ministry did not possess this information as it concerns Trinidad or the Caribbean region. However, in the Americas, it is estimated that up to one (1) in five (5) persons have some type
of mental health illness based on the ability of a person to cope with life and stress.

b. He also indicated that depression is possibly the most prevalent mental health illness, with prevalence rates similar to those of countries in the Americas since Trinidad and Tobago’s health profile is that of a developed country. He postulated that the prevalence of depression in Trinidad and Tobago may range from up to six (6) to ten (10) percent. However, for targeted populations, there will be different prevalence rates.

c. The Chief Medical Officer (Ag.) agreed that approximately twenty (20) percent of Trinidad and Tobago’s population may be living with some type of mental illness that can be treated but is not currently being treated.

vii. Regularity of the World Health Organisation AIMS Assessment of the mental health system in Trinidad and Tobago

a. The Director, Health Policy, Research and Planning indicated that in 2013, an interim study was conducted within the Caribbean, inclusive of Trinidad and Tobago. The second study on the AIMS Assessment of the mental health system is scheduled to take place in 2018 based on resources. It will be conducted by PAHO and involves a standard questionnaire from the WHO.

b. The Director, Health Policy, Research and Planning also revealed that discussions with PAHO are ongoing to establish the link and to ascertain whether the questionnaire or the methodology have changed.

viii. Can the current economic down turn lead to an increase in mental illness?

a. The Head, Psychiatry, NCRHA indicated that social stressors do contribute to the presentation of mental health problems so that increased social stress will lead to an increased number of persons displaying signs of mental health issues. However, the manner in which problems present themselves is also dependent upon a person’s ability to manage stressors, so that some persons may be more vulnerable while others may be more resilient.

b. He went on to explain that issues that contribute to vulnerability also contribute to impaired mental health such as childhood sexual abuse, physical abuse, bullying, and postpartum depression. Mental health issues can also arise during pregnancy.

c. It was indicated that if there was an increase in the number of persons presenting with mental health issues, the Ministry may encounter challenges in providing the necessary preventative resources to ensure the minimization of vulnerabilities.

ix. The number of persons who are admitted to the St. Ann's Hospital by type of mental disorder
a. The Medical Chief of Staff, St. Ann’s Hospital stated that this information was not available at the point in time. She indicated that compiling such information would necessitate a retrospective examination of admission files over a period of time.

b. She revealed that the St. Ann’s Hospital does not have electronic documentation of patient records. However, she indicated that the Ministry of Health’s Policy Agenda 2016 to 2020 a study on the prevalence of mental disorders in Trinidad and Tobago in collaboration with the University of the West Indies and CARPHA.

x. **The adequacy of staff with the requisite training to treat with the various types of ailments at the public facilities**

   a. The Medical Chief of Staff, St. Ann’s Hospital stated that the St. Ann’s Hospital has an adequate number of trained general psychiatrists largely due to the University of the West Indies’ postgraduate Doctor of Medicine Programme in Psychiatry.

   b. She indicated that persons are always graduating from the programme with general psychiatry training so that even psychiatrists at the St. Ann’s Hospital were to leave, there would be new persons to take their place. She however, indicated that the Hospital encounters difficulties with the sub-specialties. It was revealed that there are only two (2) persons trained in child and adolescent psychiatry, one (1) of whom is on post-retirement and continues to provide her services on a part-time basis, and another in private practice. Furthermore, there are no geriatric psychiatrists in the government service.

xi. **Overview of the Mental Health Gap Action Programme and the Prevention and Management of Aggression and Violence**

   a. The Mental Health GAP Action Programme is an initiative of the PAHO/WHO, and it involves the provision of technical assistance to implement the programmes across Trinidad and Tobago. It is a “train-the-trainers” based programme whereby a number of practitioners from across Trinidad and Tobago were trained in the detection and management of common psychiatric disorders. These persons would in turn train others.

   b. Some of the persons who participated were first responder Doctors involved in general practice and the emergency room.

   c. The Prevention and Management of Aggression and Violence programme was also a train-the-trainers based programme that was initiated two (2) to three (3) years ago. A foreign based team from a university did the initial training and now some of the staff that received the initial training are training others.

xii. **In relation to section 15 of the Mental Health Act, who has the authority to take persons to the St. Ann’s Hospital to be admitted?**
a. The Medical Chief of Staff, St. Ann’s Hospital stated that section 15 empowers a Mental Health Officer (a trained community Psychiatric Nurse), in the course of his/her duties, to take a person from a public place who may be displaying symptoms of a mental disorder, to the St. Ann’s Hospital or to the psychiatric ward in the San Fernando General Hospital.

b. There are other sections of the Act that deal with other ways in which to take a person to the St. Ann’s Hospital. A person may be admitted by relatives, voluntarily or as an urgent admission patient. The Act also makes provisions for the admittance of medically recommended patients, who are persons taken by relatives to doctors who would have filled out the relevant forms and submitted them to the Medical Director at the St. Ann’s Hospital or to the psychiatrist at the San Fernando General Hospital.

c. Once these forms have been received, an Apprehension Order can be filled out and the police in collaboration with a Mental Health Officer can pick up a patient.

xiii. Whether Mental Health Officers conduct patrols and the number of persons admitted to the St. Ann’s Hospital through that method

a. The Medical Chief of Staff, St. Ann’s Hospital, disclosed that the Hospital was not in possession of that information nor do the Mental Health Officers conduct patrols.

b. The Mental Health Officers work at the psychiatric outpatient clinics in the communities, conduct home visits to patients’ homes and provide injections to patients who require monthly injections.

c. The Medical Chief of Staff, St. Ann’s Hospital, was unable to indicate the number of trained Mental Health Nurses currently employed at the St. Ann’s Hospital. However, the Committee was advised that twenty-five (25) Nurses are assigned to the NWRHA, which covers from Diego Martin to Toco and Rio Claro.

d. She was also unable to indicate the number of cases that would have been brought to the St. Ann’s Hospital by the twenty-five (25) Nurses. In order to do so would require pulling patients’ files and reviewing the relevant admission forms to determine the manner in which the persons were admitted.

e. The Medical Chief of Staff, St. Ann’s Hospital also indicated that she did not know if Nurses kept a record of the persons they would have admitted to the Hospital. However, Nurses would keep logs of patients they are aware of, who may not have attended clinic or missed their monthly injections. In such instances, attempts can be made to track down the particular patients.
f. The Committee was informed that statistical data on the number of persons admitted by Mental Health Officers can be misleading since Mental Health Officers work from 8 a.m. to 4:00 p.m. Monday to Friday. Sometimes Officers conduct a search for a person based on a report, but by the time they arrive at the particular location, the person may have already left.

g. There are scenarios where persons may be familiar with the vehicles of the Mental Health Officers, and flee on sighting the vehicle in the community. This type of behavior makes it difficult for the Officers to find them.

h. The Medical Chief of Staff, St. Ann’s Hospital disclosed that the current legislation governing mental health care does not permit the administering of medication involuntarily within communities. The only place where a patient can be legally treated against his/her will is in an institution designated under section 5 of the Mental Health Act as a psychiatric hospital or psychiatric ward in a general hospital. There are also constraints regarding the terms in which interventions can be provided to persons who do not want it.

xiv. Decanting Centres for outpatients of the St. Ann’s Hospital and the use of geriatric homes as decanting centres

a. It was indicated that there are two (2) extended care centres which fall under the SWRHA, one in Point Fortin and the other in Couva. One centre has a fifty (50) bed capacity while the other has forty (40). Both Centers together, currently have eighty (80) patients, the majority of whom were brought from the St. Ann’s Hospital and some from Ward I (in San Fernando General). These are long stay facilities in which patients remain for the rest of their lives, with a few exceptions who were able to go home.

b. The rate of admissions to these centres is very low as it is dependent on the death of patients to free up bed space. In the last year, there were six (6) admissions to those facilities.

c. The Specialist Medical Officer, Psychiatry, SWRHA stated that the Centres are staffed with trained psychiatric nurses.

d. She further indicated that the RHAs considered placing patients in private facilities, however this did not come to fruition since the private facilities were found to be substandard.

e. It was indicated that mentally ill persons found at geriatric facilities would be as a result of private arrangements made by families.

f. The Permanent Secretary, Ministry of Health indicated that the Ministry committed to establishing a committee in collaboration with the Ministry of Social Development and Family Services to look more closely at geriatric facilities. The committee is comprised of public health inspectors and
clinicians who would begin gathering data so that the Ministry of Health would be more informed.

xv. The decanting process
   a. The Medical Chief of Staff, St. Ann’s Hospital disclosed that the decanting process for the St. Ann’s Hospital is difficult since there is no longer any extended care centres for ex-patients as is the case in the SWRHA. She revealed that there was one centre in Arima and one in Sangre Grande, however these have been closed.

   b. The only avenue available is to send discharged patients to the Arima Rehabilitation Centre for rehabilitation of life and social skills. The Medical Chief of Staff, St. Ann’s Hospital indicated that there were twenty-four (24) patients currently at the Rehabilitation Centre. However, there are no assisted living or supervised living arrangements for such persons in Trinidad and Tobago.

xvi. Whether the MoH collaborates with the MoSDFS to provide financial assistance to rehabilitated mentally ill patients
   a. The Chief Medical Officer (Ag.) indicated that the Ministry of Health met with the Permanent Secretary, Ministry of Social Development and Family Services to determine the terms of their collaboration as it concerns persons with disabilities. He indicated that there will be a follow-up meeting the following Friday.

   b. The Medical Chief of Staff, St. Ann’s Hospital indicated that there are psychiatric social workers at all of the public health institutions who provide assistance in accessing the grant for persons living with mental ailments.

xvii. Cases of mentally ill persons who resist/avoid treatment
   a. The Medical Chief of Staff, St. Ann’s Hospital indicated that community health care is the underpinning of mental health services. Improved community mental health services will translate into an improved outlook for a country.

   b. Trinidad and Tobago’s community health care services are not at the level they are supposed to be since there is a reliance on hospital based care. There are a number of clinics across the country with a large number of persons visiting, however, the number of doctors at any given point in time is small.

   c. The Doctors at the clinics also work at the St. Ann’s Hospital on the days on which they are not at the clinics. Services are therefore stretched.

xviii. Availability of medications such as Prozac under the CDAP Programme
a. A small number of mental health drugs are available under CDAP. The generic form of Prozac and Amitriptyline, anti-depressants, are available under CDAP. An antipsychotic, Chlorpromazine along with a few others, are also available under CDAP. The Medical Chief of Staff, St. Ann’s Hospital indicated that she believed the list of mental health drugs under CDAP can be expanded.

b. It was also indicated that there are some drugs that are in short supply at the St. Ann’s Hospital and psychiatric departments of various hospitals throughout Trinidad and Tobago.

xix. Whether there is any collaboration among the Ministry of Health, other authorities responsible for mental health and the prisons

a. Doctors from the St. Ann’s Hospital provide a clinic at the Maximum Security Prison on the second Wednesday of each month, and a clinic at the Women’s Prison on the third Wednesday of each month. Convicted persons on death row are seen on an as-needed basis.

b. Prisoners on remand go across to the Maximum Security Prison on the days the psychiatrist will be conducting a clinic there. The same applies for persons incarcerated at Carrera Island, who are brought to Trinidad the night before to attend the clinic at the Maximum Security Prison the next day. Prisoners can also be sent to the St. Ann’s Hospital if needed.

xx. Support to deal with post-partum depression and other maternity related mental illnesses

a. The Head, Psychiatry, NCRHA stated that there are no formal systems in place. However, persons who are symptomatic during pregnancy or after delivery, are referred to the mental health services depending on the area in which they are being seen.

b. As part of the post maternity treatment, it is recommended that mothers be screened both during the pregnancy and after the delivery. Based on the results of the screening, the mothers can then be referred. However, there needs to be a dedicated team in place to respond to the referrals.

xxi. Whether the MoH plans to expand outpatient facilities within communities

a. The Permanent Secretary, Ministry of Health indicated that the Ministry is in the early stages of planning an outreach strategy to effectively communicate with communities. The plan is to shift from the centralised provision of psychiatric and mental health services and get into the communities, which research has indicated is the better place to deal with such issues.

b. She disclosed that there is a need to move away from the psychiatric hospital and have units in outlying general hospitals. There is a unit at the Eric Williams’ medical centre and one (1) at San Fernando, however, they are not
as therapeutic and there are space constraints. She also indicated that the units need to be able to address different types of mental illnesses.

c. The Chief Medical Officer (Ag.) indicated that the Declaration of Caracas 1990 supports the move for decentralization and community mental health. Further, the 53rd Directing Council of the World Health Organisation developed a plan of action for mental health in 2014. This plan is currently in force and some of its objectives speak to the reduction of the reliance on psychiatric hospitals. One indicator of such a decrease would be a decrease in the hospital beds by 15 percent and integration into primary care.

xxii. **Is there more focus on medicated care as opposed to therapy?**

a. There are social workers and psychologists who do psychotherapy. However, there is an emphasis on medication.

b. It is important that the family understands what is happening to their relative and what their needs are and how to address them. As such, relatives must be involved in the therapy sessions and are always invited to discuss the illnesses and any issues that may be impacting upon the patient’s mental health.

xxiii. **Counselling services through the Student Support Services Division**

a. The Student Support Services Division is a division within the Ministry of Education which provides guidance officers, social workers and psychologists to work with students in schools. In instances where a teacher or principal has identified a student an intervention, guidance officers and social workers attached to the schools are informed. If the officers cannot provide additional assistance either due to a lack of resources or the requisite skills, the students would be referred to the MoH’s Child Guidance Clinic, of which there is one in Port of Spain, one in San Fernando and one in Tobago.

b. It was disclosed that the largest, single diagnosis of the Child Guidance Clinic is Attention Deficit Hyperactivity Disorder. Many of the children need to be on medication and currently it is not available. Families that can afford to purchase the drugs will do so and those who cannot will have to do without.

xxiv. **Alternative forms of treatment for mental disorders**

The Director, Health Policy, Research and Planning indicated that alternative forms are being used such as yoga, and the use of horses, and other comfort animals. It was revealed that approximately twenty (20) persons have been treated through this avenue.

xxv. **Mental illness, crime and monitoring and tracking mechanisms for mentally ill patients**

a. The twenty-five (25) mental health officers will not be able to successfully monitor every mentally ill person. The Medical Chief of Staff, St. Ann’s Hospital also indicated that there is no need to monitor every person with a mental
disorder since human rights need to be taken into consideration. It was also stated that a very small percentage of mentally ill persons become physically violent or aggressive.

b. She further elaborated that one (1) percent of persons in any society would have schizophrenia, substance use disorders and personality disorders which are the three (3) main psychiatric contributors to violence among mentally ill persons.

c. Furthermore, the derogatory manner in which the press portrays instances of violence by mentally ill persons was also highlighted.

xxvi. Public intervention programmes
The North-West RHA has an outreach team which visits communities on a regular basis to conduct workshops. The Medical Chief of Staff, St. Ann’s Hospital was unsure whether the community visits were publicised in the newspapers.

xxvii. Incentives/initiatives used to encourage House Officers at the St. Ann’s Hospital to become specialised medical officers

a. House Officers are encouraged to take advantage of the DM Programme in psychiatry at UWI since it is easier to access training locally than abroad in the post-specialist disciplines.

b. The programme costs TT $30,000 per annum and is partially funded by GATE as a postgraduate programme. Doctors pursing the programme have to pay TT $15,000 per year for four (4) years of training. It was suggested that scholarships be offered for sub-specialties such as child, substance abuse related, forensic or geriatric psychiatry since those are not offered in Trinidad and Tobago.

xxviii. Initiatives of the MoH to treat with persons dealing with stress
There were initial plans to have a public service EAP which would have provided mental health services for everyone who worked in the public system. However, this has not been realised. It was indicated that the process of negotiation and funding is ongoing as it concerns finding the best way to provide a universal service.

xxix. Engagement with the Ministry of Local Government and Rural Development and the MoNS on programmes to treat with the psychological aspect of disaster management
The Chief Medical Officer (Ag.), indicated that he was not aware of any specific interaction with the Ministries. He revealed that in 2011, a number of the County Medical Officers of Health were trained by PAHO and the Caribbean Epidemiology Centre in public health emergency response. One component of the training
focused on the need for the recognition of mental health and psychological support in emergencies.

xxx. Adequacy of the nurse to patient ratio at the St. Ann’s Hospital
a. The Medical Chief of Staff, St. Ann’s Hospital, indicated that the number of nursing positions dedicated to mental health care service in Trinidad and Tobago is inadequate.
b. She stated that if the reliance on inpatient care is reduced then there will be more reliance on community care and the emphasis will then be to increase the number of community mental health nurses.

xxxi. Amendments to the Mental Health Act
The State Counsel III disclosed that there is a draft revised Mental Health Act which needs some reviewing and finalisation. The draft revised Act seeks to address some of the discrepancies and shortfalls in the existing legislation and its focus will be a community based approach. This will therefore necessitate infrastructure, training and stakeholder consultation.

xxxii. Does the MoH have a national suicide prevention action plan?
a. The MoH is in the process of implementing a suicide surveillance system, which entail *inter alia*, monitoring and tracking the effectiveness of interventions.

b. Interventions and protocols do exist. However, as it concerns having a 24 hour hotline, there is no publicly instituted or funded 24 hour hotline. There is however, a hotline run by an NGO called Lifeline. It is expected that as part of the Ministry’s suicide prevention plan that is being developed, that the Ministry will either work alongside Lifeline to supplement its service or establish an alternative that can be funded and supported by the MoH.

xxxiii. Whether the MoH has jurisdiction over mental health facilities in Tobago
a. The MoH does not have jurisdiction over the facilities in Tobago. The Tobago RHA is responsible for mental health services. There is a psychiatric unit at the Scarborough Hospital which is staffed by two psychiatric nurses, social workers and mental health nurses. There are also outpatient clinics in a number of areas inclusive of Scarborough and Roxborough.

b. Current provisions of the RHA Act do not permit the reassignment of doctors from one RHA to another. As a consequence, in instances where the TRHA is in need of a psychiatrist a replacement from Trinidad, the person would have to take vacation in order to take a one month contract in Tobago. It was agreed that this arrangement should be reviewed.

**Recommendations proffered during the public hearing:**

7.5 The following recommendations emanated during the discussions:
a. that a greater effort be made by the MoH to collect data/statistics on mental health and mental illnesses in Trinidad and Tobago;
b. that a registry be established to record mentally ill patients who are brought in and admitted to the St. Ann’s Psychiatric Hospital by Mental Health Officers;
c. that the MoH in collaboration with various NGOs should invest in, and implement public awareness initiatives/programmes to educate the population on the symptoms of mental disorders and the process involved in accessing treatment at the various mental health care facilities;
d. that appropriate policies be implemented to protect children from parents who are considered mentally unstable;
e. that the MoH improve its advertising of community outreach programmes which focus on mental health and wellness;
f. that the MoH invest in more therapeutic and alternative methods to treat mentally ill patients;
g. that the MoH engage the Ministry of National Security and the Regional Corporations in establishing programmes to train emergency responders to provide psychological support to mentally ill persons during disasters;
h. that improvements be made to the operations of the current suicide hotline and that the MoH’s suicide surveillance system be fully implemented at the end of the fiscal year;
i. that the Regional Health Authority Act be reviewed and amended to facilitate the movement of medical professionals within RHAs including the TRHA;
j. that provisions be made for mental abuse to be criminalised;
k. that amendments be made to the Mental Health Act in order to facilitate tracking and monitoring of mentally ill patients outside mental health care facilities; and
l. that amendments be made to facilitate the proper categorisation of mental illnesses and disorders in Trinidad and Tobago.

**ADJOURNMENT**

8.1 The meeting was adjourned at 12:46 p.m.
I certify that these Minutes are true and correct.

Chairman

Secretary

May 29, 2017
Appendix IV

MINUTES OF THE FIFTEENTH MEETING OF THE JOINT SELECT COMMITTEE ON SOCIAL SERVICES AND PUBLIC ADMINISTRATION
MINUTES OF THE FIFTEENTH MEETING OF THE JOINT SELECT COMMITTEE OF PARLIAMENT APPOINTED TO INQUIRE INTO AND REPORT ON SOCIAL SERVICES AND PUBLIC ADMINISTRATION, HELD IN THE ARNOLD THOMASOS ROOM (EAST), LEVEL 6, AND THE J. HAMILTON MAURICE ROOM, MEZZANINE FLOOR, OFFICE OF THE PARLIAMENT, TOWER D, #1A WRIGHTSON ROAD, PORT OF SPAIN, ON

WEDNESDAY JUNE 07, 2017

PRESENT

Members
Dr. Dhanayshar Mahabir Chairman
Brig. Gen. (Ret.) Ancil Antoine, MP Member
Mrs. Glenda Jennings-Smith, MP Member
Ms. Ayanna Lewis Member
Ms. Khadijah Ameen Member

Secretariat
Mr. Julien Ogilvie Secretary
Ms. Kimberly Mitchell Assistant Secretary
Ms. Ashaki Alexis Research Assistant

ABSENT
Mr. Esmond Forde, MP Vice-Chairman (Excused)
Mrs. Christine Newallo-Hosein, MP Member
Mr. Rohan Sinanan Member

CALL TO ORDER AND ANNOUNCEMENTS

1.3 The Chairman called the meeting to order at 9:45 a.m. and welcomed those present.

1.4 Members were advised that Mr. Rohan Sinanan and Mrs. Christine Newallo-Hosein asked to be excused from the day’s proceedings.

CONFIRMATION OF MINUTES OF THE THIRTEENTH MEETING HELD ON APRIL 19, 2017

2.1 The Chairman invited Members to examine page-by-page, the Minutes of the Meeting held on May 17, 2017.
2.2 There being no omissions or corrections, the Minutes were confirmed on a motion moved by Ms. Lewis and seconded by Brig. Gen. (Ret.) Antoine.

MATTERS ARISING FROM THE MINUTES

3.2 With reference to:

f. Item 3.1(a) (on page 2), correspondence was sent to the Ministry of National Security requesting clarification on the signature affixed to the permit to import explosives (fireworks). The Chairman advised that the Ministry requested an extension to submit later on the day's date, June 07, 2017. The Secretariat was instructed to forward an urgent notice to the Ministry indicating that the Committee was not pleased with the delay.

g. Item 3.1(c) (on page 2), correspondence was sent to the Ministry of Health regarding the testing/analyzing of the chemical composition of fireworks. A response was received and circulated to Members. In the interest of time, the Chairman advised that Members take note of this issue for later consideration. The Secretariat was requested to verify that the opinion submitted by the Ministry was signed by an expert with training and experience in the field.

h. Item 3.1(d) (on page 2), correspondence was sent to the Ministry of Agriculture, Land and Fisheries concerning the Ministry's interpretation of Sections 78 and 79 of the Summary Offences Act, Chap. 11:02. The response was due on May 26, 2017. However, a request was made for an extension to June 02, 2017. The Committee was advised that the response should be received sometime that week.

i. Item 5.4 (on page 3), correspondence was sent to the Comptroller of Customs requesting data on the value of fireworks imports. A response was due on June 02, 2017 and remains outstanding. The Secretariat was instructed to send a reminder to the Comptroller regarding the submission of this information.

j. Item 5.10 (on page 4), a discussion commenced with regard to the proposed site visit to the St. Ann’s Psychiatric Hospital on June 21, 2017. The Committee agreed to conduct the site visit subject to its consideration of the evidence received at the day's public hearing with mental health stakeholders.

3.3 The Chairman recommended that in future instances, entities should be allowed a maximum of fifteen (15) days to submit information that is overdue.

DETERMINATION OF WORK SCHEDULE FOR NEXT SESSION
4.4 The Chairman advised Members that a proposal was drafted for an inquiry into the management of the Targeted Conditional Cash Transfer Programme (TCCTP). The Secretariat was instructed to circulate this Inquiry Proposal via email for the consideration of Members.

4.5 The Chairman advised Members to forward to the Secretariat any issues that they believe should be included in the Committee’s work programme. Members were asked to do so by the end of June to allow the Secretariat to capitalise on the recess period to prepare the draft Inquiry proposals.

**PRE-HEARING DISCUSSIONS**

5.1 The Chairman informed Members that representatives from the following entities were expected to participate in the day’s hearing:

- the Trinidad and Tobago Registered Nursing Association (TTRNA);
- Lifeline;
- the Nursing Council of Trinidad and Tobago; and
- the Trinidad and Tobago Association of Psychologists (TTAP).

5.2 It was noted that Lecturers in the area of Psychology at the University of the West Indies chose not to participate in the public hearing. They suggested that their knowledge/skills base does not equip them to effectively advise the Committee on the subject of the inquiry.

5.3 The Chairman informed Members that *Issues Papers* were prepared and circulated by the Secretariat based on the submissions received.

**SUSPENSION**

6.1 The Chairman suspended the meeting at 10:23 a.m.

**PUBLIC HEARING WITH OFFICIALS OF THE TRINIDAD AND TOBAGO NURSING ASSOCIATION (TTRNA); LIFELINE; THE NURSING COUNCIL OF TRINIDAD AND TOBAGO; AND THE TRINIDAD AND TOBAGO ASSOCIATION OF PSYCHOLOGISTS (TTAP)**

7.1 The meeting resumed in public at 10:33 a.m. in the J. Hamilton Maurice Room, Mezzanine Floor.

7.2 The following persons joined the meeting:

- Trinidad and Tobago Registered Nurses Association (TTRNA)
Mr. Idi Stuart  
President

Ms. Letitia D. Cox  
Social Marketing Officer

Mr. Walt Murphy  
Mental Health Officer

Lifeline

Dr. Lucretia Gabriel, PhD  
Chairperson

Trinidad and Tobago Nursing Council (TTNC)

Mr. David Murphy  
President

Trinidad and Tobago Association of Psychologists (TTAP)

Dr. Katija Khan, PhD  
President / Coordinator, MSc Clinical Psychology Programme and Lecturer in Clinical Psychology - UWI

7.3 The Chairman welcomed the officials and introductions were exchanged.

7.4 The Chairman informed those concerned of the objectives of the inquiry.

7.5 Detailed below are the issues/concerns raised and the responses which were proffered during the hearing:

Role of the Mental Health Officer

a. The Mental Health Officer, TTRNA indicated that the role of the Mental Health Officer is similar to that of a District Health Visitor (DHV) (i.e. a nurse whose job entails visiting homes and offering advice on matters such as how to for infants or people with physical disabilities).

b. The Mental Health Officer provides counselling to clients and their relatives on mental health issues and presents lectures at public institutions interested in obtaining advice on matters of mental health. Persons in this profession deal with mentally-ill patients on a day-to-day basis.

Training for Mental Health Nurses

The Social Marketing Officer, TTRNA advised the Committee that training for the specialist position of Registered Mental Nurse is available in Trinidad and Tobago.

**Services available for Children experiencing Mental Trauma**

a. The President, TTAP identified the following issues:

- There is a glaring lack of child and adolescence mental health services across the country.

- Adolescents over the age of 16 are treated as adults. The President noted that it is not prudent to place a 17 year old in an adult hospital as they have special needs that are still pertinent to their age. Given this reality, very little is available with regard to psychological counselling services for persons of this age.

- The MSc Clinical Psychology Programme does not have a component to train psychologists in child therapy. Trainees are always advised to seek further training in this area upon achieving employment. Unfortunately, this advice is not often adhered to.

- The MSc Clinical Psychology Programme will be discontinued as of September 2017 owing to financial constraints. It was stated that should the Programme be resumed, serious consideration will be given to the inclusion of a component for Child Therapy and Child Assessment, with specific focus on mental illness in children.

- Child mental health services are currently available at two (2) Child Guidance Clinics, located on Pembroke Street, Port-of-Spain and at Pleasantville, San Fernando as part of the SWRHA. At these clinics there is a minimum six (6) month waiting period before a child is attended to due to high demand which far exceeds the resources available. The President, TTAP stated that to the best of her knowledge, these clinics tend to focus on the delivery of assessment-related services. Therefore, psychological counselling services for children may not be available in the public sector. Later in the proceedings, the Mental Health Officer, TTRNA stated that he works at the Clinic on Pembroke Street and in fact treatment for mental issues is provided.

*Identifying Children at risk of Mental Illness/Disorder*

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30 South-West Regional Health Authority
a. The President, TTAP indicated that at a recent PAHO\textsuperscript{31} Suicide Prevention Panel it was revealed that there are currently over 400 students on suicide watch across the country’s Primary and Secondary System. A breakdown of the age groups was not provided but it was stated that these students are as young as seven (7) years old.

b. She agreed with the Committee that the training of School Guidance Counsellors and Social Workers can be augmented to assist in the early detection of at-risk children.

c. When asked to provide the percentage of the entire school population that experiences some kind of mental issue or mental trauma, the President, TTAP stated that she did not wish to speculate but, given the stress of examinations, the percentage is significant enough to deserve attention.

d. The Social Marketing Officer, TTRNA stated that Mental Nurses are trained to counsel persons on mental health issues. Therefore while conducting outreach in schools, Mental Nurses are able to encourage students to reveal their personal issues by utilizing different methods of interaction. With cooperation from the school administrations and the Minister of Health, Mental Nurses are then able to assist with individual assessment and treatment of the identified at-risk students.

Initiatives for Public Awareness of the Prevalence of Mental Health in Society and the Importance of Mental Health Assessments

a. Over the past two (2) years, during Psychology Awareness Week which coincides with World Mental Health Day in October, the TTAP has hosted various public conferences at UWI on various topics related to mental health.

b. The TTAP also performs outreach programmes including the distribution of brochures, consultations with members of the public and delivery of technical presentations on mental health issues.

Methods of treatment for children with mental disorders

a. The President, TTRNA indicated that prior to the passage of the Children’s Authority Act, Chap. 46.10, children with mental disorders were admitted to the St. Ann’s Psychiatric Hospital. However, at that time there were no wards dedicated to the treatment of children at the Hospital.

b. The Act now causes children with mental disorders to be housed at standard children’s homes. These institutions are not equipped with Registered

\textsuperscript{31} Pan American Health Organization
Mental Nurses. As a result, insufficiently trained persons are forced to deliver care to the children placed there.

**Lifeline Services provided to Children Under the age of 16**

a. The Chairperson, Lifeline indicated that children under the age of 16 have utilised the organisation’s services. However, the promotion of service is inadequate.

b. Often in recent times, adults have called Lifeline and asked that “Listeners” speak with children. These adults are advised that:

- it must be the child’s own desire to speak with a listener at Lifeline; and
- anything the child shares with Lifeline is confidential and will not be shared with the adult calling on behalf of a child.

c. Lifeline maintains a social media presence in the form of a Facebook Page populated with content that is regularly updated. The page’s statistics show that its main audience is between the ages of 13 to 17.

**Preventative Measures against Mental Illness**

a. The Mental Health Officer, TTRNA indicated that there is need for the establishment of a system of programmes at schools with the aim of guiding children/adolescents on healthy choices and risk prevention methods to decrease their susceptibility to mental illness. Such programmes would require collaboration between the Ministry of Education, the Ministry of Health and professionals in the field.

b. The Committee requested that the Mental Health Officer, TTRNA provide an outline of these proposed programmes. This outline should include details on the roles of each Ministry and the professionals in the field in this collaborative effort.

**Persons at risk of attempting Suicide**

a. The Chairperson of Lifeline confirmed that since October of 2016, the number of callers who were high risks in terms of suicide increased from less than 10 per cent to 80 per cent. In addition, over the past three (3) months the number of calls to Lifeline has increased.

b. A recent estimate by PAHO states that 14.4 per 100,000 persons are at risk of attempting suicide in Trinidad and Tobago. This translates to approximately 2,800 people in Trinidad and Tobago being at high-risk of attempting suicide.
c. The President, TTAP provided statistics from a study conducted by the Association using data at the Mount Hope Psychiatric Ward. Over the past year there have been approximately 121 admissions for attempted suicide. Of those admissions, about 80 to 90% were impulsive suicides attempts. The majority age group identified was 18 to 26 years.

d. The Chairperson of Lifeline indicated that the main problem faced by callers is instability in their personal relationships. However, it is believed that the current economic downturn has placed difficulty on individuals to provide basic needs. This has placed a strain on personal relationships which in turn has contributed to the general erosion of emotional stability within society.

e. The service receives an average of 10 calls per day. She stated that with better promotion of the service the organisation can receive an estimated 151 calls per day (recognised standard).

f. When a person calls Lifeline they remain in control of their lives at all times. Lifeline officials are listeners who provide emotional support rather than psychiatric professionals who assess and treat patients. However, if a caller indicates that they require professional help, Lifeline will refer them to a psychologist, psychiatrist or consultant.

g. The Committee was advised that the key to the success of the service is the selection of the listeners. Persons who are prone to listen rather than dictating are selected. It takes up to three (3) months for an individual to be approved as a Lifeline Listener. The process is rigorous and ongoing and persons are constantly being prepared to be listeners.

h. Lifeline cannot track how many lives it has been able to save due to the anonymity maintained during calls. However, the organization practices the long-term befriending of high-risk callers to help maintain their emotional stability over time.

i. In addition, due to the anonymity maintained during calls Lifeline cannot link calls to incidents of suicide or murder/suicide and prevention of such incidents cannot be confirmed.

**The working relationship between Lifeline and Government Ministries**

a. The Chairperson of Lifeline indicated that the organization has received a regular subvention from the Ministry of Social Development and Family Services since 1990. In 2016 Lifeline received a one-time grant of $50,000 and the subventions received thus far in fiscal 2017 were estimated to be $20,000.
b. Lifeline also utilizes the general services provided by the Ministry of Health and is in the process of forming a closer working relationship with the Ministry. Currently the organization engages in a formal relationship with the South-West Regional Health Authority.

c. Lifeline receives no assistance of any kind from the private sector. It was noted that the removal of the stigma on mental illness may cause an increase in the support given to the organization.

The role of stakeholders in the training the Police Officers to handle mentally-ill persons

a. It was indicated that the Minister of National Security and the Commissioner of Police have stated that police officers are now being trained at the St. James Police Academy to handle mentally-ill persons. The Committee was interested in whether any of the stakeholders present have collaborated with the Ministry and the TTPS in this regard.

b. The Mental Health Officer, TTRNA indicated that the Mental Health Act, Chap. 28:02 clearly provides that a Mental Health Officer shall be responsible for apprehending mentally-ill persons, and if required, a police officer may render assistance as may be necessary for the apprehension and safe conveyance of the person to a psychiatric hospital or ward.\(^\text{32}\)

c. The TTRNA has had no knowledge of training or formal collaboration with the Ministry or TTPS regarding the training of officers. It was noted that in past years, police officers are provided with a practical component of their training at the St. Ann’s Psychiatric Hospital and exposed to aspects of procedure and the provisions in law with respect to mentally-ill persons. There was no confirmation that this practice still exists.

d. The President, TTAP advised that the Association has no role in the current training module for police officers. However, the Association is interested in supporting the TTPS if necessary. The President, TTAP also identified a need for ongoing psycho-education for police officers handling mentally-ill persons and the general mental health of police officers.

e. The TTRNA stated that some difficulty exists in obtaining approval from the Ministry of Health to initiate programmes geared toward the promotion of the prevalence and prevention of mental illness.

f. It was noted that in general various agencies operate independently and there is a greater need for mental health professionals to integrate with

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\(^\text{32}\) Section 15 of the Mental Health Act, Chap. 28:02
various government ministries and departments in order to de-
compartmentalize the efforts related to mental health issues.

The MoH National Suicide Prevention Action Plan

The President, TTAP confirmed that the MoH is in the process of implementing a suicide surveillance system, which was mentioned at the Committee's previous public hearing held on May 17, 2017. The President, TTAP sits on the implementation committee for the National Suicide Prevention Action Plan.

Psychiatric Nursing Posts and strategies to attract persons to the field of psychiatric nursing

a. The President, TTRNA noted that in general, lower level psychiatric nursing posts are filled by the graduates of nursing programs. However, there are several vacancies at the supervisory level. Retired nurses are recalled to perform the role of Nursing Supervisor at the St. Ann's Psychiatric Hospital. The use of retired nurses essentially thwarts upward mobility in the profession for lower level nurses.

b. In addition, the position of Chief Nursing Officer has been vacant for the past two (2) years.

c. The following strategies were recommended:
   • The advertisement psychiatric nursing positions separately from general nursing positions may increase the number of applicants to the Mental Nurse profession;
   • The provision of the equipment necessary for Mental Nurses and Mental Health Officers at the St. Ann's Psychiatric Hospital to handle mentally-ill patients, in particular dangerous patients apprehended by police officers;
   • Psychiatric nursing requires extensive training. The provision of incentives such as a risk allowance, risk insurance, travel allowance and the reintroduction of the Motor Vehicle Tax Exemptions may encourage practicing General Nurses and nursing trainees to enter this specialised area of nursing.
   • Creating an avenue for upward mobility in the psychiatric nursing profession similar to what is available in general nursing. Offering nurses training opportunities in forensic psychiatry may allow for such mobility;
   • The President, TTNC indicated that the Council sends representatives to school career days to promote careers in both general and psychiatric nursing.
Decentralization of Inpatient Care

a. There should be a focus on the decentralizing of inpatient care rendered at the St. Ann’s Psychiatric Hospital. The population at the Hospital is estimated at 1000 patients.

b. Patients can be moved to their communities and in-house care utilized to decrease over-population at the Hospital. The establishment of Day Centres and Psychiatric Inpatient Units within the communities of mentally-ill patients will assist with the decentralisation process.

c. The initiative for “community care” of patients must be supplemented by a public education programme geared toward de-stigmatization of mental illness. Public education will prepare communities to be accepting of mentally-ill persons for care.

d. It was noted that there is an international shortage of Psychiatrists. International best practice suggests that the utilization of “Advanced Nurse Practitioners” can assist with augmenting the treatment of mentally ill persons. This officer is trained at a Master’s Degree level and maintains both prescriptive and diagnostic powers. The Nurse Practitioner is able to work along with the Psychiatrist as well as work independently in the community. Jurisdictions where this system was successful implementing include Belize and Jamaica.

e. The Committee requested that the TTRNA provide detailed information on the Community Care Initiative along with recommendations for its implementation in Trinidad and Tobago.

Statistics regarding the intake and graduates of the Nursing Programmes

a. COSTAATT and MTEST are the only institutions in the country that offer programmes in Psychiatric Nursing. The Social Marketing Officer, TTRNA presented some statistics to the Committee for the period 2014-2016 regarding the number of the intake and graduates of these Nursing Programmes. The President, TTNC stated that approximately 75% of these graduates have passed the subsequent license examination administered by the Nursing Council and are licensed to practice.

b. A gap analysis is performed by the St. Ann’s Psychiatric Hospital to determine the need for Registered Mental Nurses. It was indicated that there exists a 25% shortage of Resident Nurses and a 55% shortage of Enrolled Nursing Assistants at the Hospital.

The lack of public sector posts for Clinical Psychologists
a. The President, TTAP related that significantly more posts within the public sector for Clinical Psychologists must be created and advertised. There is a substantial number of Clinical Psychologists that have graduated from UWI and cannot find jobs in the public sector due to the lack of posts;

b. There is currently an inadequate number of Clinical Psychologists assigned to the various public Wellness Centres across the country. These Psychologists are overworked and the quality of the service they provide is diminished. An increase in the number of advertised posts will alleviate these issues.

**Registration and licensing for Clinical Psychologists**

a. The President, TTAP indicated that the Association is only the representative body for Clinical Psychologists in Trinidad and Tobago. Registration and licensing for the profession is currently not available.

b. The Association is currently deliberating on whether it should establish itself as an independent organization or register itself under an Act of Parliament. This is the main reason for the delay in the establishment of the TTPA as the official licensing body and registrar for psychologists in the country. The President indicated that stakeholder consultations will commence within three (3) months to assist in advancing this process.

c. In the absence of an official Register for Psychologists in the country, the Association collates the number of graduates from the Clinical Psychology programs at UWI and USC and maintains a record of its historical membership to remain aware of the number of practicing Psychologists in Trinidad and Tobago.

d. The Association is in the process of drafting a *Scope of Practice* for the Clinical Psychologist profession. This document will detail the qualifications and experience necessary to be a licensed Psychologist and the remit under which one will operate. The Association is also in the process of drafting a *Code of Ethics* to accompany the *Scope of Practice*.

**Treatment available for Alzheimer’s patients**

a. The President, TTAP stated that persons suffering from Alzheimer’s tend to present themselves at health services when they are already at a moderate to severe stage of the disease at which point little can be done. Increased public awareness of the signs and symptoms of the disease may encourage persons to present at an earlier stage which will allow for better treatment and management.
b. The President noted that in the UK it is recommended that persons over the age of 65 should be screened routinely for Alzheimer’s disease and dementia.

**Security for Nurses at the St. Ann’s Psychiatric Hospital**

a. The President, TTRNA stated that two (2) categories of persons are on wards at St. Ann’s Psychiatric Hospital; (i) persons convicted due to their mental health status; and (ii) persons who would have been charged and sent by the court for 14 days of mental evaluation.

b. These persons are housed at the Hospital without the presence of a Prison Officer. Prison transportation will only facilitate drop off and collection after the 14 day period of mental evaluation. Nurses are forced to care for these individuals, (some of whom were cleared of any mentally illness), without proper security measures.

c. The President, TTRNA reported that there have been a number of riots at the St. Ann’s Psychiatric Hospital which required the intervention of the police service. A number of nurses have sustained injuries without compensation and without any avenue for redress.

d. Attendants are used to supplement the lack of security measures at the Hospital. These Attendants are used to manage hostile situations. However, Attendants are largely untrained in mental health and managing aggressive patients. As a result, nurses are still burdened with the task of managing these hostile situations.

e. In terms of security enhancements, it was noted that a camera surveillance system was recently installed at the Forensic Ward of the Hospital.

**Recommendations proffered during the public hearing:**

7.6 The following recommendations emanated during the discussions:

m. that Community Care be utilized as a tool for the decentralization of inpatient care at the St. Ann’s Psychiatric Hospital;

n. that there be better multidisciplinary integration of treatment to create established protocols for care. The roles and relationships between professionals within the mental health field must be recognized and standardized i.e. nurses, mental health officers, social workers, occupational therapists, speech pathologists, psychiatrists, psychologists etc.

o. that consideration be given to establishing separate units/wards at public hospitals dedicated for the treatment of children/minors with mental disorders;
p. that a subject on Health and Family Life Education be included in the school curriculum. This should be a mandatory subject which involves mental health and well-being. The content of the subject should not vary across schools and have a minimum standard that is implemented across the entire education system;

q. that there be an increase in the number of care facilities for persons living with Alzheimer’s disease and dementia and improved support (training and resources) given to domestic caregivers of these persons;

ADJOURNMENT

8.1 The Chairman thanked officials and gave closing statements.

8.2 The meeting was adjourned at 12:47 p.m.

I certify that these Minutes are true and correct.

Chairman

Secretary

September 11, 2017
Appendix V

MINUTES OF THE EIGHTEENTH MEETING OF THE JOINT SELECT COMMITTEE ON SOCIAL SERVICES AND PUBLIC ADMINISTRATION
Sixth Report of the Joint Select Committee on Social Services and Public Administration

MINUTES OF THE EIGHTEENTH MEETING OF THE JOINT SELECT COMMITTEE OF PARLIAMENT APPOINTED TO INQUIRE INTO AND REPORT ON SOCIAL SERVICES AND PUBLIC ADMINISTRATION, HELD IN THE ARNOLD THOMASOS ROOM (EAST), LEVEL 6, AND THE J. HAMILTON MAURICE ROOM, MEZANINE FLOOR, OFFICE OF THE PARLIAMENT, TOWER D, #1A WRIGHTSON ROAD, PORT OF SPAIN, ON

WEDNESDAY NOVEMBER 15, 2017

PRESENT

Members
Dr. Dhanayshar Mahabir Chairman
Brig. Gen. (Ret.) Ancil Antoine, MP Member
Mrs. Glenda Jennings-Smith, MP Member
Mrs. Christine Newallo-Hosein, MP Member
Mr. Rohan Sinanan Member

Secretariat
Mr. Julien Ogilvie Secretary
Mr. Johnson Greenidge Assistant Secretary
Ms. Ashaki Alexis Research Assistant

ABSENT
Mr. Esmond Forde, MP Vice-Chairman
Ms. Khadijah Ameen Member

CALL TO ORDER AND ANNOUNCEMENTS

1.5 The Chairman called the meeting to order at 9:49 a.m. and welcomed those present.

CONFIRMATION OF MINUTES OF THE SEVENTEENTH MEETING HELD ON NOVEMBER 01, 2017

2.3 The Chairman invited Members to examine page-by-page, the Minutes of the Meeting held on November 01, 2017.

2.4 The Minutes were confirmed without amendments on a motion moved by Mrs. Christine Newallo-Hosein, MP and seconded by Brig. Gen. (Ret.) Ancil Antoine, MP.

MATTERS ARISING FROM THE MINUTES

3.4 With reference to:
The inquiry into the Targeted Conditional Cash Transfer Programme (TCCTP):

a. Item 8.5 (ii), (vii)(a) and (xii)(b), by letter dated November 20th, 2017, the Secretariat wrote to the Ministry of Social Development and Family Services (MoSDFS) requesting additional information on the Targeted Conditional Cash Transfer Programme (TCCTP).

The inquiry into mental health and wellness services and facilities in Trinidad and Tobago:

b. Item 3.1(d), the letter to the Dean of the Facility of Social Sciences expressing the Committee’s deep concern regarding the University’s response to its request was forwarded to the Dean on November 16, 2017. A response was received via email on November 20, 2017.

c. Item 3.1(a), after some discussion the Committee decided to reacquaint itself with the laws governing the storage and use of fireworks and conduct a public hearing on December 06, 2017. December 15, 2017 was tentatively scheduled for a site visit to a public marketplace to observe the storage, sale and adherence to laws regarding fireworks.

PRE-HEARING DISCUSSIONS

9.1 The Chairman informed Members that representatives of the following entities are expected to participate in the day's hearing:

   i. Ministry of Health
   ii. Ministry of Education
   iii. Children's Authority of Trinidad and Tobago
   iv. Trinidad and Tobago Association of Psychologists
   v. Association of Psychiatrists of Trinidad and Tobago

9.2 The Chairman informed Members that an Issues Paper was prepared by the Secretariat based on the submission received from the Trinidad and Tobago Association of Psychologists. The Issues Paper was circulated to Members by email on Tuesday November 14, 2017.

9.3 Members discussed and agreed on the approach to questioning to be adopted during the hearing.
OTHER BUSINESS

Proposed Date and Agenda for Next Meeting

10.1 The Committee agreed that its next meeting will be held on December 06, 2017. At this meeting the Committee will conduct a public hearing with stakeholders on the matter of the adverse health effects of fireworks.

SUSPENSION

11.1 The Chairman suspended the meeting at 10:29 a.m.

PUBLIC HEARING WITH OFFICIALS OF THE MINISTRY OF HEALTH, MINISTRY OF EDUCATION, CHILDREN'S AUTHORITY, ASSOCIATION OF PSYCHOLOGISTS AND ASSOCIATION OF PSYCHIATRISTS

12.1 The meeting resumed in public at 10:38 a.m. in the J. Hamilton Maurice Room, Mezzanine Floor.

12.2 The following persons joined the meeting:

Ministry of Education
Mrs. Lenor Baptiste-Simmons  Permanent Secretary
Mr. Kurt Meyer  Permanent Secretary
Mr. Harrilal Seecharan  Chief Education Officer
Ms. Amanda Pedro  Guidance Officer II
Mrs. Leticia Rodriguez-Cupid  Special Education Teacher II
Ms. Darlene Smith  Guidance Officer II
Mrs. Sharon Francis-Gaines  Social Work Specialist

Ministry of Health
Mr. Richard Madray  Permanent Secretary
The Chairman welcomed the officials and introductions were exchanged.

The absence of a representative of the Association of Psychiatrists of Trinidad and Tobago was noted.

The Chairman informed those concerned of the objectives of the inquiry.

Detailed below are the issues/concerns raised and the responses which were proffered during the hearing:

The mandate and strategic direction of the MoH

a. Permanent Secretary (PS) Madray remarked that the Ministry of Health through the Regional Health Authorities has the mandate to deliver mental health services to the population. This is achieved through the following:
i. 3 national service centres, located at the St. Ann’s Psychiatric Hospital, the Substance Abuse Prevention and Treatment Centre and the Arima Psychosocial Rehabilitation Centre;

ii. 3 acute inpatient psychiatric units and wards;

iii. 2 extended care centres;

iv. 3 child and adolescent outpatient clinics; and

v. 27 adult outpatient clinics.

b. A new model of mental health care is being developed. This model will consider evidence based protocols and practices for mental health such as early intervention, respect for human rights and the integration of mental health into the general health care system. No date was given for the completion of the model;

_The mandate and strategic direction of the MoE_

a. Permanent Secretary, Baptiste-Simmons indicated that the Divisions of School Supervision, Student Support Services, Educational Planning, Education Facilities Planning and Procurement, and Curriculum Planning work collaboratively to:

i. implement systems of referrals for students displaying mental health issues, from the classroom to professional internal staff and, where necessary, direct referral from the Ministry to the relevant Regional Health Authority or institutions;

ii. plan and improve accessibility for students diagnosed with special needs; and

iii. engage partners and agencies to establish protocols for effective client service delivery. These include the Ministry responsible for Gender and Child Affairs, the Children Authority and the Child Guidance Clinic at the Ministry of Health;

_The stigma attached to children living with mental illness_

a. Chairman, Children’s Authority noted the following with concern:

i. the significant number of children presenting with mental illnesses;

ii. the inability of the national framework to adequately manage and treat the large number of children as in-patient mental health care is woefully lacking as regards children; and

iii. the unfavourable labels attached to children/adolescents living with mental illness such as “bad child”, “delinquent” or “beyond control”.

_TTAP overview of the state of mental health services for children_
a. President, TTAP gave a brief overview of the state of mental health services for children, including that:
   i. Children with serious emotional disorders do not receive mental health care unless from an outside provider; and
   ii. a key player in the provision of mental health services for children is the education sector. For many children this continues to be the sole source of care as the general health care system plays a relatively minor role in service provision for children;

*The question of dedicated in-patient psychiatric care facilities for the treatment of children*

a. It was indicated that there are currently no dedicated in-patient psychiatric care facilities for children under the age of 18;

b. Notwithstanding various interim arrangements for care, a need exists for the inclusion of in-patient services for children and adolescents experiencing serious mental health issues;

c. The interim arrangements identified for children/adolescents evaluated by a Psychiatrist and require admission to a health facility, are as follow:
   i. Children under the age of 16 displaying mild behaviour may be accommodated on a ward at the Paediatric Hospital;
   ii. Children over 16 may be admitted either to the Psychiatric Unit at the Mount Hope Hospital or the LFE Lewis Unit at the St. Ann’s Hospital. This Unit is dedicated to acute care;
   iii. In relation to San Fernando and environs, children may be admitted to the San Fernando General Hospital;

*International and Local statistics regarding children living with mental illness*

a. President, TTAP indicated that current international statistics demand that children be treated in a dedicated facility:
   i. approximately 20% of children and adolescents suffer from a disabling mental illness;
   ii. suicide is the third leading cause of death among adolescents; and
   iii. approximately 50% of all mental disorders emerge during the childhood and adolescence stages;

b. President, TTAP speculated that the percentage of children suffering from a disabling mental illness in Trinidad and Tobago may be significant. Symptoms of mental illness are usually considered as part of the passing developmental phases of a child, as a result, mental illness goes unnoticed;
c. It was later noted that 243 students have been referred to the Student Support Services Division (SSSD) of the MoE and are currently being treated for mental illness. A large percentage of those have been diagnosed with ADHD. 54 students have been diagnosed with various emotional behavioural disorders. 476 other students have been evaluated to have “home morbid disorders”, which include ADHD and emotional, behavioural learning disabilities.

**The number of mental health care professionals available to treat children**

a. The number of mental health care professionals in the Ministry of Health is not adequate to effectively treat children. The Ministry lacks licensed Child Psychiatrists, Clinical Psychologists, Speech and Language Therapists and Occupational Therapists and other professionals;

b. The Committee requested that the MoH provide a list of the professional staff positions required to be filled at the Ministry whereby ensuring compliance with the provisions of the Children’s Authority Act, with regard to the treatment of children with mental illness;

c. Permanent Secretary Madray indicated that there is a global shortage of professionals in the field of Child Psychiatry. The MoH has placed the field of Child Psychiatry as an area of priority before the National Scholarship Programme. The Ministry expects the scholarship awards to attract persons to the field in the near future;

**Children/adolescents referred for mental health care by the Courts**

a. The age group usually referred for care by the Courts are adolescents over the age of 16. Children are usually referred to the Child Guidance Clinic and outpatient services in San Fernando and Tobago for evaluation and report to the Court;

b. Prior to 2016, adolescents were remanded for psychiatric evaluation at the Forensic Unit, SAPH and were admitted together with adults due to the absence of a dedicated children’s ward for forensics or general psychiatry. In 2016, a decision was taken that no children/adolescents who are referred by the Courts will be housed at the SAPH;

c. It was noted that the Forensic Unit houses dangerous mental patients. Children/adolescents are now evaluated at the Forensic Unit and sent to less threatening locations for treatment;
d. It was later indicated that children admitted to the SAPH may be housed for approximately 2 weeks until they can be evaluated by a Forensic Psychologist. This is owing to the fact that the Forensic Psychologist has stipulated 8:00 a.m. to 4:00 p.m. working hours;

e. The MoH indicated that discussions have commenced to include four beds for children and adolescents with mental illness at the Wendy Fitzwilliam Paediatric Hospital as a first initiative, with the possibility of the establishment in future. The deadline for implementation of this initiative is June 2018;

Emerging trends noted by the Children’s Authority

a. The Authority conducts multi-disciplinary assessments, including full psychological assessments, on children deemed to require care and protection. These children are either referred to the Authority by the Court or are remanded to the Authority after its own investigations.

b. 360 multi-disciplinary assessments have been completed and individual treatment plans have been successfully developed. 137 of the 360 children (38%) have were assesses as having some type of mental illness.

Definition of children displaying beyond control behaviour and acute mental illness

a. The Authority provided that:

i. the label “beyond control” is used by the Court in situations where a parent cannot cope and would therefore bring the child before a court at which time the label is deemed appropriate. These children are now referred to as “children in need of supervision” as defined in the Family and Children Division Act, 201633;

ii. a child who may be experiencing a mental episode/breakdown that is determined to be a type of behavioural instability or emotional dysregulation is deemed to be in need of acute care for mental illness;

iii. a part of the stigma associated with mental illness is the assumption that children presenting uncontrollable behaviour suffer with mental illness. Uncontrollable behaviour and mental illness are not synonymous and there are various reasons why a child may present this behaviour;

iv. in accordance with the Family and Children Division Act, the reasons for uncontrollable behaviour are determined by the assessment of the Authority, after which the child is referred for treatment at an appropriate facility;

33 Pg. 119, Schedule 5 of the Family and Children Division Act, 2016
Main types of mental illness

a. President, TTAP identified the main types of mental illness in children and adolescents categorised by developmental stage, which include:
   
   o **Early childhood**
   
   • Learning disorder (Dyslexia);
   • Attention deficit hyperactivity disorder (ADHD);
   • Trauma; and
   • Anxiety disorder
     
     o **Middle childhood**
     
     • Conduct and behaviour disorder
     • Neurological disorders;
     • Impulse control;
     • Mood disorder;
     • Anxiety disorder; and
     • Trauma
     
     o **Late childhood (adolescents)**
     
     • Depression;
     • Substance abuse;
     • Suicide;
     • Mood disorder;
     • Anxiety disorder; and
     • Trauma as a result of abuse and neglect

b. The SMO, Child and Adolescent Psychiatrist agreed with the general findings presented in this regard.

The role of MoE officials in detecting mental illness

a. It was indicated that the MoE utilises models to address the need presented by the estimated 250,000 students under the care of the Ministry. One model predicted that typically in a student population:
   
   i. 15% of the students are at risk of mental illnesses; and
   ii. 5% of students are targeted as in need of counselling or therapy;
b. The Student Support Services Division (SSSD) provides training in child needs assessment and sensitisation to Teachers.

c. The Teacher Development Division also provides more focused training opportunities at both the educational district and the individual school level during the July/August period on the needs to detect and refer students to the internal staff at SSSD. SSSD retains the service of five Clinical Psychologists and a team of Behavioural Specialists to assist internally;

d. President, TTAP noted that the MoE provides a satisfactory number of services for children with mental disorders and mental health care needs. Notwithstanding regular referrals from schools, a lack in follow-through on the process of treatment after referral was noted. The understaffing of mental health care professionals is a persistent obstacle to the provision of these services.

e. President, TTAP indicated that the advent of technological advances such as social media has caused new issues and concerns for children with regard to their mental health. The effects of the stress associated with cyber-bullying was noted;

f. There exists a significant need for mental health care facilities such as day care treatment facilities for children. Notwithstanding the services and professionals provided by the MoE. President, TTAP indicated that in her experience children and adolescents respond well to group therapy sessions. It was noted that Learning Centres or Homework Centres, as may be provided by the MoE, may serve as an excellent base for group therapy sessions with children. However, the lack of facilities and personnel is an obstacle to such an initiative;

g. The Committee requested that the MoE submit the number of students over the last five (5) years who were identified and referred to the various agencies for assistance with mental illness;

h. The Chief Education Officer identified the following challenges in relation to the provision of mental health services to students and at-risk students who go unidentified:

   i. deficiencies in the process of initial screening to highlight health challenges faced by students. The MoE intends to commence an initiative to have all students in Primary schools undergo the initial basic screening within the next 2 - 3 years;

   ii. a lack of the professional staff needed to adequately address student mental health needs. It was noted that the MoE can benefit from
additional support in terms of the follow-up services after students are referred for treatment;

**Challenges faced in providing better mental health services for children**

a. Some of the challenges identified were:
   i. an inadequate legislative framework;
   ii. financial constraints to filling professional staff requirements;
   iii. lack of statistical data and documentation of analysis;
   iv. In 2011, the TTAP proposed a plan to the Government of the day to deal with the early detection and treatment of children with mental issues. The proposal was not approved;
   v. privacy concerns arising with parents may reflect negatively on the detection rate of children with mental issues;
   vi. Teachers and MoE staff do not currently detect cases of children displaying mental issues. Cases are addressed when an obvious need arises in each case;

b. The Committee requested that the MoE indicate the measures it intends to take to reform the current system of referrals with regard to identifying children for mental health care.

**Statistics on students displaying self-harming behaviours**

For the period 2012 to present, the MoE has received 563 referrals of students displaying self-harming behaviours. The statistics are categorized by educational district and types of behaviour such as; self-mutilation, suicide ideation and suicide by stress. Upon analysis, it was discovered that a greater percentage of the data represented students experiencing suicide ideation.

**Stakeholder initiatives to improve public awareness of mental health illnesses affecting children and adolescents**

a. The MoE, MoH and Office of the Prime Minister (Gender and Child Affairs agencies), has been pursuing collaborative initiatives to increase public awareness:
   i. internal discussions on the gaps identified in detecting mental health issues in children;
   ii. discussions with parents on the challenges faced in seeking assistance for children;
iii. a Social Media Marketing Campaign, which commenced on November 25, 2016 and identified students who were willing to share preventative measures with their peers through social media and art work.

The role of the Community Police in assisting children displaying anti-social or unacceptable behaviour

The SSSD works collaboratively with the Community Police to address the needs of children displaying anti-social or unacceptable behaviour. An officer of the SSSD and if necessary the Community Police will be first on-site to handle situations in this regard.

Child Guidance Clinics

a. The 3 dedicated Child Guidance Clinics are located in San Fernando, Tobago and Port-of-Spain. The Clinic located in Port-of-Spain serves the North-West, North-Central and Eastern Regional Health Authority.

b. Children who have psychological problems identified in schools are referred to Child Guidance Clinics. At those clinics, children receive full psychiatric evaluations and treatment if needed.

c. In 2017, the Child Guidance Clinics received 386 referrals. 284 of the students referred for a preliminary interview returned for psychiatric evaluation. It was noted that a parent had the right to refuse the treatment of his/her child.

d. The 386 referrals include children significant mental health needs but are unable to attend public school for the following reasons:

i. they are underage;

ii. they are living with disabilities;

iii. they are forced to stay at home or attend private schools because of developmental difficulties that the general education system does not provide for.

e. The Child Guidance Clinic and the SSSD utilise a collaborative system for evaluation and treatment which commences when children in Primary schools are referred to SSSD. It was noted that not every child who is identified with a psychological difficulty is in need of a full psychiatric evaluation.

f. There are private psychiatrists in Trinidad and Tobago who provide some service for this section of the population. However, many parents are unable to afford these private services.

Recommendations proffered during the Public Hearing
12.7 The following recommendations emanated from the discussions:

r. The establishment of a dedicated inpatient psychiatric facility to assess and treat mental illness associated with the children and adolescent population;

s. Group therapy session as a means of assisting children and adolescents. Furthermore Learning and Homework centres can be utilized as a base for Group therapy session;

t. That the Ministry of Education and Trinidad and Tobago Association of Psychologist collaborate to design a training module for teaching staff to effectively identify children and adolescents with mental illnesses;

u. That services provided by MoH and MoE be integrated;

v. The establishment of a child/adolescent mental health action plan; and

w. That adequate data be collected by the relevant stakeholders to identify children and adolescents in need.

Requested information

12.8 The Committee requested the following information in writing:

i. With respect to MoH’s efforts to become more compliant with the Children’s Authority Act, provide a list of the professional staff positions required to be filled within the public health care system in order to become fully compliant with the provisions of this Act;

ii. that the MoE submit the number of students who were identified and referred to the various agencies for assistance with mental illness during the last five (5) years;

iii. that the MoE submit what measures it intends to take to reform the current system of referrals with regard to identifying children for mental health care.

ADJOURNMENT

13.1 Closing remarks were made by the Permanent Secretary Health, Permanent Secretary Education, President, TTAP and Chairman, Children’s Authority.

13.2 The Chairman thanked Members and gave closing statements.

13.3 The meeting was adjourned at 12:37 p.m.
I certify that these Minutes are true and correct.

Chairman

Secretary

December 14, 2017
Appendix VI

EXCERPT OF VERBATIM NOTES OF THE FOURTEENTH MEETING OF THE JOINT SELECT COMMITTEE ON SOCIAL SERVICES AND PUBLIC ADMINISTRATION
EXCERPT OF VERBATIM NOTES OF THE FOURTEENTH MEETING OF THE JOINT SELECT COMMITTEE ON SOCIAL SERVICES AND PUBLIC ADMINISTRATION, HELD IN THE ARNOLD THOMASOS ROOM (EAST), LEVEL 6, (IN CAMERA) AND THE J. HAMILTON MAURICE ROOM (MEZZANINE FLOOR) (IN PUBLIC), OFFICE OF THE PARLIAMENT, TOWER D, THE PORT OF SPAIN INTERNATIONAL WATERFRONT CENTRE, #1A WRIGHTSON ROAD, PORT OF SPAIN, ON WEDNESDAY, MAY 17, 2017 AT 9.34 A.M.

PRESENT

Dr. Dhanayshar Mahabir Chairman
Brig. Gen. Ancil Antoine Member
Mrs. Christine Newallo-Hosein Member
Miss Khadijah Ameen Member
Mrs. Glenda Jennings-Smith Member
Miss Ayanna Lewis Member

Mr. Julien Ogilvie Secretary
Miss Kimberly Mitchell Assistant Secretary
Miss Vahini Jainarine Legal Officer I

ABSENT

Mr. Rohan Sinanan Member
Mr. Esmond Forde Vice-Chairman [Excused]

10.30 a.m.: Meeting resumed.

OFFICIALS OF THE MINISTRY OF HEALTH

Mr. Richard Madray Permanent Secretary
Dr. Vishwanath Partapsingh Chief Medical Officer (Ag.)
Prof. Gerard Hutchinson Head, Psychiatry, NCRHA
Dr. Hazel Othello Medical Chief of Staff, St. Ann's Hospital
Dr. Celia Ramcharan Specialist Medical Officer, Psychiatry, SWRHA
Mr. Chairman: Good morning and welcome to the Fourteenth Meeting of the Joint Select Committee on Social Services and Public Administration. I would like to welcome the officials who are with us this morning. I would like to welcome our viewers on the Parliament Channel and those who follow us on all the social media sites; the members of the media; and members of the Committee who are present with us this morning.

This is the Committee’s first public hearing pursuant to its enquiry into the state of mental health services and facilities in Trinidad and Tobago. By way of background, this Joint Select Committee, representing both Houses of Parliament and all benches in the Parliament, held the view that the matter of mental health in Trinidad and Tobago remains relatively under-explored in relation to other areas in the health sector. And we needed to get from our own perspective what really is happening in the mental health side of the Ministry of Health’s obligations to the people of Trinidad and Tobago. We need to be sensitized with respect to some of the issues in which we may not be familiar and to get expert guidance on the way forward with respect to treating with the mental health issues afflicting the population of Trinidad and Tobago.

At this time, I would like to invite the officials of the Ministry of Health who are here with us this morning to introduce themselves; afterwards I will ask the members of the Committee to introduce themselves; and then we will open the floor for the public enquiry. May I start with the Permanent Secretary of the Ministry of Health, a familiar face to this Committee and I wish to assure you Permanent Secretary that I know the Ministry of Health has been called before this Committee on a number of occasions and this perhaps will be the last occasion in this session of the Parliament that we will lean on the Ministry of Health to come and liaise with us and the general population on health matters. But this is an important issue and it has arisen as a consequence of our enquiry into geriatric care facilities of which members would have more to say, but this hopefully will conclude our interaction, this session, with the Ministry of Health.

Mr. Madray: Good morning, Chair and good morning members. Thank you for this opportunity
Sixth Report of the Joint Select Committee on Social Services and Public Administration

to appear before this Committee, once again. Mr. Chairman, I should note that we did find it challenging to prepare over the last two days and provide comprehensive responses to your written questions on this occasion having received them on Friday last. That being said we do hope that our submission is satisfactory and my team is here to clarify any issues that may have been unclear. So we look forward to responding.

**Mr. Chairman:** Thank you very much. Before I ask other members of your team to introduce themselves I will simply indicate for the benefit of the team, our Committee and the general population the enquiry objectives, the objectives of today’s enquiry. There are really four objectives of this public hearing:

1. To determine the prevalence of mental illness in Trinidad and Tobago. Really, in relation to what the health sector has to deal with, is the mental health aspect important, unimportant by way of the percentage of patients you treat with, how critical is this sector of the health facilities area in Trinidad and Tobago?
2. To assess the adequacy of services and facilities available by the State to support mental health and well-being;
3. To determine the adequacy of the existing quantity of cadre of medical practitioners who currently specialize in mental health care and wellness in Trinidad and Tobago; and
4. Always to assess the adequacy of the legislative framework whether in fact you have reviewed the Mental Health Act, to access the adequacy of this particular Act to assist you with respect to whether there is a need to amend it in relation to the work that you discharge.

I will ask other members to introduce themselves, then after the introductions are made I will ask Permanent Secretary to start with some opening remarks. So, Mr. PS, you can invite other members of your team to introduce themselves.

**Mr. Madray:** Certainly, to my right.

[Introductions made]

**Mr. Chairman:** Thank you very much, and may I ask, starting with my right, our member to introduce herself. Khadijah.

[Members introduce themselves]

**Mr. Chairman:** I would now like to invite the Permanent Secretary, Mr. Madray, to provide to the Committee some brief opening remarks.

**Mr. Madray:** Very briefly, the Ministry of Health is a policy making and planning organization
and is responsible for monitoring and oversight over the health sector. We deliver our services through the various regional health authorities and we work closely and collaborate with them through the various divisions of our Ministry in ensuring that and in pursuit of quality health care. Those projects involve not just the issues of legislation, but the human resource capacity as well as projects for the upgrade of the medical facilities.

Mr. Chairman: Thank you very much, Mr. Madray. And let me start with a broad opening question that your technical officers may want to address. What really are the major issues concerning mental health in Trinidad and Tobago? It is broad. What are the major issues concerning mental health? Is it that we are unaware as a public? Is it that we are insensitive? Is it that we do not understand the various dimensions of mental issues? Your technical officer, any one, please, you can open by telling us what we the public need to know about the state of mental health in Trinidad and Tobago.

Prof. Hutchinson: Yes, well I think it is a very broad question. I think the two major issues would be the detection and availability of treatment for mental health problems. Internationally as well as here more than half of the people who suffer with mental health problems do not seek or are unable to access treatment and I think that percentage is probably larger, it is probably closer to maybe 70 per cent here. So I think the capacity to reach more people and for them to be able to access services, I think for those who access services, the second major issue is the stigma that is associated with the seeking of and the utilization of mental health services and that stigma interferes with the process of treatment and in some instances the success of interventions that are indicated to address the problems. I think those would be the major issues; of course, within those broad headings there are a lot of sub-issues but I would say those are the things that—

Mr. Chairman: Thank you very much.

Prof. Hutchinson:—require urgent attention.

10.40 a.m.

Mr. Chairman: Thank you very much. And now that you have brought up the issue of sub-issues, may I, using the prerogative of the Chair, raise some of these issues? Could you again, from a technical perspective, advise members of the Committee about the range of mental health issues that you as medical practitioners have to deal with, starting from what could be diagnosed to be a mild form that, perhaps, I would imagine afflicts a lot of people, and the severe form? Could you indicate to us, from your experience, what are the types of ailments that you treat with on a daily
basis or that you have observed in the population of Trinidad and Tobago?—starting with phobias, I would imagine. A fear of spiders might be a mild form and then you move on to other things

Prof. Hutchinson: Well, I think it might be better to look at it in a chronological way, so I think you could start with disorders that affect children and adolescents. So these would be the developmental disorders, beginning with things like intellectual handicap to things like attention deficit disorder, autism spectrum disorder, childhood depression, conduct disorder and other disorders that affect the child and adolescent age range.

And then among adults, the question of anxiety disorders under which phobias would come; these would be, perhaps, towards the milder end of the spectrum. But we have the anxiety disorders. We have the mood disorders, depression and bipolar disorder which would be manic-depressive illness. And then you have the psychotic illnesses such as schizophrenia and the schizophrenia spectrum disorders.

You also have in adulthood, a group of disorders called personality disorders, which have become increasingly important and of increasing relevance to us here as well, because of its association with self-harm and suicide. So while self-harm and suicide is a behaviour and can be a feature of all of the disorders I have described, in people with personality disorders it is even more so.

And then you have the substance-use disorders: alcohol, cannabis and all the other substances that people abuse in a way that would disrupt their level of functioning. And then in the elderly population you have the dementias and the so-called—they are described as neuropsychiatric disorders. So these would be disorders, in addition to the dementia like Parkinson’s disease, which although it is a neurological disorder, also has psychiatric consequences; and a range of other disorders related to the dementias and disorders affecting the brain that are more likely to occur in old age. And then you also have disorders like epilepsy which also impacts on the mental health services.

Mr. Chairman: Thank you very much. Is it fair then to say that mental illness constitutes a very broad spectrum of illness in the medical profession? That it is not narrow; it is broad.

Prof. Hutchinson: Extremely broad, yes.

Mr. Chairman: Okay. I would like to pose a question to the Medical Chief of Staff, and that is: mental health is illness and since it is an illness it was earlier submitted that there is a problem with the diagnosis. We are aware of the stigma associated. I was not aware that there is a problem with
the diagnosis. What it is telling me is that there are perhaps people who are experiencing some of these mental ailments and who are not diagnosed. What are the problems in relation to the early diagnostics of the medical health issues affecting the population?

**Dr. Othello:** As Prof. Hutchinson indicated, for a number of reasons people do not access care as early as they could or should, sometimes due to stigma, sometimes due to a lack of awareness of what services are available or where services are available; sometimes due to inability to recognize symptoms. So that, for instance, a depressed person may lack motivation or drive to do anything and they may be perceived as lazy, or maybe sad and may be perceived as simply moody. So that they may not realize, or the persons around them may not realize that there is a need to access services. So that are for a number of reasons if persons do not present in a timely manner, it affects the early detection and early diagnosis of the disorder.

**Mr. Chairman:** Okay. A follow-up question based again on what the professor indicated, and that is, he started with the ailments affecting children. I would like to know from a medical perspective whether paediatricians who deal with children are trained to identify when a child goes in for a normal traditional cough and cold ailment. Is the paediatrician trained to identify that this child, perhaps, may have a mental problem that requires specialist treatment? And the same for general practitioners, when an adult were to visit the general practitioner or the health centre to get standard normal medical care, are the medical practitioners trained to identify, to pick up the cues on the fact that this individual may be suffering from any one of the disorders indicated by the professor?

**Dr. Othello:** On that subject I would like to indicate that in the training of doctors, everyone does some mental health training regardless of what specialty you later end up in. During your basic medical training you would have been exposed to psychiatry as a specialty and you would have done some practical work in a psychiatric service. So that all medical practitioners are exposed to a basic understanding of psychiatry.

During some specialty training, additional training in mental health is provided. I cannot speak to how much is provided during the training of paediatricians but I am aware that when it comes particularly to the developmental disorders, paediatricians are very versed in picking up and, when necessary, referring those patients. I would suspect that if symptoms are severe enough to be easily detected there is no reason why a paediatrician would not pick it up.

**Mr. Chairman:** Thank you very much. And again, it raises—we are coming to the Ministry of
Health now. I see the PS understands that I have to come to the Ministry of Health. Before I go through the floor we need some preliminaries and that is, the Ministry of Health, in their statistical submission indicated the numbers of people who are currently, or who have been referred to mental health facilities. To the Ministry of Health, what I would like to know is this—because it was raised to us that diagnosis might be a problem. There could be many more people who are in need of care and who have not been identified in need.

And I would like to know from the Ministry of Health from the numbers you have submitted to us, what percentage of these people who are in receipt of mental care, at the level of the State, have been referred to you by standard general practitioners, people outside the mental care field? Is it that there is collaboration? I understand that there is training of all medical practitioners in this area, but can you say that 95 per cent of the patients in the mental institutions in Trinidad and Tobago, or who are currently being trained, are referred to you all by members of the general medical profession? Or is it that they just come to you and say, “I feel depressed. Treat me”? What is the process like? Yes, Permanent Secretary, and then you can refer that question to the other members.

Mr. Madray: Well, firstly, whilst the team ponders that question, I would like to ask the CMO to respond to the earlier aspect of it, which is the extent to which diagnosis can be done at our regional centres.

Mr. Chairman: Thank you very much, PS.

Dr. Partapsingh: So to build on Dr. Othello’s response, within the primary care environment and general practitioners, or primary care physicians who practise within that environment, their training does involve a mental health component. So there is an element of awareness and perhaps some sort of variable screening that takes place in terms of, for example the NCDs, non-communicable chronic diseases. There is an association, a link, between NCDs and mental health. And so, I think within the primary care environment the practitioners are oriented to be aware that persons with NCDs can present with mental health illnesses that they themselves may not be aware that this is a mental health illness, and in so doing bring to fore the diagnosis.

PS, with your permission, to continue now to the question that was asked. In the same regard, that process, that patient, that person, is then referred to the mental health services. So I would have to say that there is collaboration. There is collaboration from the primary care level where someone may not come in for mental health but may be diagnosed with, or suspected of
having a mental health disorder, or mental health illness, and then be referred to one of the regional centres—at the peripheral centres—for further assessment or to the institutions for further assessment, including the St. Ann’s Psychiatric Hospital.

**Mr. Chairman:** Okay. So I need to get the process clear. A patient attends a general practitioner, or a paediatrician in the case of a child, and he or she visits the public or the private facility for the flu, something like that, but there is a mental health issue as well. I need to get clear that the medical practitioner who is treating the patient for, what I call a standard ailment, is also likely to identify a mental health issue and make a further referral. And is that the process which is currently in place in Trinidad and Tobago to identify and diagnose mental health?

**Dr. Partapsingh:** I would say, yes. I would say that they are definitely oriented to be aware of mental health and then they are aware of the process for referring such a person.

**Mr. Chairman:** Okay. And I want to get a follow-up to the professor’s point and that is, he says there might be a problem with diagnosis. We know there is a problem of stigma. That much I do not need much edification on. But if that is the practice, whither the problem of diagnosis? It would appear that everyone who visits a practitioner for a standard ailment should then have the practitioner screen him or her for any mental health issue which arises. Should that then not minimize the problem of misdiagnosis so that people are living in a prolonged state without any kind of assistance? What would you say is the percentage of the population, then, that is living with a mental health issue that is undiagnosed? Do you have any idea of that?

**Dr. Partapsingh:** We do not have that specifically for the Caribbean region or for Trinidad, but we know for the Americas it is estimated up to about one in five persons with some type of mental health illness. Now the WHO definition for mental health illness is not specifically a disorder, but it is the ability of a person to cope with life and stress, and that is what is defined as mental health illness. And with that, the prevalence of one in five is given.

Within our setting, again, building on the Americas, depression is perhaps the most prevalent mental health illness and I think prevalence rates will be very similar to that of countries in the Americas because our health profile is very much that of a developed country. So I would think it is sometimes ranging from up to 6 to 10 per cent of persons. But again, in your targeted populations or in specific populations, you will have different prevalence rates. I think that comes to answer the question about the diagnosis and in that setting. Patients or the public generally do not—because of the stigma associated with mental health—they may not come to you, or they
usually do not come to you, and say, “I have a mental illness” or “I am depressed.” They will have some other signs and symptoms.

Within the chronic disease clinics or the lifestyle clinics that, for example, that takes place within the primary care environment, you will have a higher percentage of those persons because of the nature of people accessing that clinic. And the referral to the mental health unit, the referral to specialist care, I think the process is there, the orientation is there.

Mr. Chairman: Thank you very much. And therefore we can say that there are, consistent with international norms, maybe 20 per cent of our population is living with a type of mental illness which is amenable to treatment but is not currently being treated? Is it fair to say that we have a number of people who are living with ailments which can be treated but which are currently not being treated, given international norms on mental issues?

Dr. Partapsingh: I think that is a fair statement.

Mr. Chairman: Very well. Okay. Thank you. And I have said much as Chairman. I would now like to open the floor to our colleagues. I see Sen. Ameen. [To Mrs. Newallo-Hosein] Would you like to give way to Sen. Ameen? Yes, Sen. Ameen, you can ask the first questions.

Miss Ameen: Thank you, Mr. Chairman. It really stems from the discussion that we have already begun with regard to diagnosis and the number of people in Trinidad and Tobago who may be suffering with some sort of mental illness. I see in your submissions that you indicated the last study was conducted in 2007 for a World Health Organization AIMS assessment of the mental health system in the Republic of Trinidad and Tobago. That was 10 years ago. Can you indicate if there is a set regularity with which studies are conducted? How often? Who conducts it or who may be best positioned to conduct it, and if one is due any time soon? Because, of course, in the last decade we would have had a lot of social changes that would impact on our culture, our ability to withstand and cope and, of course, could exacerbate mental health illnesses in individuals.

Mr. Jaisingh: Thanks, member, for the question. Post-2007, another study was done within the Caribbean itself in 2013 that brought all of the scope of the report into being. So an interim study was done in Trinidad and Tobago with other Caribbean countries in 2013 and it is planned that this country-specific study will be done in 2018. We have discussions with PAHO right now to establish the link, whether the questionnaire had changed, or what are the dynamics of the methodology that have changed.

So, in the 2018 fiscal year we are hoping to commence this second study on the AIMS
assessment of the mental health system. It is done by PAHO. It is a standard questionnaire from WHO and it varies in timelines, basically. Other countries like Barbados, for instance, they have done in it within a time gap of about seven or eight years as well. So based on resources and based on the methodology, we are hoping to commence our study in 2018.

**Mr. Chairman:** MP Newallo-Hosein.

**Mrs. Newallo-Hosein:** Thank you, Chair. Further to the question that the Chairman had asked regarding the persons who actually present themselves for testing. In your submission you indicated that during the period October 2015 to September 2016, the total number of patients admitted at the St. Ann’s Hospital stood at 2,210 out of a total with outpatient clinics of 22,668 for the same period. How many of those persons would you say could be classified in categories such as voluntary? Did they voluntarily submit themselves for testing? How many were, in fact, ordered by the court, if that is, in fact, done? And how many were, in fact, brought in by a relative or a friend?

And further to that, I know that you indicated that WHO states that the well-being of an individual is encompassed in the realization of their abilities, coping with normal stress, and so forth. And it states also that a person struggling with his or her mental health may experience stress, depression, anxiety, relationship problems, grief, addiction and so forth. But I am asking, can this statement be reversed? I suppose, to someone struggling with his or her mental health to experience this, would it not be the opposite or the reverse to say that one’s stress or relationship problems or grief can, in fact, cause mental illness? And if it does, what we are experiencing today in terms of loss of employment and so forth, can we, in fact, see an increase in mental illness in our country?

**Prof. Hutchinson:** Well, to address the last question, I think that the social stressors that you have identified do contribute to the presentation of mental health problems. But the process of that presentation is also dependent on the person’s ability to manage those stressors. So some people are more vulnerable than others and some people are more resilient than others. So the same stressor might not have the same consequence in two people.

So invariably, the issues that contribute to vulnerability are issues that would also contribute to impaired mental health. So for example, one of the major ones in the society is childhood sexual abuse. So somebody who has been sexually abused as a child, when faced with unemployment, when faced with relationship problems, is more likely to develop a mental health
problem than somebody who had not been sexually abused as a child. So I think it is important to acknowledge the things that make people more vulnerable.

**Mrs. Newallo-Hosein:** But one does not know until one is in that position. I would not know that I can mentally cope with what is happening until something actually happens for my whole equilibrium to be shattered, and then to realize, hey, I can, in fact, cope or not. And therefore it is not possible for us to say, well, what will happen, but we can at least look at a situation and say, well, if we continue in this vein there are indications that are higher than normal that this could, in fact, happen. And I am asking, in light of all that is happening now, do you foresee an increase in mental illness impacting our nation? And if it does, are you in a position to cope with such an increase, seeing that you already have an outpatient factor of 22,668?

**Prof. Hutchinson:** Yes. Well, as I said, the social stressors will cause more people to present who have been vulnerable. But I think that we have to—one of the challenges we face is in making, or providing the preventative resources to ensure that those vulnerabilities are minimized. But in situations where there is increased social stress you do see more mental illness presenting.

**Mrs. Newallo-Hosein:** What are the preventatives?

**Prof. Hutchinson:** That is a very broad question, but starting from maternal health—because many of the people who develop mental health problems have had, while they were gestating, their mothers would have had problems; mothers who have postpartum depression, and a range of issues that occur. As I said, childhood sexual abuse, physical abuse, bullying, all those things all contribute to a person’s vulnerability, and then, of course, providing the social supports to help them cope with the challenging social stressors that might occur when they are becoming adults.

**Mrs. Newallo-Hosein:** Thank you.

**Mr. Chairman:** Sen. Lewis.

**Miss Lewis:** A question to the professor or anyone else who could answer this question. I am looking at your submission and you have stated the main diagnosis for mental diseases in Trinidad and Tobago. You have bipolar disorder, substance abuse, depression, anxiety, and then I am seeing here the most common mental illnesses are depression, anxiety and schizo. Do you have a breakdown of the statistics as you have a breakdown here submitted as to persons who end up in the health care facility? Do you have a breakdown of how many persons enter with depression issues; how many persons enter with the various diseases?

**Dr. Othello:** That information is not available at this time.
Mr. Chairman: But could we get it in writing at some time, if you are able to compile it?

Dr. Othello: It would require a significant research project. We would have to do a retrospective study going across admission files over a period of time. We do not have electronic documentation of patient records, so you would have to go into files, find the diagnosis and tabulate how many came in for the different disorders.

Miss Lewis: Okay. So why I asked also is that any decisions that we make need to be data-driven. So we are sitting here to deal with mental health care and the issues that deal with persons in Trinidad and Tobago. We cannot embark on solutions without proper data. So it is something that I would like to definitely see happen. Thank you.

Dr. Othello: That need has been acknowledged and, in fact, the Ministry of Health Policy Agenda 2016 to 2020, on page 104, highlights as one of its initiatives: to conduct a study on the prevalence of mental disorders in Trinidad and Tobago in collaboration with the University of the West Indies and CARPHA.

Miss Lewis: Okay. Thank you.

Mr. Chairman: Thank you very much, Miss Lewis. But a follow-up for Sen. Lewis’ question, and that is: we were, in your submission, told that there were things like neuroses and psychoses and a range of issues and that there were, I think, some, maybe a dozen or so trained psychiatrists or so. I am not sure about the figures. But with respect to the various types of ailments with which you are treating at the public facilities, do you have the requisite number of staff with the requisite training in the sub-specialties to deal with the range? I do not know. I would imagine that a psychiatrist who is a specialist in one area may not be aware of what the issues concerning children might be. But do we have the numbers in place? Because in one of our public hearings for the Ministry of Health we were told that there is no trained geriatrician in Trinidad and Tobago, although our over-60 population is growing every year. So I am looking at forward planning with respect to the current technical staffing at the medical level for the range that Prof. Hutchinson indicated to us which exists in Trinidad and Tobago.

Dr. Othello: In terms of general psychiatrists we have an adequate number of trained persons largely because of the presence of the University of the West Indies and the DM—Doctor of Medicine—Programme in psychiatry, which is a postgraduate training programme. So we always have additional persons graduating from the programme with general psychiatry training. So that even as people leave, you know, attrition for a variety of reasons, we always have new persons
coming in.

The area of difficulty is the sub-specialties. We have only two people trained in child and adolescent psychiatry, one of whom is post-retirement who continues to give her service on a part-time basis. In addition, we do not have any geriatric psychiatrists in the government service. There is one person that I know of locally in private practice. So that the sub-specialty areas are where the difficulty is.

**Mr. Chairman:** And hence it underscores the point of Sen. Lewis that we do need to know, of the range indicated to us by Prof. Hutchinson, the range of the afflictions; we do need to know what the trend has been over time and therefore how we plan for it going forward with respect to having the medical staff in place to deal readily with the problems that they will encounter.

From an economic angle I know our population is ageing, so I know we need geriatricians. How much per thousand or hundred thousand of our elderly population, I do not know. You will tell me. But I know, having none in the country cannot be good for the ageing population, and therefore I think we do need now the data. I am sure Mr. Jaisingh will understand as well, the need for collecting for your agency—collecting the necessary data, having it in electronic form so that when a question such as that posed by Sen. Lewis is posed, how many patients of the X thousands are suffering from psychoses of various orders, we ought to be able to know in order to determine the staffing over the next few years.

Thank you very much. But could I ask MP Jennings-Smith to pose her question?

**Mrs. Jennings-Smith:** Thank you, Chairman. I noted in your submission your concerns with regard to the adolescents and children engaging in mental illness and the effects it has on them. And I want to refer particularly to two of your programmes which you said you had done to support the integration of mental health with primary care. And I refer particularly to the Mental Health Gap Action Programme and the Prevention and Management of Aggression and Violence. And I am asking you this because of its relationship to crime and criminality in our society today, where young people engage in criminal activities and they sometimes say, you know, they have their papers already. And I want to know for the benefit of the public, can you please provide us with an overview of these two initiatives? And can you also explain how the public can get involved to benefit from these programmes? And whilst you are at it, can you tell me if you have done it before, in what areas of Trinidad and Tobago these programmes were initiated?

11.10 a.m.
Dr. Othello: The mental health GAP is an initiative of the PAHO/WHO. So that they provided us with technical assistance in rolling that out across Trinidad and Tobago. It is a train-the-trainers based programme so that a number of practitioners from across Trinidad and Tobago were trained in the detection and management of common psychiatric disorders, and training can continue because they can now train others. Persons trained included doctors from general practice, from emergency room settings and so on—basically first responder doctors.

The training in management of violence and aggressive patients was also a train-the-trainers based programme that was initiated, I think it was probably about two or three years ago, with a team from a foreign university coming down and doing the initial training, and now some of our staff who were trained are rolling out the training on an ongoing basis to staff of the St. Ann’s Hospital and providing that training. What was the next question? I am sorry.

Mrs. Jennings-Smith: I have a last question for you. I want us to refer to section 15 of the Mental Health Act, Chap. 28.02, and I will read it for the benefit of everyone present. It provides authority where:

“(1) A person found wandering at large on a highway or in any public place and who by reason of his appearance, conduct or conversation, a mental health officer has reason to believe is mentally ill and in need of care and treatment in a psychiatric hospital or ward”—that person—“may be taken into custody and conveyed to such hospital or ward for admission for observation...”

Now my question to you: Who takes that person to the mental health institution, let us say St. Ann’s, to be admitted? Because my experiences in the past as a police officer, you will have mentally ill persons roaming the street, or even mentally challenged persons in family engaging in fights and they would call a police officer and there would be very negative repercussions of a police officer not being trained. As the authority or the body employed under this particular section, have you ever thought about dealing with that particular issue? Because you have families, you have persons roaming the street, interfering with persons on the streets. Have you, as a body, dealt with this issue to train people, where there is no police officer, to respond to and take in those persons? Because, yes, the law is there and you state that you can take them up, but who takes them up?

Dr. Othello: Okay. The section of the Act that you are reading is specific to a mental health officer picking up a person. A mental officer is a trained community psychiatric nurse. So that if
a mental health officer in the course of their duties or while going somewhere happens to see somebody in a public place who fits that description, they are empowered under the law to escort that person to the St. Ann’s Hospital, or in the case of San Fernando, the psychiatric ward in the general hospital at San Fernando. There are other sections of the Act that deal with other ways to get somebody to hospital. So that, for instance, if the person is in the home, relatives may take the person to hospital, that person will not be a mental health officer admission. That person if they are willing to be admitted can be admitted on a voluntary basis and, if not, they can be admitted as an urgent admission patient.

There is also another area of the Act that allows for persons to be admitted as a medically recommended patient, and those would be persons who the relatives would have gotten to doctors to see a person, to fill out the requisite forms. They would have submitted those forms to the Medical Director at St. Ann’s Hospital or the psychiatrist at San Fernando hospital, and once that is done there is something called an Apprehension Order that can be filled out, and once the Apprehension Order is done then the police in collaboration with the mental officer can pick up that patient.

**Mrs. Jennings-Smith:** Yes, but I hear all that you have said and sometimes, you know, we hide behind all of these words and these laws. In reality, there are people on the streets roaming and, as you said, a nurse could pick up that person, but can you tell me how many times for the last three years persons were taken to the St. Ann’s medical institute or in San Fernando by this particular way, a nurse or a mental health officer took those persons that were seen on the streets because if you go down to the street now, you would see such persons roaming on that street? So is it that the nurses do not do patrol, or do they do patrol? And if they do patrol, tell me for the past two years how many of these people were brought in by this process?

**Dr. Othello:** We do not have those statistics available unfortunately. The nurses do not do patrols. The community psychiatric nurses, or we call them mental health officers, have a wide range of responsibilities. They work at the psychiatric outpatient clinics in the communities; they do home visits to patients homes; they provide, for instance, patients who are on monthly injections. If the person cannot come to the clinic they go to the house and give the injection and so on. So they have a wide range of responsibilities which do not specifically include what you would call patrols as such. However, if while about their normal business they were to see someone who they thought had a mental illness, as long as the description of the person and the circumstances in which they
find that person meets the provisions of the Act—

**Mrs. Newallo-Hosein:** Could you indicate how many trained mental health nurses do you have currently employed?

**Dr. Othello:** I cannot say of the top of my head. I think we have some figures for North-West RHA? Yes. For North-West we have 25 and I would add that North-West covers from Diego Martin all the way east to Toco, and we provide services all the way down to Rio Claro.

**Mr. Chairman:** Thank you. And a follow-up—

**Mrs. Jennings-Smith:** One final question.

**Mr. Chairman:**—and then you will have a follow-up. And that is: Could you from the 25 identify sometime subsequently for the benefit of the Committee how many of these 25 persons actually enforced section 15? How many of them?

**Dr. Othello:** They all do it.

**Mr. Chairman:** Okay, but we would like to know the numbers. We would like to know the numbers of the 25, how many cases were brought before you by these nurses going about their normal duties who were able to identify such wandering persons, if you can get the statistics? Because I would imagine once they are sent to your institution there would a record, this individual has been brought in by nurse A on so and so day for testing.

**Dr. Othello:** Actually, once again, it would require pulling those patients’ files and in each file looking in the section with the legal forms to see which category of patient that was, whether it was voluntary, whether it was mental health officer, whether it was urgent admission.

**Mr. Chairman:** Would the nurses themselves keep a record of the persons they brought in because I am wondering about bypassing that difficult problem as simply interviewing the nurses to say for 2016 how many did you take in for diagnoses, would that data be available?

**Dr. Othello:** I do not know.

**Mr. Chairman:** Okay. I would recommend that we start collecting that so that the nurses keep a record on some kind of register, so that they keep a record on the persons that they have brought in because they are enforcing the law. It is not as if they are bringing it on their own volition, and that you are able to record as well so that there is some collaboration with the data. I also have another follow-up, but MP Jennings-Smith.

**Mrs. Jennings-Smith:** I want to go back—and thank you, Chairman, because that was my concern to tell me how many persons were brought in that way. I cannot stay here quiet because
I have been a police officer for the past 34 years and I have seen and have even experienced taking mentally ill persons to St. Ann’s. I remember a time I took a mentally ill person and the person actually exploded, and the doctor and everybody ran and left me and one other officer there in the room and it has always impacted on my mind. Do you all think about how you respond to mentally ill people out there?

Police officers are not trained to deal with mentally ill people and you are the institution charged with that responsibility, and to come here and say you do not know how many persons were brought in for the year that is unsatisfactory because, you know, a number of institutions are charged with responsibility and we pass the buck. If we stand up and insist that things are carried out as we are authorized to do, we would solve a lot of problems. I want to support the Chairman on that observation, and to provide us with the number of persons brought in for the past year or two years by the nurses who are assigned. Twenty-five nurses assigned to this particular task, we need to have that information. Thank you, Chairman.

Dr. Othello: Okay. I would like to add, however, that one of the things we have to bear in mind—because we may look at statistics and they may mislead us. So we may look at a certain number of admissions and say that looks relatively small, but we have to remember that sometimes our mental health officers work 8.00 to 4.00, Monday to Friday. That is their current collective agreement. Sometimes they go in search of a person based on a report they received and by the time they reached that person has left. Sometimes they go several times in the same week and they do not find that person. Sometimes the persons know the vehicles, so as soon as they see that vehicle coming into the community they disappear into the bushes. So it is a really challenging problem. It is not as simple as if they brought in one for month then they are not doing their job. It is much more complex than that.

Mr. Chairman: It is understood, but you see the Committee did deal with the homeless, the socially displaced in a public hearing. I would want to ask MP Antoine to follow up after I am concluded with my own questioning, and that was: there seems to have been a need for some collaboration between community police to identify the socially displaced—some of whom were mentally challenged—to work with your trained officers, your nursing officers, so that once there is a programme in place where the community police, or the regular police force, can assist your nurses even after hours, we would be able to identify more and more of those individuals who are wandering on the streets and on the highways undiagnosed.
But my question again, I want to follow up on again this section 15 because when I read section 15, I saw that:

“A person found wandering at large on a highway or in any public place…”

It gives the impression that a mentally ill person is someone who is displaying irregular behaviour, but given what the Chief Medical Officer indicated to us that there is a 20 per cent probability that the general population is afflicted. It is highly likely that someone is suffering a mental illness but he is not to be found muttering to himself, wandering in any public place, and by reason of his appearance, conduct—

In fact, if there are 15 of us in this room, as I suspect, given the statistics presented by your Chief Medical Officer, three of us here, three in jacket and tie, and we are not muttering to ourselves, including the Chairman, could be suffering if we are a random population. Prof. Hutchinson understand very much of random testing. So if Mr. Jaisingh, three of us here are suffering from a mental ailment—and I think really if we are to remove stigma it is important. I would like to put this out as a suggestion because part of the remit of the Committee is to offer suggestions as well, having interacted with the stakeholders, to publicly educate individuals that someone does not have to be muttering to himself, walking randomly and behaving in a manner that is outside the social norm in order to be suffering from a mental ailment. And I think we do need desperately a public health campaign to take a photograph of this Committee to indicate that statistically three of us here are potentially suffering from a medical ailment.

So it has nothing to do with your look, it has nothing to do with your appearance. You see depression, anxiety, all these disorders that you mentioned in your submission really are not manifested out in outward behaviour. They are internal feelings, and for the benefit of the population I would recommend to the Ministry of Health that you work with your PR department, if there is such, to publicly educate the population that mental health does not have a look. And I see a flaw in the Act therefore, where there is already putting in the mind of the population that you have to look and behave in a particular way to be suffering, and therefore, in need of mental challenge.

But before you respond, a question to your legal officer and the question is this: the issue of cruelty to animals was raised in our last public hearing on fireworks where there is a law in Trinidad and Tobago, I think section 78 of the Summary Offences Act, you cannot be cruel to animals. Is there any law in Trinidad and Tobago which says that if you inflict mental cruelty on someone and that
person suffers as a consequence, any of the range of mental illnesses indicated to us by Prof. Hutchinson and the medical officers, that that is a criminal as opposed to a civil offence? Is there any criminal law against inflicting mental cruelty on an individual which will then result in some kind of mental condition of the person?

**Ms. Kowlessar:** I do not think so, but I would have to check it.

**Mr. Chairman:** Please check. I really would like to know because we do have a law on cruelty on animals, and since mental cruelty, that is, you are the—Prof. Hutchinson indicated that a child who is sexually abused—that is a physical cruelty—is going to suffer a mental ailment, but if it could be determined that your action is going to result in a mental problem, any of the psychosis or neurosis that you speak about—I do not know, it is not my field—if that is a criminal offence, I really would like to know what the law states on that because it was not clear to me in the Mental Health Act—or mental distress, mental anguished, anxiety disorder, stress at the work place, bullying, if those things which result in mental anguish and which require treatment are criminal offences? So if you can check I will be grateful for that. And now after the musings of the Chairman, I must ask retired Brigadier to raise his question, followed by Sen. Ameen.

**Brig. Gen. Antoine:** Good morning. In the response from the submission from the Ministry of Health, you identified St. Ann’s Mental Hospital, a number of other facilities like mental health outpatient facilities, community-based psychiatric inpatient units, community residential facilities, and you also mentioned the decanting of patients. In our visits to the geriatric homes, we observed that it became evident during a site visit to a particular home located in St. James which is characterized as a geriatric care facility but accommodates socially displaced and mentally disabled persons under the age of 65. So my question is: it appears that geriatric homes are being used as decanting centres for mentally ill patients, I would like to know how widespread is this? Are there decanting centres for outpatients of the St. Ann’s Hospital, if so, how many? Where are they located? How many outpatients are in these centres? How long do people stay in these locations? Is medical treatment available at those geriatric homes that are being used for mental patients; are they visited; do they get their proper medication? So I would like to know what is the system in place for these outpatients who are in geriatric homes because I was very disturbed to see people in their 80s and 90s along with 16- and 20-year-old mentally ill patients. So I would like to get a response from the Ministry of Health.

**Mr. Chairman:** Yes, it is a question on the decanting facilities that we saw with our own eyes in
St. James for mentally ill patients living with really bona fide geriatric people.

Dr. Ramcharan: I can speak for the two extended care centres, one in Point Fortin and one in Couva, and these come under the South-West Regional Health Authority. One is a 50-bed unit and one is a 40-bed unit. Right now they have together about 80 patients. The majority of those patients have been brought from St. Ann’s Hospital, some have been brought from Ward 1, and those are long-stay units. So the patients coming in remain there virtually for the rest of their lives, with a few exceptions who have been able to get home. So they are chronic long-stay facilities and their rate of admission would be very low because it would depend on patients dying and beds being freed up.

So for last year there were six admissions to those facilities, and those are facilities with trained psychiatric nurses and I think they provide patients with excellent care for mentally ill patients. The private facilities that you talked about, we have no control over those. There was a time when the region had considered placing patients in those homes, but they were found not to be up to the standard that we would require because they would not have had the staff with the training for taking care of mentally ill persons. So those would be private homes and those would be private arrangements made by families to place them there. The home in St. James, I cannot speak to that.

Mr. Chairman: Before Brig. Antoine follows up, a follow-up on that is this. Your facilities in St. Ann’s of course, like all facilities, are limited for the caring of individuals for a relatively short stay, when you have a capacity constraint that you need to admit someone in critical need and there are those who can be cared for by family or by other facilities, what is the process of decision-making on decanting, and where do you decant these people to?

Dr. Othello: Currently, that is a very difficult situation that the St. Ann’s Hospital is grappling with, because unlike the South-West region we no longer have those extended care centres. There was one in Arima and one in Sangre Grande in years gone by, but both have been closed over the years. So that the only place that we can—for instance, people who have been at St. Ann’s for a long time, who we want to move out into the community but who need rehabilitation of their social skills and the activities of daily living and so on, we have the Arima Rehabilitation Centre where we send them. However, we currently have I think probably about 24 patients at this time.

So it is a relatively small number of patients right now being cared for at that facility, and the challenge we face is that when those patients get to the point where they are well enough and capable enough to be living in the community either on their own or with some form of assisted
living, or some sort of supervised living arrangements, those kinds of arrangements do not exist in Trinidad and Tobago. So that for those who do not have homes to return to, we have a bottleneck situation. A small number of them can work and earn and find their own accommodation, but that is a very small number.

**Mr. Chairman:** This is now a problem that the Committee, of course, will have to address because there is the issue of individuals who have not been fully cured or recovered, having to leave the facilities of the State and we are really constrained as a society in where they are decanted to. Brig. Antoine has identified, I have seen as well, the facility in St. James where individuals there were living together with geriatric individuals.

To the Permanent Secretary, the question I want to ask is this: I understand the problem, do you in the Ministry have any liaison with the Ministry of Social Development and Family Services so that individuals who are released in the care of their families, who are rehabilitated but still need care, they cannot function on their own, they do have mental issues which prevent them from earning a living, do you have any kind of liaison with the Ministry of Social Development and Family Services to assist these people to get any kind of financial assistance so that their families can assist in looking after them, and hence easing the burden on the state sector with respect to their care? Yes, PS and afterwards we go back to MP Antoine.

**Mr. Madray:** Well firstly, let me try to answer the earlier question. And again coming out if the work of the earlier Committee on geriatric homes, the Ministry committed to establishing a committee in collaboration with the Ministry of Social Development and Family Services to begin looking at these facilities more closely. So we do have a committee that is comprised of public health inspectors, some of our quality individuals and clinicians that have started the work of looking into the facilities. So, over time the data could be gathered, and based on some of your questions perhaps we would be better informed us to some of the things that we should be looking for and records that we should be keeping.

With respect to the collaboration with the Ministry of Social Development and Family Services and the financial assistance, I am not sure that I can answer that question. I do not know whether the Acting CMO can.

**Dr. Partapsingh:** So last week we actually met with the Permanent Secretary from the Ministry of Social Development and Family Services with a view to looking at this collaboration, this cooperation between the two sectors, or the two Ministries. It was framed under the umbrella of
persons with disabilities. And, Chair, to come back to your point on mental health does not have a look, so you got the illness, you got the disease, you have the disabilities, and I think it is from that part of the spectrum that the collaboration/cooperation with Ministry of Social Development and Family Services is looking at, and we are looking at what sort of centres, what sort of services, what sort of priority groups to focus these services on, and they are all guided by the anecdotal evidence in terms of what is the need. So that I think with time—we do have a follow-up meeting for next week Friday, so it is something that is happening.

**Mr. Chairman:** Medical Officer, I am aware that there is an assistance grant for people living with disabilities—the Ministry of Social Development and Family Services is not here. They would be in the best position I understand—but can you advise that someone who is living with a mental ailment is also a potential recipient of such financial assistance from the State so that the family can in fact be assisted in the health and welfare of that person?

**Dr. Partapsingh:** I would pass that to Dr. Othello, Sir.

**Dr. Othello:** We have psychiatric social workers at all of the public health institutions, all of the hospitals that have a mental health service and they also work in the psychiatric outpatient clinics across the country, and they assist persons with that need in accessing that grant.

**Mr. Chairman:** Could you tell us what the quantum of that grant is? Is it a fixed grant, or—

**Dr. Othello:** It is a fixed grant.

**Mr. Chairman:** The amount that is given to—

**Dr. Othello:** I cannot remember the amount off the top of my head.

**Mr. Chairman:** Okay, thank you very much. Back to Brig. Antoine.

**Brig. Gen. Antoine:** I thank the Ministry of Health for its response, but I want to broaden the situation a little bit. I am only an MP for 20 months, MP for D’Abadie/O’Meara, and in that 20 months I have a number of constituents who have come to me with different problems in terms of mental health patients. In some instances, there are neighbours who have a mentally ill person next door and although they may be mentally ill, they are very intelligent. So when they are behaving badly and the police is called, they put on their best behaviour when the police arrives, but the minute the police leaves they go back to the situation, causing problems for the neighbours.

In addition, I also had family members coming to me who want to deal with a mental family member but they do not want to call the police because two things they do not want. One, they do not want them to be arrested, and they do not want them to be committed to the St. Ann’s Hospital,
but then they come to me as the MP to give a solution. So I am trying to find out how widespread is this because I am just an MP for 20 months and I am seeing a number of cases coming along those lines? How widespread is it? And what is the Ministry of Health doing towards these situations in the communities?

**Dr. Othello:** In any well-developed society, community mental health is the underpinning of mental health services. The better your community mental health services, the better the entire outlook for your country in terms of mental health. Our mental health services are not yet what we would like them to be in the community, in the sense that we still have too much reliance on hospital-based care. We have clinics across the country, but we have clinics where we have large numbers of people, small numbers of doctors at a given point in time. The doctors are not at the clinic every day because the same doctors have to work at the hospital on the days that they are not in the clinics. So that the services are a bit stretched, however, the community mental health nurses, there is usually a nurse or a social worker present in the clinic on any given day and they are the ones who are on the ground in the communities providing day to day services.

**11.40 a.m.**

It is because of the patient to mental health officer ratio in terms of across the country. As I said earlier, the 25 mental health officers assigned to North West RHA provide services from Diego Martin to Toco down to Sangre Grande. So that sometimes, unfortunately, it is difficult to track every single patient. They do keep logs of the patients that they are aware of, so that if a patient that we know has not attended clinic and for instance that person is supposed to be on a monthly injection, we know, therefore, that they have not had an injection for that month. We are able to make attempts to track down that patient and try and make sure they get it.

But as you indicated, sometimes, people evade us as well. So we too face that problem, if the person does not want to receive it. Our current laws make no provision for giving anybody any medication against their will out in the community. The only place you could legally treat a patient against their will is in an institution that has been designated under Section 5 of the Mental Health Act as either a psychiatric hospital or a psychiatric ward in a general hospital. So that there is only so much you could do involuntarily out there in the community.

But other than that, we too are constrained by having to—we have to abide by the provisions of the Act in terms of how we provide interventions to persons, particularly those who do not want intervention.
Mr. Chairman: A follow-up because you raised a very important point about you cannot, of course, force someone taking the prescribed pharmaceuticals. Out of curiosity, pharmaceuticals such as Prozac, I understand Prozac is one of those things that deal with depression and so on. Are these medications available under CDAP? What is the cost of it? Is the cost partially defrayed by the State? Are mental health drugs given any kind of priority in the CDAP programme? I am not sure. Could we get some advice on that?

Dr. Othello: A small number of mental health drugs are on CDAP. Prozac is not available on CDAP as Prozac; a generic form of it is available. Amitriptyline is available, that is another antidepressant. Chlorpromazine, an antipsychotic, is available. And one or two others, not a whole lot of them but the main categories.

Mr. Chairman: But you have no complaints about the quantum in CDAP? You are okay with what is contained in CDAP or would you like to see a larger list?

Dr. Othello: I think it can be expanded.

Mr. Chairman: Okay, very well. Thank you very much. Sen. Ameen, and then we will be coming over there.

Miss Ameen: Mr. Chairman, I have three very quick questions if you would allow me. The first one has to do with the question you were asking with regard to CDAP and I want to ask if there is any shortage of medication at St. Ann’s or the psychiatric departments in the various hospitals throughout the country at this time considering that we have had reports of drug shortages in other areas such as anaesthetic and so on within the hospitals. That is one.

Dr. Othello: Yes, at this time, there are some drugs that are in short supply.

Miss Ameen: Mr. Chairman, my second question is whether there is any official collaboration between the Ministry of Health and the authorities responsible for mental health in Trinidad and Tobago and the prisons. Because in the prisons, you do have a number of people who commit crimes because of their mental illness or who because of their imprisonment experience mental illness, whether it is temporary or it is a prolonged period of that illness. But do you have any official collaboration between the Ministry and the prisons?

Dr. Othello: Doctors from the St. Ann’s Hospital provide a clinic at the Maximum Security Prison on the second Wednesday, I think it is, of every month. At the Women’s Prison, I think it is the third Wednesday of every month. Persons who have been convicted and who are housed—who are on death row in Port of Spain, they are seen on an as-needed basis because there are not as
many persons there, so when there is a need, they call and one of our psychiatrists go across and see those persons.

**Miss Ameen:** What about the remand prison?

**Dr. Othello:** Prisoners on remand come across to the Maximum Security Prison on the days when the psychiatrist is going to the Maximum Security Prison. Similarly, the same thing applies to persons in Carrera. They bring them across to Trinidad, I think, the night before so that on the morning of the clinic, they come to the Maximum Security Prison. In addition, persons in prison can be sent to St. Ann’s Hospital if they need to be admitted. The law provides for that.

**Miss Ameen:** Mr. Chairman, my third quick question is with regard to our mothers and the possibility of postpartum depression and other illnesses that would affect particularly new mothers. Is there any system within our maternity services and the maternity departments of our hospitals to treat with mothers and postpartum depression or any maternity-related mental illness?

**Prof. Hutchinson:** There are no formally developed systems. That is a problem that is currently being addressed. What happens now is that people who are overtly symptomatic, when they are either during the pregnancy or in the aftermath of the delivery, might be referred to the mental health services depending on where they are being seen. So that those in Port of Spain, for example, might be referred to the psychiatrist who covers Port of Spain from St. Ann’s; those in Mount Hope would be seen by the psychiatric team in Mount Hope. But that only applies to those who are significantly affected and even then, sometimes, because the process is not formally developed, by the time the referral is responded to, the person might already have been discharged or might have delivered the baby if they were pregnant and left. So that is certainly something that we are working on to develop a service for that population subgroup.

**Miss Ameen:** So would you recommend that that becomes a part of post-maternity treatment as well as in the clinics when mothers of young children take their children for immunization, for example, that that opportunity be used to interface with mothers and medical practitioners to ascertain if there are any mental illnesses?

**Prof. Hutchinson:** An ideal mechanism would be to screen them, both during the pregnancy and after they have delivered the babies and then, based on results of that screening, they could then be referred. But, as I said, for that referral system to work, there would have to be a dedicated team that could respond to the referrals which, at present, is not the case. So that definitely should be put in place.
Mr. Chairman: May I recommend—I see a solution here. I am taking on from Sen. Ameen. May I recommend that at all of those health centres that we have, where mothers with young children are taking their babies for their monthly check-up, immunizations, that you have a video clip or something playing while they are waiting, telling the mothers, informing them, that if you feel sad, hopeless, depressed, you may be suffering from postpartum, please talk to the nurse if any of these things.

So while you are taking your baby for immunization, you are also educating the mother who may be a mother for the first time, who may not have a network, but who may not be aware that what she is feeling is something that thousands of mothers are also feeling, but she may not be aware of it if she is not educated on it. Again, do you not think like a TV or something, while the mother is waiting, informing her that this is something that is not abnormal and she should tell the nurse if she is feeling this way, can, in some way, contribute to a better diagnosis of the problem?

Prof. Hutchinson: Well, I think that speaks to the problems we identified earlier because many times, when referrals are made, mothers do not follow up because they fear being labelled as being mad or being mentally ill. I think that the service in terms of engaging with the mothers and helping them to understand that, like you say, this is something that is a function of their condition at the time, would be helpful but I think as well that presence requires dedicated staff which, at present, is not available.

Mr. Chairman: But PS, before you continue, we have so many arms of the State; we have so many problems and in my mind, the solutions are so very simple. There is a government film unit, I do not know see how long it will take simply to make a little clip, play it as a video, a five-minute video, to a mother and in a room where they are all waiting for their immunizations for their babies. Just let them know that this is not unexpected. If you are feeling sad, hopeless, depressed, if you are feeling in some way as if you are unhappy, that this is a treatable situation, do not hesitate to contact the nurse. And I think if there is any communication—I think public education is critical, PS. So that public education on stigma and public education, using the government film unit and all the media that we have, it certainly will go many light years away in ensuring that we are more aware. We need to be aware that these things are normal. They are as normal as catching the cold and there are professionals who can help you but only if they know that you are experiencing these types of feelings and so on.

So I would recommend strongly to the Ministry of Health to look at its public education
programme and use the other arms of the state: social services, government film unit, put into your budget. Put into your budget something about promotional programmes because when I was little, I remember seeing posters on a lot of things, PS, such as gastroenteritis and so on and flies on food, so you knew that you had to cover the food or else the baby would—so public education, I think, in my mind, is something that the Ministry should be giving attention to. Back to you, Sen. Ameen. Okay, PS, respond. I know you would not disagree with my position.

Mr. Madray: Well, exactly. So I agree with you and I will, of course, explore your very useful suggestion with our communications division.

Mr. Chairman: Sen. Ameen. MP Antoine has a burning question and then we come over to this side.

Miss Ameen: Mr. Chairman, at this point, I really must express that the discussion has reiterated my own feelings that we are failing our children, our nation’s children, because we have seen a number of incidents of horrific deaths of young children and infants by the hands of their parents who, after the death, I mean the entire nation is expressing that this parent obviously has a mental health issue and we have seen instances where they go straight into the penal system and which might make their mental illness even worse.

But the fact is that at some point where we make it mandatory for parents to bring the children for immunization, there is an interface between the medical practitioners and the parents, both male and female. And there are a number of opportunities for us to diagnosis parents with mental illnesses who end up abusing and even killing their own children. And before the police, for example, step in with regard to upholding the law and the police are not trained to deal with mental illnesses such as that. I would really like to see efforts made to protect our nation, our vulnerable children, whose parents have mental illnesses and to engage stakeholders to ensure that the proper policies are put in place and programmes to protect our children.

Mr. Chairman: Before you respond, I will ask MP Antoine to pose. We will take the response to MP Antoine and then we go on to MP Newallo-Hosein.

Brig. Gen. Antoine: To the Permanent Secretary, in your response, financing of the mental services, you said that 4 per cent of health care expenditure by the Ministry of Health is devoted to mental health and 85 per cent of these funds allocated to the mental hospital. Therefore, it means that 15 per cent of 4 per cent of health care expenditure is allocated outside of the St. Ann’s Hospital. My question to you: are there any plans to expand the construction of additional centres?
Because we realize that it is woefully inadequate, so much so that you are using geriatric homes for mental health patients and as an MP, I am saying that in the communities, we are already getting feedback from the constituents that there is a need to deal with the mentally ill amongst the citizens. Are there any plans for the expansion of these outpatient facilities within the communities to deal with mental health patients?

**Mr. Madray:** Again, as I say, briefly, that we are in the early stages of planning a strategy for reaching out to the communities more effectively, so shifting a little bit away from the centralized provision of psychiatric and mental health services and getting into the communities where much of the research suggests that these issues can be better dealt with. But I am not able to—I am not sure whether anyone here can speak with any more assurance of the details of our plan, but we are in the early stages of planning for this effort. I think Dr. Ramcharan would like to come into it.

**Dr. Ramcharan:** Yeah, I think the focus has to be on community mental health services in order to reduce the number of admissions that we get to hospital. And we do have, in South West, community mental health centres in about five locations, the five main areas, five district health facilities, but there are limitations. Because there are limitations in terms of space and there are limitations in terms of community staff which I think is a direction that we need to go in. We need the space, we need the community mental health centres, we need the community staff to man those centres.

Also, we need to look at moving away from the mental hospital, from the psychiatric hospital, into having units in outlying general hospitals. And well, Prof. Hutchinson, they have a unit at Eric Williams and we have a unit at San Fernando, but there is a lot more that we need to do with those units. Because the units themselves are not as therapeutic—I am speaking from my end, not Prof. Hutchinson. The unit itself needs to be more therapeutic, it needs to provide more in terms of space because we have that very crowded facility. We need to be able to address different types of mental illnesses because, for example, we have patients who would be mildly depressed, and very psychotic patients, patients who are depressed and they have to be treated in one area.

So I think this is what we have to look at. We have to look at expanding our community services and we have to look at putting in place in general hospitals, psychiatric units which can provide really quality care for patients.

**Brig. Gen. Antoine:** So therefore, can we expect some recommendations from the Ministry of Health and the regional authorities as a way forward to deal with the situation, the lack of facilities,
to deal in the communities?

Mr. Madray: Actually, I think that the Chief Medical Officer would also like to make a comment on how he sees the issue.

Dr. Partapsingh: So to support the move for decentralization, in 1990, one of the ground-breaking or the sort of basic tenets for that move was the Declaration of Caracas, which spoke to supporting mental health decentralization and community mental health. In 2014, the 53rd Directing Council World Health Organization met and they developed the plan of action for mental health and that is the plan of action that is currently in force and some of the objectives of that speak to reducing hospital—the dependency or the reliance on psychiatric hospitals.

One of the indicators of that is a decrease in the hospital beds by 15 per cent and the integration into primary care. And the vision or the evidence of that that you see with the periphery mental health clinics, the St. Ann’s hospital, reaching out to the different sides is evidence for that move to that action.

Mrs. Newallo-Hosein: I just have a couple of questions. Before I go right back, I am going to start with—Dr. Ramcharan, you spoke about the therapeutic aspect. Is it that currently the focus is more on medicated care as opposed to therapeutic?

Dr. Ramcharan: We do have in place social workers, psychologists, who do therapy in terms of psychotherapy. There is an emphasis, yes, on medication but when I said therapeutic, I was thinking of the whole environment that the patients are being treated in. The environment needs to facilitate their recovery which is something that we do not have because we have a very crowded, you know, without too many things in place in terms of occupational therapy and other forms of therapy that they need—so, yes.

Mrs. Newallo-Hosein: Thank you. And also, when you have therapy with the patients, are the families usually included in the whole form of counselling and therapy? Because you know, you could treat someone but if the situation at home does not change and there is a situation at home that is contributing to the mental wellness of the person. Is that a consideration? Is it done in practice?

Dr. Ramcharan: Yes, certainly, because whenever we treat patients, the families are involved. The families are always invited in to discuss the problems, to discuss the illness, to discuss anything in the environment which may be impacting on the patient’s mental health and the patient having to return home to the family, too, so the family has to understand what is happening with
them and what their needs are, what changes maybe they need to make in their interaction with the person. So yes, there is a lot done in terms of family intervention.

**Mrs. Newallo-Hosein:** I saw that you indicated that counselling is provided in schools to students that have displayed signs or symptoms of mental illness through the Students Support Division. Could you tell me when did this programme start? How many students have accessed the counselling and how is the programme accessed?

**Dr. Ramcharan:** Well, the Students Support Division is a division of the Ministry of Education. They provide guidance officers and social workers and psychologists to work with children in the schools. And if a teacher or a principal identifies a child as in need of some kind of intervention, the first step would be to bring that child to the attention of the guidance officer or the social worker in the school. What happens next is that many of these children may need further interventions which they are not trained or do not have the resources to provide and the Students Support Services would then refer the child to the Child Guidance Clinic. Now, the Child Guidance Clinic comes under the Ministry of Health, under the region. There is a child guidance clinic in Port of Spain, there is one in San Fernando and there is one in Tobago.

**Mrs. Newallo-Hosein:** Okay. In light of that fact that you are stating that there are all these facilities in place, supposing that one of the students required medication—you had indicated that there is a shortage of medication currently—if a patient is unable to access medication, whether it is a student or an adult, how does this impact and how will it impact on the population because you have persons who are dependent on these medications to maintain mental wellness to be able to function in society and they are without medication? Do you see a negative impact upon the population at large as a result of it?

**Dr. Ramcharan:** Well, we do have shortages of medication periodically and it does impact. The largest single diagnosis of the Child Guidance Clinic is attention deficit hyperactivity disorder and most of these children need to be on medication. Currently, the medication is not available. So families who can afford to purchase it will, but those who cannot, then the children will have to not have it. And that impacts on the child’s behaviour in school because, you know, without the medication, they would be more hyperactive, they would be more easily distractible, there would be more impulsive, they might disrupt the class. So it certainly has an impact and something that we need to look at.

**Mr. Chairman:** Coming back to a point—thank you very much—that MP Antoine raised on
community health support services, mental health support services, I am just wondering whether the Ministry, the medical doctors in the mainstream medical profession have given thought to meditation versus medication, and that is, there is a widespread use of things like comfort animals to help people with trauma. I have seen situations where hardened criminals being given the task of treating horses were rehabilitated in that way. Children with anxiety disorders and traumas are looking after their dogs and their pets were given supplemental treatment. Is that accepted in the medical profession or is that something you frown upon? Do you look at alternative forms of treatment, yoga and so on, as also treatments that will contribute at minimum cost to the mentally ill patients?

Mr. Jaisingh: Chair, in terms of the yoga style of it and also the assistance of other NGOs, the Ministry has engaged horses helping humans in the last two years and they have assisted us in terms of that capacity—building that capacity in terms of ensuring an alternative form of treatment of the disorder as well.

Mr. Chairman: So it is not discounted?

Mr. Jaisingh: No.

Mr. Chairman: And therefore, you include things like comfort animals for anxiety disorders as well?

Mr. Jaisingh: That is correct.

Mr. Chairman: Hence, you see on the last hearing, we were looking at animal welfare in relation to health welfare and well-being, so it ties in in that way.

Mr. Jaisingh: About 20 persons have been treated so far in that programme itself.

Mr. Chairman: Okay, very well, good to hear. I will have to go to MP Jennings-Smith and then—Sen. Ayanna, do you have something?

Miss Lewis: I do.

Mr. Chairman: Right, so MP Jennings-Smith, Sen. Ayanna and then of course, we come back to Sen. Khadijah.

Mrs. Jennings-Smith: Thank you, Chair. I want to go back to mental illness and crime and I want to look at section 4 of the Offences Against the Person Act provides for a defence of diminished responsibility and section 13(1) of the Mental Health Act provides that a person accused of a crime who is believed to be mentally ill and in need of care and treatment is first taken into custody and conveyed to a hospital or ward for observation.
Now, those two pieces of legislation give a responsibility of care upon your organization and a responsibility that is, you know, one which I really feel that you need to take very seriously because it is a thin line between a person who has committed murder who, in this instance, would be kind of looked at as “losing it”. And they are usually taken into custody for observation by the St. Ann’s medical institution.

Now, I am asking these questions to simply enquire of you whether you have a process of monitoring and tracking of individuals who have mental illness because there are some occasions where you see murders being committed and the family said, “You know, he was acting up, he was acting up and we tried to get to the people at St. Ann’s or wherever and they could not come or they did not come”. So immediately, we look at that section 4 of the Offences Against the Person Act which provides for a defence in court of diminished responsibility. This is very serious.

And because of that, it is important—I am going back to the 25 mental health officers that we have. Do we have a system in place of tracking all patients externally? And I am suggesting also that the community intervention programme, it must be tied in to getting information, feeding you information, who may be challenged in those areas that you could have monitoring and tracking continuously done and have an impact on the amount of crimes committed through those kinds of acts.

**Dr. Othello:** Okay, I think I will take that one. There is no way for 25 mental health officers to successfully monitor every person with a mental health disorder and I dare say it is not even necessary for every person with a mental health disorder to be “monitored” and I say that quite respectfully. We have to remember the human rights of the individual with a mental disorder and people have the right to autonomy and dignity and things like that, which we do not want to cross that line unless it becomes absolutely necessary. So that in cases where there is—the other thing I need to add at this point quite emphatically is that a very small percentage of persons with mental illness become physically violent or become aggressive or violent at all.

**Mr. Chairman:** Could you repeat that because it is important for the population to know that?

**Dr. Othello:** Yeah, I would like to say that very, very emphatically. A very small percentage of persons with mental health disorders are violent.

**Mr. Chairman:** Would you say it is like 1 per cent, 2 per cent? Do you have statistics?

12.10 p.m.

**Dr. Othello:** Okay, if we would consider that 1 per cent of persons in any society would have
schizophrenia and schizophrenia is probably the most common diagnosis among mentally ill persons who offend, separate and apart from personality disorders, which we do not have good data for the prevalence of. Right? Personality disorders, substance use disorders and schizophrenia are the three main psychiatric contributors to violence among mentally ill persons.

If among all persons in a society only 1 per cent develops schizophrenia and only a small percentage of persons with schizophrenia will ever become violent, it speaks loudly to the fact that by and large, mentally ill persons do not become violent. Because when a mentally ill person becomes violent, the press treats with it in a certain way, the society treats—remember this person is already stigmatized so the first thing everybody says, if they do something violent, is you know he is a mad man or you know he is a psychiatric patient and we emphasize that, without bearing in mind that the vast majority of violent crimes are not committed by mentally ill persons. Thank you.

**Mrs. Jennings-Smith:** I want to have a follow-up. So are you satisfied and are you telling us and the public of Trinidad and Tobago that you would rather persons who are mentally challenged be kept in the dark or be kept quiet? Are you telling us that?

**Dr. Othello:** I am not sure what you mean by in the dark or quiet.

**Mrs. Jennings-Smith:** Are you telling us that when we see signs or symptoms or we know of persons in the society and in communities and they are showing signs of mental incapacity and they are showing signs that they have those challenges recognized that you identified a while ago, are you saying that your approach to it would be rather to keep it quiet?

**Dr. Othello:** No, no, no, absolutely not. We advocate for early intervention, early diagnosis, early treatment. We have absolutely, I mean, those are our priorities. The point I am making is that we have to also be aware of stigma and we have to be aware of, in our desire to treat, we have to not cross certain boundaries. So that yes, we want to treat early but there are ways of assessing risk and the person who carries a certain risk clearly demands a different type of intervention from the person who does not carry that risk. So the fact that somebody has a diagnosis of schizophrenia does not mean that people should be afraid of them or they should be in a hospital all the time or anything of that nature.

It simply means that they need to be diagnosed, they need to be treated and they need to be maintained on treatment; so that even if that person has a coexisting personality disorder that predisposes them towards violence—because that is what happens most of the time. Most of the
time it is the pre-existing personality disorder that makes the difference between the person with schizophrenia, who does not offend and the person with schizophrenia, who offends. So that, if at any point that person’s symptoms are reoccurring or escalating, intervention takes place quickly in order to prevent a violent act.

Mrs. Jennings-Smith: One final question to you. How public are your public intervention programmes? How public are your public intervention programmes working with communities?

Dr. Othello: The North-West RHA has an outreach team that goes out into the community on a regular basis doing workshops. They go to several work places.

Mrs. Jennings-Smith: Do you have a chart that you publicize, make public on the newspaper so that people could follow when your team goes to a particular community? That is why I ask how public are your public intervention programmes?

Dr. Othello: I am not sure.

Mrs. Jennings-Smith: The first question I had asked you: what programmes do you have and I identified two of your programmes and I asked you also to tell us how often and how many communities you interface with. Because most importantly in this issue is working with the community and families in communities, and my first question, I asked you how often and where are they held? So now I am asking you: How public? Do you publicize it? Do you publish it so that people know when you all are coming or where you all are, so that we could have that intervention?

I remember as a child we knew who the public health nurse was. She wore a different colour uniform. But now the population has exploded and I want to know how do people access these services in communities? My colleague there, Brig. Gen. Ancil Antoine, he spoke about it too. And his speaking about it signals that it is absent and I want to know what you are doing.

Mr. Chairman: Member, I am posing a straight question. Member, yes. Do you have a system in place where, whenever there is an outreach activity it is publicized?

Dr. Othello: I would have to check with the Corporate Communications Department to find out that and get back to you.

Mr. Chairman: If they do not have it, implement it. So people will know.

Dr. Othello: Certainly, absolutely.

Mr. Chairman: Because unless people know, the effectiveness of the programme will be neutralized. Individuals need to know that step. They need to be informed. Sen. Lewis has been
silent for quite a while. Sen. Lewis, the floor is yours.

Miss Lewis: Thank you, Chair. Based on the data that you submitted, I see that most persons who are admitted to the St. Ann’s Hospital are from north-central, right, and you have a staffing of 25 house officers for St. Ann’s. It is clear that your staffing is not sufficient for the number of persons that are admitted to the hospitals, not just St. Ann's but throughout the country. What incentives or what initiatives the Ministry is going to put in place to encourage house officers to become specialized medical officers in this particular area? Because I am seeing here that you have three part-time special medical officers and then eight full-time. Three plus eight, 11. That is not sufficient. So I want to know what is the Ministry going to put in place to encourage house officers to get more involved in specializing in medical health care.

Mr. Ali: Hi member, thank you. As Prof. Hutchinson had mentioned we do have the DM programme at UWI in psychiatry and we have been encouraging our house officers to take advantage of that. It is easier to access training locally than abroad right now in these post specialist disciplines. So that is one way we have been working with UWI to have our house officers access that programme.

Miss Lewis: All right. What is the cost? Is it free? Is it—what is the cost per person? Is it expensive?

Prof. Hutchinson: Well it is partially funded by GATE as a postgraduate programme. The cost is TT $30,000 per annum. So that works out at a cost to the doctor pursuing the programme at $15,000 given the current GATE allocation. So it is $15,000 per year for four years of training.

Miss Lewis: Would you consider that programme being a programme that should be added to the scholarship programme where persons could probably apply for some kind of scholarship to get for free to encourage them to then get involved in it?

Prof. Hutchinson: They are employed while they are pursuing the programme. Because the programme requires that they work in psychiatry while they are being trained. I think the issue of scholarships is probably more relevant for sub-specializing. So having done that general training, when they want to specialize in child psychiatry or substance abuse related or forensic or geriatric, that they could access scholarships because we do not provide training in those sub-specialties here. So they would have to go abroad for those. We have had people who have obtained scholarships to do child psychiatry; well one person, forensic psychiatry and the encouragement, I guess, through scholarships might be the way to encourage more people to do that.
Miss Lewis: All right, I just have a couple. Just one question again and a comment. In terms of stress and depression. I am going back to that because I am not feeling like we are speaking a lot on that. Stress usually manifests itself in something physical and then persons end up in hospital and then they have to deal with physical treatment in terms of heart diseases, and stuff. My father would have suffered a severe heart attack some years ago and he would have recovered, thank God. It was stress-related because his diet was extremely well. He was very fit. So I want to know, what is the Ministry doing in place, in terms of alongside NGOs, to deal with persons dealing with stress-related issues? And mind you, the UN would have sanctioned a report, the Happiness Report, 2016. I was just going through it and I realise that Trinidad is ranked No. 43 out of 157 countries and the United States is ranked at 13, and of course, we are going one in four persons suffering from mental health care based on the United States and that is why the importance of us having our own data to verify what we are doing going forward. That is just a comment, but also I would like to know what are we doing or what are we putting in place to deal with persons dealing with stress?

Prof. Hutchinson: Well, one of the problems, I think even the issues that the member, I think Mrs. Jennings-Smith made reference to is that health issues transcend the discipline of health. For example, in crime, the Ministry of National Security has to be involved, in terms of the training and the monitoring and the management of people who get into the criminal justice system. And similarly, the Ministry of Labour and the CPO, the Chief Personnel Officer, they have worked alongside the Ministry in terms of developing employee assistance programmes for people who work in the various Ministries.

The plan initially was to provide a public service EAP, which would then provide mental health services for everybody who worked in the public system. Several private companies have EAPs as well. But that, so far, has not been fully realized, although there are some Ministries that do have. Ministry of Education, for example has an EAP. So that process of negotiation and funding, again, I think, is ongoing, in terms of the best way to provide universal service. I think thus far the services that are provided are relatively piecemeal depending on the sensitivity of the various stakeholders in the particular area of employment.

Miss Lewis: Okay. Just one other question. Well, it is part A and B and it is guided to you, Sir. I just want to find out, in your research, if you found it or would you embark on it, a therapeutic method like massage? I want to find out if massages can be considered or has it been considered
as something therapeutic for persons dealing with mental disorders and would you consider that to be something that should be insured? Because in some countries you can use the insurance to get massages because they consider it a type of method to deal with mental health issues.

Mr. Jaisingh: Certainly, based on the discussion I would conduct a research to ensure there is a link between the massage and also the mental health disorder part of it and I will get back to you.

Miss Lewis: Thank you, and lastly, I am not sure if you mentioned this before, the team, but in terms of monitoring private health care facilities that treat with mental health care patients combined with geriatrics, because my grandfather would have passed away from Alzheimer’s and we placed him in a home and when we visited him we noticed that they just left him on the bed. They did not move him so he got a lot of bedsores, et cetera. What monitoring mechanism does the Ministry have to deal with something like that and would you put and pull everyone under the ambit of the Ministry to deal with private health care that services persons with mental health disorders?

Mr. Chairman: Before you respond, I would just like to advise all members, in case you are becoming anxious, we would like to conclude within a reasonable time, so maybe in about 10 minutes, but we do have a round to go. I do not intend to keep you here longer than necessary, so maybe by quarter to one, if we can have a cut-off time, that will then determine the proceedings. Yes, yes, Permanent Secretary.

Miss Lewis: That is my final question, by the way.

Mr. Madray: The answer to that is yes, we have established a multidisciplinary team comprised of different fields to inspect such facilities and that has been recently established. So, over time you will get a better sense of what is actually on the ground.

Miss Lewis: Thank you very much. Thank you for your responses and thank you for your patience.

Mr. Chairman: Thank you for your patience, Senator Lewis, because you have been sitting quietly very well for a while. I would ask Sen. Ameen to pose her question.

Miss Ameen: Mr. Chairman, you know my passion is local government. When I was the Chairman of a regional corporation, we engaged in an exercise of community emergency response teams being trained in communities. And one aspect that a number of people volunteered for was with regard to the whole idea of, well, particularly treating with children, having storytelling, and so on. So it keeps the children calm and therefore their reaction in the face of disaster, you know,
would sort of just keep—and it affected the adults in a positive way as well, because instead of focusing on the negatives of the disaster at hand in the shelter, they could sit with the children and do wholesome activities. And this aspect, we were given advice from some people who we engaged. There was a retired principal, I think, who was part of it. But certainly a child psychologist could make recommendations to speak to policy. Because this was something we did as a one-off.

But in terms of policy recommendations, has the Ministry, or any of the persons who operate in terms of advising on mental health, been engaged by the Ministry of Local Government or the Ministry of National Security, the two Ministries who deal with disaster response and disaster management and setting up shelters to advise on programmes that could be included when you have disaster, in terms of treating with the psychological aspect of disaster management? And is it an area that you think you can make recommendations for?

**Mr. Chairman:** Anyone from your team, brief response.

**Dr. Partapsingh:** I cannot speak specifically for the interaction or the collaboration with those two sectors that you referenced but I do know that there has been training. In 2011, a cadre of persons in the Ministry of Health were trained through the Pan American Health Organization and the Caribbean Epidemiology Centre in public health emergency response and within that umbrella they were trained in the need for the awareness or the recognition of mental health and psychological support in emergencies. The persons who were trained were the county medical officers of health who provide the Ministry of Health with that support or that link at the front-line level in the situation if there were disasters. So that training has happened, and, again I think, you know, in terms of continuing that, the awareness is there for that in mental health and psychological support in the emergency setting.

**Miss Ameen:** Mr. Chairman, I always like, when we have our discussions, for us to have policy recommendations and I really think that this is an area that should be explored where policy recommendations can be made for collaboration between the trained county medical officers because they work with the regional corporations, but for them to make a firm policy that would mandate all persons involved in disaster management and disaster response to have to consider that aspect, in terms of dealing with the mental health and any anxiety, and so on, that may come up. Right?

**Mr. Chairman:** Very well. Thank you. I will ask Sen. Newallo-Hosein to pose her final
question/questions. Be short and to the point, MP.

Mrs. Newallo-Hosein: Thank you, Chair. I saw in you submission that the St. Ann’s Hospital serves several sectors throughout the country and you have registered mental nurses, number of positions, 500 of which only 52 vacancies are outstanding. So, therefore, it means that you have more or less almost a full complement. Can you indicate with this number what is the nurse-to-patient ratio with these figures and in fact if these figures should be upped, or if it is a satisfactory figure, 500 persons. For the number of positions you have 500, of which you require 50. You have 52 vacancies, so I am asking what is the nurse-to-patient ratio with these figures and if these 500 positions are adequate?

Dr. Othello: The number of nursing positions that we have in the mental health service in Trinidad right now is not adequate for the number of patients that we have in the inpatient setting. You may see that number of nurses but remember they are on different shifts so they are not all there at the same time and that sort of thing, obviously. And you have to cater for sick leave and all those types of things that we cannot predict, vacation, maternity leave, all those things. So that, on an average day, the nurse-to-patient ratio in St. Ann’s Hospital is not adequate.

That being said, in terms of policy and long-term planning, if we achieve the goals of reducing the reliance on inpatient care and we have more reliance on community care then the emphasis should be on increasing the number of community mental health nurses to provide those services, because the number of nurses that would be needed in the inpatient setting, when that is ever achieved, would be significantly lower than what is needed right now.

Mrs. Newallo-Hosein: Well, when I read your submission it indicates that it is inclusive of the mental health services at three clinics, that is Barataria Wellness, Carenage, and Pembroke Street, the Child Guidance Unit, Arima Rehabilitation and Caura. So this here includes the out-services and, therefore, I am saying if these are the number of positions that are here, is there a need, therefore, to increase the positions and is there any intention to do so? Because in your submission, I did not submit it, you submitted that this is in fact throughout the country in your mental health service.

Dr. Othello: Yes, there is a need to increase the number of posts.

Mrs. Newallo-Hosein: Okay, and I need to know the nurse-to-patient ratio. I know it is not good but we need to know. Thank you.

Dr. Othello: I would have to calculate that for you.
Mr. Chairman: One final short question.

Mrs. Jennings-Smith: From our interventions this morning with you I have realized that three words seem to be creating some problems are: data, monitoring, and tracking. We live in a world where everything is evidence-based and data-driven and I would like to ask you, bearing in mind that we saw a lot of issues that we have to treat with, for example, one, where certain categories of persons who have entered the treatment centres can walk out. It is not mandatory that they be held. You cannot hold then against their will. Do you intend to recommend amendments to the Mental Health Act or to pursue additional legislative interventions to deal with that? That is my final question.

Mr. Chairman: That would be the final question from members of our Committee before the Chairman poses his final questions.

Ms. Kowlessar: With respect to your question in terms of amendments to the legislation that exists, there is a draft revised Mental Health Act, and I say draft. It needs some reviewing. The policy needs finalization and the Act primarily, while it aims to address some of the discrepancies and some of the shortfalls in the present legislation, the main focus of the Act would be a community-based approach so you will appreciate that that requires a lot of infrastructure as well as training and stakeholder consultation. So that is where the Ministry is at, at this time regarding new legislation.

Mr. Chairman: Thank you very much, members. We do have some other matters to deal with before we close. One is we do invite members of the public to pose questions that we may not have posed. One just came in and that is with respect to suicide. And the question that came in from the member of the public is: Whether the Ministry of Health has a national suicide prevention action plan and what are the plans currently in place? What are the procedures and protocols to deal with this issue of suicide in Trinidad and Tobago?

Dr. Partapsingh: So the Ministry of Health is embarking on a process of implementing a suicide surveillance system. So that would be one of the measures that we would put in place to monitor, to track and to see the effectiveness of interventions. I think from the clinical side, the interventions, in terms of the protocols on how to manage a patient with suicidal ideation do exist and so that would provide for—the suicide surveillance system would support that clinical strength, in terms of addressing suicidal ideation. Thank you.

Mr. Chairman: Is there a 24 hour hotline where someone who is suicidal knows he or she can
call and get some kind of counselling 24/7 in Trinidad and Tobago?

**Dr. Partapsingh:** I think that would be best answered by the—

**Prof. Hutchinson:** There is no publicly instituted or funded 24 hour hotline. A hotline does exist but it is run by an NGO, Lifeline, and as part of the suicide prevention plan that is being developed and hopefully will be implemented soon is a proposal to either work alongside Lifeline, in terms of supplementing and supporting their service, because they have had lots of problems with volunteers and continue or maintaining the 24 hour service, or indeed setting up an alternative 24 hour hotline that the Ministry could fund and support.

**Mr. Chairman:** Okay. Thank you very much. And the second question is in relation to Tobago. We do not know very much about the incidence or the prevalence of mental health problems in Tobago. Does the Ministry of Health, Trinidad have jurisdiction over the mental health facilities in Tobago? If so, what is the relationship between the institutions in Trinidad and the institutions which exist in Tobago treating with mentally challenged patients?

**Mr. Madray:** Generally speaking, we do not have jurisdiction over the Tobago institutions.

**Mr. Chairman:** If the mental health facilities in Tobago, I imagine they would have them, need any assistance is it that the Ministry of Health of Trinidad will not be in a position to provide or is it that they must request, and upon request you will provide whatever assistance they need? If they, perhaps need a psychiatrist to come in once a week that they do not have or a psychologist? Do you provide that kind of assistance?

**Dr. Othello:** The Tobago RHA is responsible for mental health services in Tobago. They have a psychiatric unit at the Scarborough Hospital, which is currently staffed by two psychiatric nurses, social workers, mental health nurses, et cetera. So they have a full inpatient service, in addition to which they have outpatient clinics in a number of areas: Roxborough, Scarborough. I cannot remember all of them but they have clinics across the island as well. So their services follow basically the same model as the services in Trinidad and any requests for assistance, I imagine, would have to come from the TRHA to the Ministry.

**Mr. Chairman:** Has it ever occurred, to the best of your knowledge, that there was a request for assistance? I would imagine with two professionals only in the island if two of them get ill at the time or if they must travel and they do not have any technical experts, would you be in a position to reassign some of your experts to provide temporary assistance if they need?

**Dr. Othello:** The current RHA arrangements do not allow for reassigning of doctors from one
RHA to another RHA. So that, in the past for instance when they had one psychiatrist if that person were going on leave somebody would have to take vacation from their job in Trinidad and take up a one month contract in Tobago if the person were on leave for one month or something like that.

Mr. Chairman: Administratively, do you think that that is an arrangement we should review to ensure that there is some continuity with respect to—and not be confined by, you see, Parliament can change laws. That is what we do. If there is a law preventing the professionals from discharging their functions it is our responsibility to change the law.

Dr. Othello: I think it should be looked at because particularly that arrangement also affects postgraduate training. For instance, persons employed at the North-Central RHA who need to do some of their clinical rotations in forensic psychiatry and substance use disorders, as well as child guidance have to leave their job at North-Central RHA and take up a contract with North-West RHA in order to do those rotations. Similarly, persons in south who want to come to St. Ann’s to do their forensic training, you know. So it is something that should be looked at, both for the provision of service to the patients and to make it easier and more flexible for postgraduate students.

12.40 p.m.

Mr. Chairman: Thank you very much, and we are close to our cut-off time. Let me, while I summarize from our end at the level of the Committee, indicate the following. As far as I am aware, this is the first time in the Republic of Trinidad and Tobago that the issue of mental health has been discussed so openly and frankly in the public domain. I am very grateful to all members of your committee for being here and for imparting the knowledge that you have had so that we in the Parliament and the general population can now be made aware of the following. I would like to summarize what I have learnt that I did not know before.

First, what I have learnt is that mental illness does not have a face contrary to what the Act says. Someone does not have to be wandering and muttering to himself and be dressing in outlandish clothes for him to be deemed to be liable for mental health problems. We are all subject—being 20 or 25 per cent of our population—to the range of ailments that Prof. Hutchinson indicated would be categorized in this particular field of health care need.

So there is no face, and because there is no face, I think what has come out—based upon the submissions from the medical doctors—is that there is a need for a public education campaign
from the Ministry of Health, in particular, so that people will become aware of what the mental issues are that they can expect to confront themselves, since we are dealing with one in five, as our Chief Medical Staff indicated, maybe one in four, we do not know. So we do need to get the data, but I know it is greater than what we think it is.

There is a need for there to be discharged facilities and a programme to think it through so that the fixed facilities for short-term care at St. Ann’s and elsewhere, once they are running to capacity, must find a mechanism to decant their patients who can be cared for by others, and we need to be looking at the circumstances, so that we will not be commingling the mentally ill with the geriatric population. We would need to be looking at family care, community care.

We will, of course, be looking at the law, whether in fact mental cruelty is something which ought to be criminalized, because we are now dealing with stress, workplace stress. There is not only sexual abuse, but sexual harassment. These are the issues we are going to have to confront now as legislators. So whether, in fact, ensuring or acting in a way which will induce someone to suffer a nervous breakdown or any of the mental ailments or even to become suicidal, we need to look at whether we should be criminalizing this activity as opposed to making it simply to be a civil matter.

We need to collect data, tracking our population with respect to the range. Because as was indicated to us, we have very mild forms of mental disorders—the fear of crowds, the fear of public speaking, the fear of spiders and we have major problems schizophrenia or bipolar disorders, the various things that we are hearing about. We do need to track and categorize, so that if you were to have a submission to the Parliament on 2,500 or 3,000 persons admitted to your institutions, one would think that the computer will be able to say X numbers were mild, so many were severe and these were the problems and this will then guide the kind of staff we will need, maybe even the kind of medication we need to have readily available in the CDAP programme. I hope that the medications that are not available in CDAP are available in the private pharmacies, so that it is not as if we are short of medication entirely to treat with mental issues in Trinidad and Tobago.

What came out, very importantly, is that when we are dealing with mental health individuals or mentally challenged persons, maybe less than one in 100 might be a violent person. In fact, in the normal population, the level of violence may be higher than amongst the mentally ill patients, given the range of ailments that you are dealing with. Someone can be prone to violence for a number of reasons of which mental health will be only one. So I think we need to remove the stigma in the society with respect to violence and mental health and also treating the mentally-ill
patients in any way different from someone who has any ailment like diabetes, hypertension and HIV. I think if we can get to the stage in looking at mentally-ill patients as how we are looking now at HIV afflicted patients simply with a viral infection, I think we would have made much progress in the past little while.

So that these are some of the information which has come out and which I think would have edified the Committee and the public as a whole. We are now opening out the investigation on this critical issue. It is the beginning, but we will be probing deeper into what we at the level of the Parliament can do to ensure that mentally challenged persons in Trinidad and Tobago are given the type of care that they need at all levels.

Before I close, from the Committee level, I will ask the Permanent Secretary to offer brief closing remarks on behalf of his team.

Mr. Madray: Chairman and members, again, thank you for this opportunity. It has been enlightening for all of us and I hope that we have been able to respond fully and satisfactorily to all of your questions. Thank you.

Mr. Chairman: Thank you very much. I want to thank all members, all the witnesses, all the members from the Ministry of Health, the panellist and the professional assistants. We have had a very fruitful and productive discussion this morning. I want to thank all the members of the media for being here covering, as usual, the proceedings of this Committee; members of the Committee who have expressed a deep interest in this particular subject; and the members of the public for listening in and for sending us their questions and queries.

At this time, I am just one minute past our scheduled time, 12.46. I would now bring this meeting to a close. This meeting is now adjourned. Thank you very much and have a good afternoon.

12.46 p.m.: Meeting adjourned.
Appendix VII

EXCERPT OF VERBATIM
NOTES OF THE
FIFTHTEENTH MEETING
OF THE JOINT SELECT
COMMITTEE ON SOCIAL
SERVICES AND PUBLIC
ADMINISTRATION
EXCERPT OF VERBATIM NOTES OF THE FIFTEENTH MEETING OF
THE JOINT SELECT COMMITTEE ON SOCIAL SERVICES AND PUBLIC
ADMINISTRATION, HELD IN THE ARNOLD THOMASOS ROOM
(EAST), LEVEL 6, (IN CAMERA) AND THE J. HAMILTON MAURICE
ROOM (MEZZANINE FLOOR) (IN PUBLIC), OFFICE OF THE
PARLIAMENT, TOWER D, THE PORT OF SPAIN INTERNATIONAL
WATERFRONT CENTRE, #1A WRIGHTSON ROAD, PORT OF SPAIN, ON
WEDNESDAY, JUNE 07, 2017 AT 9.45 A.M.

PRESENT
Dr. Dhanayshar Mahabir Chairman
Brig. Gen. Ancil Antoine Member
Miss Ayanna Lewis Member
Miss Khadijah Ameen Member
Mrs. Glenda Jennings-Smith Member
Mr. Julien Ogilvie Secretary
Miss Kimberly Mitchell Assistant Secretary
Miss Vahini Jainarine Legal Officer I

ABSENT
Mr. Esmond Forde Vice-Chairman [Excused]
Mrs. Christine Newallo-Hosein Member [Excused]
Mr. Rohan Sinanan Member

10.33 a.m.: Meeting resumed.

TRINIDAD AND TOBAGO REGISTERED NURSES ASSOCIATION
Mr. Idi Stuart President
Ms. Letitia D. Cox Social Marketing Officer
Mr. Walt Murphy  
Mental Health Officer

**LIFELINE**

Dr. Lucretia Gabriel, PhD  
Chairperson

**TRINIDAD AND TOBAGO NURSING COUNCIL**

Mr. David Murphy  
President

**TRINIDAD AND TOBAGO ASSOCIATION OF PSYCHOLOGISTS**

Dr. Khatija Khan, PhD  
Coordinator, MSc Clinical Psychology Programme/  
Lecturer in Clinical Psychology

**Mr. Chairman:** Good morning. Welcome to this the Fifteenth Meeting of the Joint Select Committee on Social Services and Public Administration.

This morning we have with us representatives of the Trinidad and Tobago Registered Nurses Association, a representative from Lifeline, the Nursing Council of Trinidad and Tobago and the Trinidad and Tobago Association of Psychologists.

This is the Fifteenth Meeting and it is our second public hearing, pursuant to our enquiry into the state of mental health services and facilities in Trinidad and Tobago.

On our prior public hearing we engaged the Ministry of Health, the Chief Medical Officer at the St. Ann’s Hospital, other officials responsible for mental health in the public sector, and today we are looking at mental health from a different perspective, a perspective of stakeholders outside the medical profession who are actively engaged in treating individuals who are experiencing a mental health problem.

At this time I would like to welcome the officials who are here with us, but also all of our viewers, faithful viewers on the Parliament Channel and those who are interacting with us on social media. There is the YouTube channel, ParlView that we also broadcasting. And we invite, in the interest of democracy, individuals
who are not before us but who have a vested interest and who have solutions that they would like to offer to the Committee, to send to us their own solutions during the course of this hearing, their own solutions to some of the problems that the Committee is addressing.

There are really four objectives of this enquiry. The first, to determine the prevalence of mental illness in Trinidad and Tobago. We needed to emphasize that because in the public domain we are very much aware of illnesses other than mental, be it HIV, STDs, cardiovascular, hypertension, diabetes. We are familiar with the incidence and the prevalence of those, but the issue of mental health is something, from the perspective of the Committee, remained underexplored, and it is the objective for us to understand what really is the prevalence of this particular ailment in the Republic of Trinidad and Tobago.

With that understanding, we are then interested in assessing the adequacy of services and facilities available to support mental health and well-being amongst the population. And, three, to determine the adequacy of the existing cadre of medical practitioners who specialize in mental health, and other practitioners as well, who may not be members of the Medical Board of Trinidad and Tobago, but we understand that the issue of mental health is broad, and that there may be other practitioners outside the medical field who are contributing in a significant way towards the mental health treatments in the Trinidad and Tobago.

Finally, since we are the Parliament, we are always interested in assessing the adequacy of the legislative framework, the laws governing mental health. We wish to determine from the perspective of practitioners whether these laws need to be amended, if so how, why and that then forms an important component of the work of the Committee.

We did observe some issues with the Mental Health Act from the perspective of the Ministry of Health officials, medical doctors of the Ministry of Health on the
last occasion. So we would seek to solicit from you what are some of your concerns, if any, with respect to the legislation which governs how you conduct your professional activities.

At this time I will ask the representatives who are with us to introduce themselves, and then I will ask for brief openings remarks, once all the introductions are made. May I start with Ms. Cox, the Social Marketing Officer.

**Ms. Cox:** Good morning, Chair, Dr. Mahabir. My name is Letitia Cox. I am by profession a registered mental nurse. I am the Social Marketing Officer of the Trinidad and Tobago Registered Nurses Association.

**Mr. Chairman:** Could you repeat that. You are a mental health nurse.

**Ms. Cox:** Registered mental nurse.

**Mr. Chairman:** Very well, thank you very much.

**Ms. Cox:** I am also the Social Marketing Officer of the Association and the Chair of the northern branch of the Association. It is indeed a privilege to be here, because I am actually an activist for mental health, and TTRNA has an awesome role. We are both interested in the rights of patients and the rights of nurses.

**Mr. Chairman:** I will ask you subsequently for that brief opening, but I would like all members to introduce themselves with respect to their organizations and their professional background, and then I will ask members to give us a brief opening remark before we start the questioning. Thank you. Anyone else who could introduce themselves. It does not have to be in any order, but introduce yourselves. Yes, colleague on my left.

**Mr. W. Murphy:** My name is Walt Murphy. By profession, I am a mental health officer of 32 years. I am in the mental health profession.

**Mr. Chairman:** A mental health officer. What does a mental health officer do?

**Mr. W. Murphy:** A variety of jobs.

**Mr. Chairman:** Very well, you will tell us what.
Mr. Stuart: Good morning, my name is Idi Stuart, the new President of Trinidad and Tobago Registered Nurses Association, a registered mental nurse also, but left that field about two years ago, spent 10 years in mental health.

Dr. Khan: Good morning, I am Dr. Khatija Khan. I am the President of the Trinidad and Tobago Association of Psychologists. I am a neuropsychologist by profession, and my full-time job is as a lecturer in clinical psychology in the Faculty of Medical Sciences at UWI, where I coordinate the clinical psychology programme as well. I am also a member of the North West Regional Health Authority, Regional Mental Health Committee.

Mr. D. Murphy: Good morning, Chair and members of the Committee. I am David Murphy, the younger brother of Walt Murphy. I represent today the Nursing Council of Trinidad and Tobago as its President. I have also been in mental health for the last 32 years, and subsequent to this I will share the rest. It is my pleasure to be here.

Dr. Gabriel: Good morning, Dr. Mahabir, good morning members of this select committee. My name is Lucretia Gabriel. Yes I have a PhD, but not in psychology or medicine. I am an analytical chemist. I am the Chairperson of Lifeline. It seems that my sins have caught up with me, because I have been associated with Lifeline for 40 years. We befriend the despairing and the suicidal.

Mr. Chairman: Very well, thank you very much. Before I proceed to ask the doctor to make a few opening remarks, I would also ask members of the Committee on Social Services and Public Administration to introduce themselves.

[Introductions made]

Mr. Chairman: And I who have been talking all the time without introducing myself, I am Independent Senator, Dhanayshar Mahabir, Chairman of the Committee. I will now proceed to ask, starting with Mr. W. Murphy, Mental Health Officer, to start with a brief opening remark of what you do and what are the perspectives you are bringing to the investigations that we are undertaking.
Mr. W. Murphy: I am here as part of the TTRNA delegation. I am bringing to bear my vast experience in the area of mental health. A mental health officer, so that it could be better understood, is the equivalent of the DHV, which is the brownie nurse in the general nursing sense. The mental health officer is that equivalent in the mental health field.

Mr. Chairman: Very well.

Mr. W. Murphy: My role involves—well I am generally counselling clients and their relatives on mental health issues. I am doing lectures in schools and other public interest places, inclusive of churches and any other entity that is interested in the aspect of mental health.

Mr. Chairman: Just for clarification, your profession really allows you to deal with the mentally ill patient on a day-to-day basis?

Mr. W. Murphy: Yes.

Mr. Chairman: Very well, thank you. Could I ask Ms. Cox, before I interrupted her.

Ms. Cox: Thank you, Dr. Mahabir. Yes, as I was saying, I am a registered mental nurse, and I was saying that TTRNA has an awesome responsibility, in that, as an association we not only look after the rights of nurses, we also talk about and engage discussions about the quality of care that is dispensed.

I am also intimately involved with the day-to-day care of the mentally challenged, or those persons who have mental health challenges. I am au courant with all the difficulties, the challenges that are in the mental hospital, as well as, in some part, the community.

So I see myself as an activist, and I see this forum as a very wonderful and positive step in the right direction, and I am here to actually put forward solutions in the area of the nurse practitioner.

Mr. Chairman: Very well, thank you very much. One question, since I am not
familiar with the field at all, is it that the training for mental health nurses in Trinidad and Tobago is complete, and you can, if you wish to become a mental health nurse, undertake all training within Trinidad and Tobago?

I am talking about the training for someone with your specialty. Is there training within Trinidad and Tobago to provide full certification for you to be become a mental health nurse?

Ms. Cox: Yes, however, it is limited in that this is a specialty area. It is not considered a specialty area here locally. This is actually an area of a nurse practitioner. It is something usually internationally you would start off as a registered general trained nurse and then specialize in mental health care.

Mr. Chairman: To get it clearly, there is training available in Trinidad and Tobago?

Ms. Cox: Yes, there is training available at two schools.

Mr. Chairman: For a registered nurse who wishes to specialize in your field?

Ms. Cox: Yes, there is.

Mr. Chairman: Very well, thank you very much. May I move on to your colleague.

Mr. Stuart: Once again it is a pleasure to be in here. As President of the TTRNA we have been representing nurses over 87 years of the organization. But recently we attained union status in the last two years, 2014, so we are attempting to pick up that arm of negotiating and settling disputes of our nursing personnel. There are a lot of issues, I hope we have the opportunity to ventilate them here today. I will be focusing more on the policy side of what the Ministry of Health, the Ministry of Education—who is a big stakeholder in this and also what the Parliament, through the review of the laws, could do to treat with some of these shortfalls in nursing and health care on our own.

Dr. Khan: On behalf of the Association of Psychologists, we would like to say thank you very much for this opportunity to contribute to the discussions.

Our Association was incorporated by an Act of Parliament in 2000, so we are
the representative body for psychologists in the country. Our members of psychologists work in all sectors in the public and private sector and in my different fields as well, in health, education, social services. We deal with a variety of populations of mental health, spanning the whole age range. So with our combined membership we do have a lot of, I think, field experience, but also and personally as an academic, as a researcher and clinician, we also have contributions to make with respect to research and policy and advocacy for mental health. So we do look forward to the rest of these discussions today.

Mr. Chairman: Thank you. Mr. Murphy.

Mr. D. Murphy: The Nursing Council of Trinidad and Tobago is the regulatory body for both nursing and midwifery. [Inaudible] We provide licensure and give permission for—

Mr. Chairman: Please activate your mike. Could you repeat for the record what you said prior.

Mr. D. Murphy: The Nursing Council is the regulatory body for the practice of nursing and midwifery in Trinidad and Tobago. We not only register and license persons trained locally, but those who are trained in the region who desire to work in Trinidad and Tobago, and those who are also trained internationally to work here. We regulate the profession by setting standards, and in today’s context, I am here yes as the President of the Nursing Council, but I will also use my other role as the Principal of the Psychiatric Nursing School, so issues of curriculum, discussion and so on I am sure I can make a meaningful contribution.

Mr. Chairman: Thank you very much.

Dr. Gabriel: Thank you. Unlike my colleagues, I am not trained in psychology or medicine.

Mr. Chairman: You are trained in chemistry, yes.

Dr. Gabriel: Yes, and if I treated you, you would die for sure because my specialty
is the analysis of pesticides. Lifeline really operates on the basis that ordinary people can do extraordinary things, and one of them is to listen rather than hear, and by listening and meeting those who feel that nobody would listen to them, nobody would understand, and therefore they will kill themselves, we help to save lives.

Lifeline is basically, I would say crazy, because in 1976, 10 of us got together and decided we would like to start such an organization. We realized that the great system that we had in the Caribbean and in Trinidad and Tobago was in danger—that is, the family or families have generally taken care of those things. But all of us were on it and realized this was breaking down.

We talked to an equally mad person in May 1977, who was Chad Varah who started the Samaritans in England in 1953. We expected him to say you are crazy, you cannot start a telephone helpline when you live in a country that has a moratorium on new phones. He said no, he said start with whatever you have and do whatever you can. We did. We got a new phone. We started listening in June 1978 and we got a new phone in June 1985, and we have been doing that kind of thing ever since.

I would say that in terms of what my other people at the table do, we refer to them as consultants, but it is the equivalent in their terms of if you have a road accident and you are badly injured, we know enough not to move you. We will be the people who will come and visit you in hospital. We will listen to you at all hours of the day and night, but we are not the doctor to do the orthopaedic work. That is what we do.

10.50 a.m.

Mr. Chairman: Thank you very much. And I would like, as usual with leave of the Committee, of course, I always like to open the questioning by a first preliminary question and that is, in our discussions with the Ministry of Health on the last occasion we were informed that the mental health and wellbeing of
children in Trinidad and Tobago is not perhaps what it should be. We know that the adolescent period, the ages between the teenage years can be very, very difficult and traumatic for children. Could you advise me and, by extension, the rest of the country, what are the facilities which are currently available for treating with children who are experiencing traumas of all types, mental difficulties and who are finding it difficult to cope with the challenges of growing up either in the school, in the home or in the communities? What are the facilities that are available to assist our young children who may be the victims of bullying, incest, sexual abuse, a number of issues affecting children? Are the facilities available? If they are not, what would you recommend? And the floor is open to any one of the representatives who are with us today, from your experience, if you can speak from your experience with treating with children?

**Dr. Khan:** So, I also work at the Eric Williams Medical Sciences Complex at Mount Hope, and I would say that services, and we have put it in our written comments to the this Committee, there is a glaring lack of child and adolescence mental health services across the country. Medically, if there is a medical problem with the child, so if we have a child who has sustained an injury or if they are suicidal, then they could be admitted into hospital, but, past that, there is very little that is available.

Also, the cut off for adolescence is 16 years, so after age 16 they are treated as adults, but you cannot put a 17 year old on an adult ward, they have needs that are still pertinent to their developmental age. So with respect to psychological counselling services there is very little that is available.

The programme that I coordinate which is the masters in clinical psychology, unfortunately, does not have a component to train psychologists for child therapy. So, we always advise our trainees that if you go out and when you
get employed you need to receive further training and further supervision for that. That, unfortunately, is not done to the standard that we expect. So I think there are insufficiently trained people who do deliver child therapy.

The services that are currently available at the two child guidance clinics, so that is on Pembroke Street and at Pleasantville in San Fernando is part of the SWRHA, I think, have a long waiting time. So there is, at least, a minimum six months waiting period and that is due to demand, the demand thus far exceeds the resources that they have available. And they also, to the best of our knowledge, deliver more assessment-related services. So again, with respect to therapy, with respect to counselling I would say I am at pains to think about where a child in need can get those services in the public sector.

**Mr. Chairman:** Right. One of our first doctors, one of our first enquiry was with respect to school violence and bullying and it was revealed to us that the Ministry of Education does have the social workers, the school guidance counsellors who are supposed to be visiting the schools. Do you think that if these social workers and school guidance counsellors are given some kind of training from your unit, for example, to simply identify children who are at-risk that that, in fact, may be the first stage of identifying the children who ordinarily will fall through the cracks?

**Dr. Khan:** I think, yes, in part. One, I think they are doing, they are collecting data on children at-risk. So, for example, at the recent PAHO suicide prevention panel it was revealed that there are currently over 400 students on suicide watch across our primary and secondary schools. So, we already have an idea of how critical the problem is, but then as to what is happening to these children, what treatment are they receiving, what intervention, what follow up and monitoring, I think, that is where we fall short. So, I agree with you, yes, definitely we need
to be able to detect, to flag these kids and get them the help they need.

With respect to the training definitely. For a guidance counsellor, you do not require these specialized. You can become a guidance counsellor with a bachelor’s degree in psychology, so it is not a specialized training to deliver services. So certainly, I think, we can augment the training of guidance counsellors and social workers for the already fantastic work that they are doing, but we definitely need to increase that because, as we are seeing, the problem is great. So suicide is a public health crisis in the country and it is extending to our very young and our very vulnerable students as well.

**Mr. Chairman:** Okay. And further question, as a fellow academic, we always work with numbers.

**Dr. Khan:** Yes.

**Mr. Chairman:** If the school age population, the children writing the SEA exams amount to some 18,000 students, what percentage of those students do you think experience some kind of mental issue or mental trauma in their teenage years? So we are taking a cohort, 18,000 writing the SEA exam, they are going to spend five years in secondary, out of the 18,000 how many of them, from your research, do you think will experience a trauma which requires some treatment?

**Dr. Khan:** I do not currently have any study or data that I can refer to, tangible data, but if I were to estimate I think the stressful nature of the SEA exam and the current nature of schooling in Trinidad where people feel if you do not pass for a certain school your academic trajectory is dismal, puts a lot of pressure on children and parents. So, I think, certainly for children if we just go at a modest—we are talking about those, I think everyone experiences stress, but in terms of those who go on to have a level that where it becomes dysfunctional and they are incapable of coping, I do not want to speculate, but I would say it is very
significant and worthy of looking at.

**Mr. Chairman:** Because it was revealed on the last occasion that 20 per cent of the population, the adult population, is statistically expected to suffer some form of mental issue or another, and I was wondering whether the percentage amounts, the child cohort, the teenage cohort was higher or lower. That would be valuable information as to whether, in fact, the children population is in keeping with the overall population or whether there are certain child specific issues that will make children more at-risk maybe 25 per cent of them, 30 per cent to them, that kind of information will certainly inform public policy.

**Dr. Khan:** I think it is definitely not going to be less. So, yes, that 20 to 25 figure is the figure that is bandied about, and I would also say that children who have mental health issues if they are unresolved and untreated go onto become adults with mental health issues. So as to the point you are raising as to the role of the SEA exam in contributing, I think that is also a valid argument and needs to be held.

**Mr. Chairman:** I am not really casting aspersions on the SEA, I am simply taking them because I know the numbers of students writing the SEA are around 18,000, and basically on a longitudinal study I would like to track them from primary school to high school until they finish Form 5 and see over that five-year period how did 18,000 fare. How many of them cope; how many of them dropped out; and how many of them suffered mental ailments, but I am sure that will inform your research agenda in your unit.

**Dr. Khan:** I was just going to say, Chair, that sounds like a great study proposal.

**Mr. Chairman:** Thank you. It is the old academic in me coming out looking at opportunities. Sen. Ayanna Lewis would like to come, through the Chair has many more questions, but Sen. Ayanna Lewis wants to come in. So, Senator, yes.
**Miss Lewis:** Small comment and question to Dr. Khan. You mentioned 400 students are under suicidal watch. I want to find out in terms of age group of the 400, what is the breakdown?

**Dr. Khan:** I do not have that specific data because when I found out from the social workers’ data we also wanted to get. I did however, ask and the age, the lower age limit was as young as seven. So, of course, I expect that it is going to span the whole age group of primary and secondary school, but we are looking at very young children as well.

**Mr. Chairman:** Very well. And Sen. Ameen would like to come in now.

**Miss Ameen:** I have a question, but just as a follow up to this discussion. Are you, Dr. Khan, in a position to recommend to be included in the studies at UWI specific for children for your speciality programme?

**Dr. Khan:** To include training for children?

**Miss Ameen:** Well, training to deal with psychological problems.

**Dr. Khan:** Yes. Yes. There is a gap that we recognize, but I will tell you frankly, this programme is actually we are not accepting an intake come September, and it is largely because of financial reasons. So I think it comes down to that, that is the “brass tax” that right now we cannot afford to run the programme. The programme is in heavy demand. There is no shortage of persons who want to come into the programme and not just for Trinidad, but the Caribbean region as well, but, unfortunately, at this point we have had to put a stop to it.

And yes, we are in a position, while the programme is being stopped what we are going to do is to go back to the books, look at how we can improve it and that has always been identified as a gap. And yes we do, we can access the resources should it come on board again to include that component for child therapy, child assessment, looking at specifically mental illness in children.
Miss Ameen: Mr. Chairman, if I may, my own question well it would go to Dr. Khan because it comes out of the submission made by the Trinidad and Tobago Association of Psychologists and it has to do with whether the association has embarked on any initiative or programme to create awareness among the public about the prevalence of mental health in our society and the importance of mental health assessments, and also if any programme has in terms of reducing the stigma surrounding mental illness?

Dr. Khan: So, we do a number of things. So, first of all, the association is voluntary for psychologists. We are currently working on establishing a registration and licensure. So, as such, we are a voluntary body, all of us who sit on the executive are voluntary members as well, so we try to do the best with the resources and personnel we have. Every year we embark on a series of activities. One of the things on our calendar which is always very popular is during psychology awareness week which coincides with World Mental Health day in October, we do public conferences, and for the past two years they have been hosted at the UWI and we cover a number of topics. So whether it is parenting, whether it is Asperger syndrome, Alzheimer disease, last year I did two topics on depression and anxiety. So we continue every year to have these talks and, as I said, they are very popular. One interesting thing we noted was the years that we have the talks free to the public, they are less well attended than when we charge a nominal cost. So, we have taken that into consideration for our future.

What we also do is we have also had—we also do outreach. So wherever we are invited, we go. So we participated this year—the Trinidad and Tobago Group of Professional Associations had professional services day and every year they go to different parts of the country. So two years ago it was in Debe, last year was in Arima, this year was both in Arima and Sangre Grande. So, we also
give out brochures, we do consultations with members of the public. I also do a lot of invited talks. So, for example, I delivered the technical talk for the Ministry of Health’s public campaign for World Health Day because depression was the theme. So, I have been giving a lot of talks on depression, this year just trying to emphasize to break down some of these stigma, to start the conversation more. It is one of the things that we have been—

Mr. Chairman: Very well. I will put a—the stigma issue has to be addressed and we will come back to it over and over again. But I would like to bring in Brig. Ancil Antoine at this time.

Brig. Gen. Antoine: Just a correction with Dr. Khan. The Professional Services Day took place in Sangre Grande and D’Abadie/O’Meara, my constituency.

Mr. Chairman: Okay. Very well.

Dr. Khan: My apologies, and the correction is noted. Thank you very much.

Mr. Chairman: Very well. Thank you. But I do wish to bring in the nurse practitioners here, and we will move on from children to adults. But I want to find out from the nurse practitioners, the mental health practitioners, what, how do you treat a child who is experiencing a mental ailment which requires institutional care? Do we have facilities in Trinidad for that or is it that you place them in a general hospital and you treat them separately?

Mr. Stuart: Through you, Chair, before I hand over to Mr. Walt Murphy to give more of the specifics, may I just give a little background. Children with mental illness used to be admitted at St. Ann’s Hospital. Following the Children’s Health Authority Act and passage and the whole roll out of that it has resolved one problem and created a different problem. So that no longer the mentally—children with mental disorders are placed in St. Ann’s Hospital because that issue was—there were no wards specific for children. The two children’s wards
actually housed subnormal patients with sub-normalities which really, in a true sense, they were no longer children, they were 18, 19, 20 and they were still housed in the institution, so they were no longer children. So there were really no wards for children. So with the whole passage of the Children’s Health Authority Bill, they were removed from the institution, but now they are no longer in the institutions where you have mental health nurses or—

**Mr. Chairman:** Okay. So the question is: Where are they placed at this time?

**Mr. Stuart:** At normal children homes for children.

**Mr. Chairman:** And is there a recommendation from the nurse practitioners, the professionals who deal with the problems on a day-to-day basis that there should be consideration for having a separate unit somewhere in some hospital dealing with children with mental illnesses? Do you think that there is a sufficient number of children to justify such a public policy position?—a ward in a hospital such as the Mount Hope. We do have Dr. Khan working at the Mount Hope unit, but do you think there is a ward where we could provide the dedicated services so that we could treat more efficiently children who are experiencing these mental ailments and who need hospitalization or hospital care?

**Mr. Stuart:** Yes. Well I would say, yes, in my own opinion, because placing them in the standard children’s home, they would bring added problems to those homes with their shortfalls. So, I would say, yes.

**Mr. Chairman:** Okay. Before I take that submission I would like Dr. Gabriel to ask a question. Do you get calls to Lifeline from children under 16?

**Dr. Gabriel:** Yes. Of course.

**Mr. Chairman:** Oh, you get them. All right. And is it from your knowledge that they are aware of this service or is it that someone refers them to this service? Is it that they grow up knowing that there is Lifeline? How do they come to the
information if they feel very depressed that there is a number to call?

Dr. Gabriel: [Laughter] Nobody grows up knowing there is Lifeline.

Mr. Chairman: Okay.

Dr. Gabriel: There is simply not enough promotion of the service for that, but it happens in that children do call. What we are getting at present is where an adult calls and says, “Will you talk to this child”? And we say, well what you have to do for us, is that you have to first persuade the child that if they want to talk to us, and also if the child talks to us, it is in complete confidence. We will not tell the parent or another adult what that child tells us.

Mr. Chairman: Okay. Just out of curiosity, the young members of our society are all now on social media.

Dr. Gabriel: Yes.

Mr. Chairman: I am not there. You will not find me on any of those things, but they are there. Do you have a promotional campaign on things like Facebook that children will be aware of?

Dr. Gabriel: Yes.

Mr. Chairman: Is there a Facebook page and so on?

Dr. Gabriel: Yes. We have a Facebook page. Our Facebook page has 18,500 likes on it and we put posts that the population is 13 to 17 and that is one of the populations that has the highest number of responses, so it goes direct.

Mr. Chairman: But still you are saying that it is an adult who encourages the child.

Dr. Gabriel: It is quite often it is an adult, and then also you get the child themselves. So we are very aware of the need to reach out directly.

Mr. Chairman: Yes. Okay. Any other contributions on this subject. Yeah.

Mr. W. Murphy: Okay. I myself, you know, I am taking leave from TTRNA.
I actually work at the Child Guidance Clinic on Pembroke Street and much more than assessment takes place, there is also treatment, but I think it would be remiss of me, as a practitioner, I am not to make this statement. Now, usually when we hear the term mental health we think of mental illness. There is that promotional preventative aspect of care that is not given any prominence. I guess it is not as good for business. But our next generation of mentally challenged persons are currently at school and we are simply sitting and waiting until the next incident to intervene and treat. Whereas there is a role for prevention, for setting up a school contact system where persons, young people can be guided on healthy choices; where they can be guided on risk prevention; where they can be guided to avoid certain red flags in order to give themselves the best chance. Here I am putting in a plug because I myself have visited schools and have conducted several lecture discussions, take questions from children. There is a role to go into the school and to do preventative programmes.

Mr. Chairman: Okay. Could you elaborate on that, and is it that these programmes are not being currently being administered by the school guidance officers, the social workers or individuals who interact with the child on a regular basis?

Mr. W. Murphy: Well, in my humble opinion, the course curriculum for these two specialities you have mentioned, does not entail any depth of mental health.

Mr. Chairman: Okay.

Mr. W. Murphy: And so the professionals in the field, as a matter of fact, there needs to be collaboration between both the Ministry of Education and the Ministry of Health so that we can significantly do prevention to reduce these numbers instead of waiting to intervene after the problem has already emerged.

Mr. Chairman: Could you then, for the benefit of the Committee, in writing,
indicate what that intervention can be, that collaboration between health and education? What can that programme entail? Because it will involve collaboration between two Ministries.

**Mr. W. Murphy:** Yes. Yes.

**Mr. Chairman:** And it will involve maybe the intervention of professionals such as professionals trained by Dr. Khan and people who are on the ground working in the school environment. Okay.

**Mr. W. Murphy:** All right. So, in writing, it would come to whom?—the secretary.

**Mr. Chairman:** Yes. In writing to the Secretary of the Committee. I would personally, as Chairman, would like to see what your proposals are that we can suggest to the Ministry of Education and the Ministry of Health, as a collaborative exercise dealing with adolescent problems of mental health.

**Mr. W. Murphy:** Okay. Beautiful. It is almost complete actually, but I did not know such would have been needed today.

**Mr. Chairman:** Right. Yes.

**Mr. W. Murphy:** Sorry.

**Mr. Chairman:** Very well. Sen. Ameen.

**Miss Ameen:** Chair, my question goes up to the Lifeline representative and I want to commend Dr. Gabriel on this initiate because for as long—well all of my life Lifeline has been around and it operates in the background and you have been doing tremendous work. I recall in this Sunday’s *Newsday* there was an article that indicated that since October of 2016, the number of callers who were high risks in terms of suicide increased from less than 10 per cent to 80 per cent, and, in addition, that over the past three months the number of calls to Lifeline has increased. Can you share with us whether, you know, what you feel or if you are
Sixth Report of the Joint Select Committee on Social Services and Public Administration

in such a position, what you feel may have contributed to this dramatic increase; whether it is, you know, the whole socioeconomic atmosphere in our country and what supports we can put in place to treat with this dramatic increase?

**Dr. Gabriel:** The increase, I think, is that people’s—the basic problem that comes across is the person who is suicidal it is their personal relationships, the family, the partner, very few is their work. So that if somebody has a stable relationship and we have an economic downturn which is what we have, the relationship stays. However, looking at it over 40 years, this particular economic downturn has been brutal. It has had an impact on those things when people struggle for their daily food, et cetera, and it seems as if our resilience has eroded over the years.

**Mr. Chairman:** I need clarification and I would like to put a class structure to it. Are you finding individuals who are middle income earners experiencing greater difficulty today than, say, 10 years ago or is it confined to low income earners?

**Dr. Gabriel:** It is not a matter of class, it is a matter of people being accustomed to, for example, a man who is accustomed to paying his bills and he has income that should come in and it does not, therefore, it tips over his relationships because it affects his sense of self. It is having to struggle, women having to struggle to feed their children, so it is across the board. It is not a matter of class. We have been available, more since October than before, and we always tracked the calls. Before that it was 7.3 per cent, it is now about 80 per cent.

We have got a toll free number, it has been available publicly since June the 1st, and the number of calls we get has increased and people have come to see it. They actually know more the line, and you really have to say and this is where you tackle the stigma of mental health and suicide that they will say, if I have this
problem this is the line I call, and they call in. And for each call we take, we assess how suicidal is this person and that is what we are getting. Really and truly, we get about an average of 10 calls per day, it could be less than a minute to six hours. So the number of calls, it is also the length of the calls and, really and truly, if the service was promoted as it should be, we should get 151 calls a day. We have a long way to go.

**Mr. Chairman:** Before I ask, our colleagues would like to come in amass, but I need clarification with respect to the procedure.

**Dr. Gabriel:** Yes.

**Mr. Chairman:** A call comes through and an individual is in need of professional help, is it that the individual who is taking the call at Lifeline has the authority to call a professional and indicate, well I think you should see this person?

**Dr. Gabriel:** No.

**Mr. Chairman:** So it ends with Lifeline.

**Dr. Gabriel:** No. It does not.

**Mr. Chairman:** Okay. What is the procedure?

**Dr. Gabriel:** The procedure is, the person calls you, calls Lifeline and they remain in the control of their lives at all times. So basically we are listeners. We will listen and that is the critical point. When we do not listen to reply, we listen to give emotional support, so we steer into the person’s feeling of anger, fear, et cetera, and when that calms down then the person feels able to talk about other things they want to do, but that is the critical thing. We only refer if the caller says, “I want to be referred to a psychologist to a psychiatrist”, then we refer. We do have consultants we can refer to, but it is the caller who decides that.

**Mr. Chairman:** Very well. One follow up. I know we have to, but there is a
follow up to my follow up and that is, all of us can speak, but few of us can listen.

**Dr. Gabriel:** Yes.

**Mr. Chairman:** What kind of training is offered to the individuals who are on your end of the line so that they can listen with empathy and listen in a manner that will prevent someone from engaging in a most horrific act?

**Dr. Gabriel:** The key to the service is the selection of the listeners. It has to be somebody who listens. The vast majority of people in our society take action. It can be very frustrating to somebody who wants to rush out there and they are going to save somebody, call the police “duh, duh, duh” to sit and listen to the person. So that is the first thing. It takes initially up to three months for somebody to be approved to be a full Lifeline listener. It is a continuing process, but it is rigorously done, this is why we are always preparing people to be listeners. That is a continuous process.

11.20 a.m.

**Mr. Chairman:** And so the order of questioning I would ask Brig. Antoine, MP Jennings-Smith; and then Sen. Ayanna Lewis, you would go last.

**Brig. Gen. Antoine:** And this is a follow-up. In your responses to the question in terms of the availability of mental health and resources, what is the relationship between your organization and the Ministry of Health and the Ministry of Social Development and Family Services? Are any of the resources available at these Ministries, state resources, made available to you, as your organization deals with the people who call in to your service?

**Dr. Gabriel:** When it comes to the Ministry of Health, it is that we would tap the general services that the Ministry of Health provides, and we are slowly building a relationship with them. For example, the South West Regional Health Authority, that we would have a formal relationship with them. When it comes
to the Ministry of Social Development and Family Services, they have given Lifeline a subvention since 1990. At present we are waiting for it to be renewed. We are very thankful to them for their continued support over the years, and that is a closer relationship. Does that answer your question?

**Brig. Gen. Antoine:** Could you elaborate what is the value of the subvention? How does it impact your organization?

**Dr. Gabriel:** [Laughs] My being an analytical chemist means I am very much into figures. So, we did an analysis, we looked at how much it cost in terms of volunteers’ time, the works to provide the service. We have asked for 16 cents in every dollar it costs to provide that service. We are grateful for the fact that in 2011 to 2013 we were given six cents in a dollar. It has not come to anything like that since then. We are grateful for it, because the Government, whichever government, has given us six cents. The private sector has not given one. So, we are grateful for whatever we are given. But that is a matter, and this is something I would like to say, that this is why I am grateful too for the opportunity to present to you, that I hope that you will lead on the breaking of the stigma on mental health and suicide. If that is broken, then not only will Ministries give more money to emotional support, but so will the private sector in terms of not only in cash, but in kind. There is a need for leadership from whoever is in Government to break that stigma.

**Brig. Gen. Antoine:** I do not want to put you on the line, but you talked about the 2011 to 2013, when was the last time that your organization received a subvention from the State, the last year?

**Dr. Gabriel:** We received part subvention in 2015, that was for April 2015 to September 2015. In 2016, we got $50,000, a one-time grant; in 2017, so far we have received $20,000.
Mr. Chairman: Thank you very much, and I will ask MP Jennings-Smith to pose her question.

Mrs. Jennings-Smith: I want to go back, through you, Chair, and I will keep my questioning with Dr. Gabriel. I compliment you for the hard work you are doing, because Lifeline, I believe, is a place where you listen, something that most of us cannot do. But, I want to draw us back to the point where you referred to 10 per cent—suicide increased from 10 per cent to 80 per cent, and I want to ask you if you and your organization did any data collection in terms of numbers over the years where you can really compare numbers? Because when we speak percentage it really does not give us a correct picture of what is exactly happening. Can you tell us, or provide us—the Committee after, not really today—with the numbers that you speak of? Because I am concerned about the numbers, because I know a lot of people will call Lifeline to have someone listen to them. They have problems. And from the question posed to you it would suggest that we want to go along the line of socio-economic and things like that, and did you do a study to really capture that result, or is it just mere speculation?

Dr. Gabriel: I am sorry. Again, you come back to my profession. I do not speculate on figures. It is that we look at the figures we have. We collate the figures, the numbers we get, and then at every call, when somebody calls us, we ask how suicidal are you, and therefore 10 per cent—7.3 per cent of our calls are from people who are normally highly suicidal. A percentage is a good figure because it says per 100. No matter the number, how many have that, and this is about the same thing for the Samaritans in the UK who get seven million calls a year, they have 122 centres.

So, I would only use figures that I am reasonably certain have some accuracy and some weight to them. But the major thing of knowing whether
somebody is suicidal is to simply ask them. When it comes to the figures for Trinidad and Tobago, the CSO used to be the most reliable source for our suicide figures. As far as I know, the last reliable figures they produced was for 2009. We are at present using an estimate, I think, that PAHO did, which is 14.4 per 100,000, which makes us the third highest in the Caribbean. We used to be the highest. It makes us that. What they do too is if you want to go look at figures, they say that every 20 to 50 people, if you look at your people who appear in the statistics, 20 to 50 people are at high risk of attempting suicide. If you take the lower level, which is 20, it means that 2,800 people in Trinidad are at high risk of suicide. If you then make that 7.3 per cent of the calls you would expect us to have, and that goes from the silent call, the person hears your voice and they put the phone down immediately, to talking for up to six hours, you are then looking at a 151 calls per day, before anybody can say that Lifeline is doing—is covering all the people who are highly suicidal in this country. Never.

**Mrs. Jennings-Smith:** I want to ask you, based upon what you concluded, the reason for suicides going up?

**Dr. Gabriel:** The reason for suicides going up is people’s—they tell you it is the problems within their personal relationships. You have both men and women who, their personal relationships with their partner, boyfriend/girlfriend—our family systems are under tremendous pressure, and so when there is a fallout, if you look at it, the tighter the family structure, the more dependent they are on each other, and when that starts to rock, the person can feel totally alienated, and in that sense of alienation get to the state where they will become suicidal.

There is significant family trauma within families which is kept very quiet, and it is when somebody talks to us it will come out. It will come out that somebody may have been—a girl may have been raped as a child by a family
member, it was covered down, and then everybody says, well, you know, you should get over that. But it has not been treated. There has been no psychologist to go to, no psychiatrist to deal with, but that girl becomes disturbed at 18, 19, and says nobody listens to me. Nobody will hear me. I said this happened to me and nobody reacted.

Mr. Chairman: It brings to point what our colleague from the nursing profession has indicated, that we do need to catch the children, because children with problems will grow up to be adults with greater problems.

Dr. Gabriel: That is right.

Mr. Chairman: So, that is one of the proposals coming out. Now, Sen. Ayanna Lewis has been silent for quite a while and she must be given the floor at this time.

Miss Lewis: Thank you, Chairman. To you Dr. Gabriel and to the nursing association, based on the feedback that you were given earlier and the main cause of the callers calling in to Lifeline is really the breakdown of relationships, do you know how many lives you would have saved? Do you have that figure, like a follow-up on the persons who would have called?

Dr. Gabriel: I think the way we would measure that is call by call. The fact that somebody calls us, and by the end of the call they feel they could live one day longer, that is how we do it. Because, it is an anonymous caller. We do not keep phone numbers, we do not ask for names, so that is how you do it.

Ms. Lewis: So, would you consider though, at least offering that information at the end of the call, like who you can contact just in case, instead of asking them if they want a follow-up?

Dr. Gabriel: What do you mean by follow-up?

Ms. Lewis: Okay, so I know you mentioned that when persons call, you ask them
if it is they want a follow-up, or they need some kind of a—

**Dr. Gabriel:** No, no, no. We do not ask them if they want a follow-up. If during the call they determine that they need to be referred to a psychiatrist or psychologist, then we suggest it. But that has to be very, very carefully managed, because people react so negatively to the thing that there could be anything mentally wrong with them. You cannot just say that, so that is a different case. The person may feel much better and say what we would do, is to say will you give permission for us to call you back, and then we would do that when we feel they are really down, because we realize that the suicide feeling goes up and down. The fact that at the end of our conversation the person feels okay, does not mean they feel okay forever, so we would call back. We do long-term befriending of a caller.

**Miss Lewis:** Thank you for your feedback, and this is for the Trinidad and Tobago nursing association. In light of the police officers and the situation whereby someone was shot recently for dealing with a mental care patient, I know a lot of police officers are not trained in dealing with mental health patients, is there some kind of collaboration that could happen in the future in which the police service then, dealing with mental health patients and being able to at least deal with them in the medical way that you would recommend?

**Mr. Chairman:** Before you answer that, Ret. Brigadier has a follow-up to that question.

**Brig. Gen. Antoine:** The Minister of National Security and the Commissioner of Police say that police are now being trained at the St. James Barracks to deal with mentally ill patients, my question, a follow-up is, is there an input from any of your organizations into this training as being provided for police officers to deal with mentally ill patients? For instance, last night I read on the news that a
mentally ill patient who was throwing stones was shot by the police, so is there any input you all have into the training of the police officers?

**Mr. W. Murphy:** Well, I am not into the education aspect of things, but as a mental health officer that is one of my roles in apprehending clients. Now, the Mental Health Act is very clear on the functioning and who does what. The mental health officer, if there is need, can call upon the police officer to assist. The Mental Health Act is clear, the police role in a situation like that is one of assisting. In terms of what is done in the training component at the police barracks, I do not know, and I do not know who is doing it. But I recall when I worked on the clinical area, namely the forensic ward at St. Ann’s Hospital, where I spent nine years, at intervals policemen, prison officers were brought unto the forensic ward for part of their practical experience, and also had the privilege of sharing with them our own expertise and what is contained in the Mental Health Act. I do not know if that practicum is still afforded. But there is no better component than the practical components.

**Mr. Chairman:** One follow-up, and that is, are you in the nursing profession or in the psychology profession aware of any of your colleagues who have been invited to the Police Training Academy in St. James to offer modules of training on dealing with mentally ill individuals in Trinidad and Tobago? Are you aware of any instance like that?

**Mr. W. Murphy:** I am not, but if it exists, kudos. If it does not, then as a matter of emergency it needs to be.

**Mr. Chairman:** So, basically, again colleague, to reiterate you are saying that there is a need for collaboration between the Ministry of Education and the Ministry of Health, and now the Ministry of National Security and the Ministry of Health. Very well, thank you. Yes, and we have response from—[Inaudible]
Ms. Cox: Yes, I am seeing here that the word “collaboration”, stakeholders need to be aware of these modules. As far as I know, as the Social Marketing Officer, the association is not aware of any training that involves the police officers, and we would be quite interested to be involved in that so we can also have our input to know that the best curriculum is being afforded to the police officers, because we had some unfortunate situations recently in the media with regard to the loss of life of mentally ill persons. I would like to also say and endorse, with regard to the children, it was burning in my heart that we are underutilized as practitioners. That is the registered mental nurse.

In our role as teacher and educator, we are well able to counsel and share information that would help the child and the adolescent. As an association, we have been invited to career fairs at various schools, and I have been a part of it, and I have encountered the teenager who would ask about cutting. I have encountered the teenagers that would be asking about, or may try to evade about substance abuse, such as marijuana and alcohol. I have had students who broke down in tears after I shared about mental illness, and the signs, and come to me after saying I am experiencing this. And, it was really touching, and I knew that this was a ripe opportunity for the registered mental nurse to go out in the community—and this is part of the role of the nurse practitioner, the promotion of mental health, and we are not given that opportunity in lieu of what is going on.

And, there was a group that came out of such career fairs, called itself ATNA, a drama group. We used drama therapy to reach the young ones, and that group was stopped by the specific regional health authority. We went out there, we shared drama, we talked about mental illness, depression, suicide. All those topics were dealt with, but the group was stopped from going out. So I say, there
are things there, there are persons who are willing within the field of mental health to go out and reach the school-age child, be it teenager or the young child at the primary school. And we need the support, as I said from the other team, the Ministry of Education, the Ministry of Health, to give the approval for us to do these things. So, that is my input.

Mr. Chairman: Before the psychologist comes in, you are saying that you need the approval, is it that there were overtures to the Ministry of Education to visit schools to discuss with students the issues of mental health and the treatment which may be available, and that you are finding it difficult to get the approval to visit schools? Or is it that you think there will be a difficulty getting the approval?

Ms. Cox: Now, the group that I talked about were under the specific RHA, regional health authority, and, of course, they are under the CEO and the board’s regime, so they need the approval to go out under the name of the North West Regional Health Authority. Now, if it was a private group established as an association itself then they can do it on their own. But because it was under, and the board made a decision based on some anomaly that the group will no longer go out. The group actually won a competition held by the Ministry of Health with actually sharing drama on anxiety disorders and so forth. You know, it was really sad to see the end of that group, because it was doing a really great job.

Mr. Chairman: We appreciate the information, and now we realize, as usual, in all our Committee hearings, what we know is that various agencies in Trinidad and Tobago operate independent and they are compartmentalized, and what is coming out from the discussions this morning is that there is a greater need for the practitioners on the ground to integrate with various arms of the State, and there is a need for some kind of effort to smooth the relationships so that we can streamline what you can do for the rest of the society. I will ask Dr. Khan to come
in and then Sen. Lewis to pose further questions.

**Dr. Khan:** So, in responding to your question about Trinidad and Tobago Police Service, one of our past executive members was the clinical psychologist for the police service, but then she left and there is currently a vacancy. I am not sure if it has been filled, because we shared the vacancy with our members. As to the role of the psychologist, I am not fully clear as to whether their role is to treat members of the police force, or how much they are involved in the training as well, because I think those are two separate strands. I read the same article that member Brig. General read, and my thoughts were that, it is good to hear that they are getting training in the academy, but I wondered about the continuing and ongoing training, because I think there is also a need for ongoing psycho-education, both for in terms of dealing with mental health populations, but also for officers themselves, and dealing with the stress and how it is exacerbated when you deal with a mentally ill person. I did some work with the Jamaica constabulary force some years ago, and they have a dedicated psycho-education unit for their officers, and they do regular periodic training. We also worked on a technical manual for a helpline for officers—

**Mr. Chairman:** Officers who are having problems, or officers who are dealing with people who are having problems?

**Dr. Khan:** All and every. *[Laughter]* I think they are interrelated. If you have an officer who is having a problem and is not dealing well, then that is going to exacerbate and compromise the ability to handle somebody who is a little more challenging. So, I think definitely both strands are essential. They are also at risk given the nature of their work, and the rest of the protective services are at risk for mental health issues. There is also an increased stigma for mental health issues within the protective services.
So, when I did read the article I said I wanted the association to reach out to the TTPS to find out more about the nature of their training and how we can play a role, because to my knowledge we do not currently have an input into that training model that they spoke of. I also wanted to comment briefly, and asking about the two members who asked about the figures with respect to suicide. So, at the university and at Mount Hope we have been doing some research, so Prof. Hutchinson and myself, and our trainee students—so we currently are looking at two things. One, completed suicides, and looking at the demographics and collecting the data for a five-year period. Since we have—well, it is not an official psychiatric ward, but since it has been there at Mount Hope in August/September 2015, we have been looking at the data of the patients there, and we are looking at, in the past over a one-year period, we had approximately 121 admissions for attempted suicide. And of those, about the 80 to 90 per cent were impulsive suicides, meaning that there was not a plan. This was the stressor, became overbearing, and impulsively they made the attempt, and this is across a variety of methods as well.

What we are also noticing is the age group. So, the vast majority of those are 18 to 26 years. So, we are looking at a very young population. So, we want to compare as well, the persons who completed as well as those who attempted, to see if we could identify what are some of the predictors to help us understand, one, how to target intervention, and identify the at-risk populations. As to the reasons as well for why, I think a lot of things are pointing at poor coping, that when the stressor becomes too overbearing, people do not have—so, it is lack of resilience, and I think with the economic stressors, with personal stressors, et cetera, what we have is a lack of coping skills, and it is something that redounds to early childhood and development in childhood.
And, to my final point, where you asked about the training in the schools, I think there is definitely a need for health and family life education in the curriculum. So, just as much as social studies: math, English, et cetera, we need to have an aspect, starting from primary school where we involve mental health and well-being that is not optional and does not vary across schools. But we have a minimum standard that is implemented across the entire education system.

I did a research study with a student a couple years ago, looking at—and I am very happy to share these findings in more detail with the Committee—we asked teachers in public and private secondary schools, if they would be willing to implement, to teach about mental health in classrooms, and what would be the factors, whether it would be personal factors or school-related institutional factors. And a couple of the things we found was that every single teacher had encountered a child, at least one in their classroom who had behavioural or mental health problems, and also the teachers were quite happy to deliver those programmes as well. What it depended on was the principal support and the school support. So, if principals and schools and the Ministry of Education provide that mandate and the support, teachers were willing to add this to their duties as well.

**Mr. Chairman:** We need to follow up from the Chair, before we go onto the floor; the follow-up is, on the last day when the Ministry of Health addressed us, they indicated that they were in the process of implementing a suicide surveillance system which entailed, inter alia, monitoring and tracking the effectiveness of interventions—are you aware of this system? Are you a part of it? Do you know at what stage they are?

**Dr. Khan:** Yes, I am aware of it and I am a part of it. I sit on that committee as well. At the last meeting we were in the process of drafting that
national suicide plan in term of agreeing on terms, and standards, and the remit, and about the surveillance and monitoring as well.

**Mr. Chairman:** Could I ask MP Jennings-Smith to come in and they you come in there, Sen. Lewis, again.

**Mrs. Jennings-Smith:** I want to ask a question—

**Mr. Chairman:** Is it a follow-up from this?

**Mrs. Jennings-Smith:** Yes, it is a follow-up, but it goes further. Basically, what you have been saying to me, it seems as though mental health is a word that people do not like to associate with, because we look at stressors—you spoke of stressors, you also spoke about identifying predictors, and another point I want to draw along with that is to the nurses association, where there seemed to be a problem in attracting persons to go into the field of mental health nursing. So, the entire regime there, of mental health seems to be a not-attractive place for people to identify with. Nurses, we have a shortage, because people do not want to go into mental health nursing, because it is stated here, and now the schools, when we talk about going to schools and doing a topic on mental health, people will say “I am not mad, why you telling me that”. But, we must admit that we have things like stressors and inability to cope with it, which would lead to the said behavior. I am certain that you all would have recognized that before me saying this today, what are your recommendations to deal with these particular—these issues, one? How you approach schools to make it attractive for them to be responsive? And two, how do we encourage people to get into that area of mental health nursing?

**Ms. Cox:** I would like to address the, how do we approach schools? There is a term used in mental health, self-disclosure; that is quite popular when I go and speak to the children. They tend to listen to you when it is relative. So, at times when I speak to them I start off with some of the challenges I encountered
as a child and as a teenager.

11.50 a.m.

And I start off from there and I said, mental illness, people tend to think it is somebody running around with a big stick with some loincloth. But it is not that, you know. Do you know I have persons as young as nine years old, nine years, with mental health challenges and I think that wakes them up. Fourteen years, and then I would ask a question: Why do you think they are there? And they answered it themselves. Miss, alcohol; Miss, drugs; “Miss, somebody geh horn” and down-to-earth just like that. So you start off by being down-to-earth with the children and we approach the school. Once we have the permission, once we have the co-operation with the school administration and with the Minister of Health then we can really go in there and help the young people. It is all about reaching them where they are and being real and, as registered mental nurses, we learn this in our curriculum. We are taught how to deal with, how to counsel, how to reach persons of every strata, no matter rich, poor—[Interruption]

Mr. Chairman: Could I intervene, because I think one of the questions imposed by our member was how do you make the field attractive to individuals—

Ms. Cox: I was giving it over to the President. I was dealing with the schools.

Mr. Chairman: Yes, and after that, Sen. Lewis, you definitely will be coming again.

Mr. Murphy: One of the first things we must admit is that we have a society that perhaps strives on taboos. The church sometimes does not help and when I say the church I say the church in plurality. If the Minister, for example, believes that somebody who behaves different to what is considered to be normal, is a person who is demon possessed and not mentally ill, they may treat the person as somebody who is demonic. One of the things we must appreciate in this country is that Ministers of religion are very powerful people and I have long argued that we have got to get into
the churches, the temples, mandir and speak to the religious leaders, could be powerful figures. If we can convince our religious leaders that a lot of what perhaps even presents at the very congregation and in the congregation as not being persons who are demon possessed necessarily, but persons who are genuinely mentally ill, then we will get the co-operation because the church is an audience in itself. That is one.

We have a society that believes that anything mental is mad and then one of the first things we need to do as well is to see whether we can change our vocabulary from being mad, being crazy, to being mentally ill. And because of that we got to start to provide incentives to people to enter our School of Nursing, but let me even leave the School of Nursing and go into medicine, for example. The pool of physiatrists in this country and I suppose outside of this country, the pool is generally very shallow, meaning, that there are not many psychiatrists around.

One, it is not a profession that is so lucrative in medicine. In fact, it is perhaps the least lucrative of the specializations of the medicine. Why? Because the people who need the care most are those who can least afford it. The very said thing in nursing. So I remember one year the Ministry embarked on an experiment, because you would also appreciate that the men are the minority in nursing and for a group of—an intake of psychiatric nurses the Ministry limit it to only males. And a number of males applied. What we discover happening is that once you send out an advertisement to recruit nurses most of your applicants are going to be those who apply to do general nursing. And my argument has been for years now, advertise only for psychi nursing and you would be shock to see how many more persons applied because that is the only field that you are offering training for a particular cohort.

My other argument is—and I concur with Ms. Cox—and that is the services, the resources are grossly underutilized. A psychiatric nurse is trained either at the
diploma level, the associate degree level or at the bachelors’ level. These are persons with vast experience, with vast knowledge, but they are usually confined to in-house and in-care facilities and that is confined to health centres or confined to hospitals. In other words, the person must become mentally ill before there is an intervention.

So it is more at the secondary level than it is at the primary or the preventative level. And it is a resource that is grossly underutilized. We have begun, even at the level of the nursing council, whenever schools have their career days, they would ask for input from the nursing council in terms of sending nurses who can speak to the young people in terms of career pathways and we have been very mindful not only would we send nurses to encourage persons to get into general nursing, but also into psychiatric nursing and indeed we are making a significant dent.

**Mr. Chairman:** Sen. Lewis, it is your turn.

**Miss Lewis:** I think Mr. Stuart—

**Mr. Stuart:** Yes. From the Association point of view also, psychiatric nursing, like nursing on the whole, has been challenged to attract the correct persons into nursing. Nurses are a kind of unique profession where you really need to have that sense of care to really get into nursing otherwise you will end up with a number of problems which would have been evident over the years due to poor nursing care, because the correct persons did not really get into nursing. And when you have persons coming out of school with—well, to get into nursing, first to begin, you need five O levels, but the majority of nurses have more than five O levels, A levels. So what would make those persons come towards nursing rather than to some other profession? What would make an individual coming out of school having to go through four years of training to get a bachelors in nursing education and then want to go and do psychiatric nursing, having to deal with an environment—work in an environment that is over 100 years old; St. Ann’s Hospital is 100 years old.

If you get injured on the job, which is a frequent possibility in psychiatric
nursing, you do not have the resources to subdue persons. Well, you do not have some of the tools that the police officers would have and it was a comment made at a public forum about five years ago where the police officers or the prison officers bring the patient to St. Ann’s Hospital in handcuffs, baton and guns and stuff on them and then they hand them over to the nurse and the nurse has nothing and they have to deal with some of these most violent persons that society shuns and stays away from. And you do not have risk insurance as a psychiatric nurse. You do not have, the mental health officers who have to go from district to district, they do not have mileage, kilometric allowance which may have been afforded to the doctors, but it is MH who actually visits these patients. The motor vehicle tax exemption was taken away from psychiatric nursing.

So there are a number of issues, continued education. If you are going into psychiatric nursing, it is a dead end job. There is no upward mobility, there is course in specializing once you become a psychiatric nurse. So most persons do not choose that avenue, they will go to the general aspect, because in general you could do ICU, theatre and all these other trauma nursing, but in psychi, it is a dead end job. There is the forensic unit, no nurse on the forensic unit is trained in forensic psychiatry. None. There was one nurse who was trained, went abroad and came back and trained and they did not even place that person and the person just got fed up and left and went away.

Mr. Chairman: Thank you.

Miss Lewis: All right, so—thank you for your contribution. I have about two or three questions.

Mr. Chairman: The floor is yours.

Miss Lewis: Thank you. First of all, I do not think anyone answered this question even based on your submissions, but how many persons register as nurses and then as mental, well, training for mental health care and how many persons gradate in the
nursing programme?

**Mr. Stuart:** I do not know if you recently see our last submission because we made modifications and presented it today for it to be photocopied. So I do not know if you got that update where we have some statistics from the—[Interruption]

**Mr. Chairman:** We did not receive that submission, it was sent—

**Miss Lewis:** No, we did not.

**Mr. Chairman:** It was sent just prior to the hearing. It is in our package but we had no updated to review.

**Miss Lewis:** Can you respond based on the submission that you would have had?

**Ms. Cox:** Yes, it was a little bit difficult but there are only two schools that provide training for the psychiatric nurses. From COSTAATT and under the Director of Nursing, DM, Mr. Rupert Jones, they send statistics for us between the years 2014 to 2016. They offer both the baccalaureate and the associate degree. Their intake for September 2014, was 11; for the baccalaureate and the associate degree was 10. For November 2014, they had 24 graduated, that is under the baccalaureate. Under the associate, they had five graduated. In all for 2014, 29 psychiatric nurses graduated for 2014.

For January 2015, the only intake was eight, for the baccalaureate and for the associate, seven. In 2015, 11 intake for the baccalaureate and zero graduated for that same year. The total graduated number was 11. For September 2015, only eight total was intake. For 2015 November, graduated, the total was 20 psychiatric nurses.

For January 2016, the total intake for that year was 15 and for September 2016, 34 psychiatric nurses were taken in. For November 2016, a total of 17 graduated. That is the statistics for COSTAATT. Now, what we were told from MTEST, the Director of Nursing Education, Ms. Joycelyn Clarke from her office that they deal with cohorts. Previously, COSTAATT took in cohorts but they stopped and it is whoever applied would have been granted to be a part of the
programme. The cohort for the Ministry of Health apprenticeship programme were 60 students. However, we were told by the office that they could not meet that figure in terms of persons who applied. So it was under 60. They did not give the actual figure, but it was under—

**Mr. Chairman:** Sen. Lewis has a follow up.

**Ms. Cox:** Yes.

**Miss Lewis:** I just have a question. Have you done a gap analysis based on how many nurses that have graduated and the need of the population?

**Ms. Cox:** Well, what the problem is, we did not receive statistics from the mental hospital, the main unit as to what their needs are, because you need to have that in order to know if there is a shortage. However, unofficially, because we were waiting for official information in order to present it here, we can only present official information, we were told that the shortage of RNs are 25 per cent and the shortage of enrolled nursing assistant is 55 per cent, but we wanted to have that officially so we can present it, but it will come after.

**Miss Lewis:** All right, so, thank you very much.

**Ms. Cox:** You are welcome.

**Mr. Murphy:** If I can just come in here because apart from the data that says how many persons would have been enrolled and how many would have graduated, there is a differential between your enrollment, those who graduate and those who eventually receive a licence to practise. For example, 100 nurses could probably graduate from any given school but yet there is a license examination administered by the nursing council of Trinidad and Tobago of which not all persons are going to pass with their first, second or even third attempt. So that the data that you probably would really need would be how many persons who were actually licensed to practise for the given years. And that I am here to say is just about 75 per cent of the total intake that Ms. Cox spoke about for the given years. So the numbers are
smaller.

Miss Lewis: Thank you very much. Everything that was said today was quite enlightening and I do want to commend you guys for all the work that you have done. Also a lot of the work that you have done so far has been tremendously volunteerism and you could never quantify volunteer work. Based on the feedback of treatment for persons with mental health care needed, most persons are put into a hospital, but what would be your recommendation, what kind of environment should be created to deal with persons with mental health issues?—and that is for any one can answer.

Mr. Murphy: Well, that is a broad question because mental health issues is so board, is so general. If we are talking about those who are mentally ill, who would have received a diagnosis of mental illness, then clearly we would have to first go the route of an in-house, in-hospital treatment, diagnosis treatment with a proper discharge plan to get the person back into the community and back into their homes. If we are talking about mental health, even mental illness issues which are much larger than admissions, then clearly there is need for the very things we spoke about— education in the schools, education in the community. I know there was some movements some time ago that spoke to the issue of decentralizing inpatient care. In other words, right now St. Ann’s Hospital has an inpatient population of about 1,000 on a daily basis and there is a movement to get these patients out in the community. My question had always been, if you get them out of the institution into the community, do you have the necessary support? And a major component of that would be, you have got to go on a massive community public education programme because the whole issue of stigmatization and so on, people you are now taking folks from an inpatient facility to put them in the community and you are likely to get some resistance out there as well.

Miss Lewis: Dr. Khan you spoke about persons: One of the issues with a person
with mental health issues, is lack of coping skills and especially if the person is between the ages of 18 to 26 years old. Now that we have a serious social media community that is growing, the coping skills will be at a disadvantage going forward. Do you all have any kind of measures put in place to deal with such issues?

**Dr. Khan:** I will try to keep my comments as brief as possible because this response can go for hours, but just to reference your previous question and then I will answer specifically about that. With respect to what treatment is needed for people with mental illness, because I think we have to also think about it as a continuum. So there are those who are institutionalized and will require institutionalization, probably, for most of their lives. For example, the patients, Mr. Murphy spoke about at St. Ann’s. But in addition to finding places to house them and communities that will be accepting, I think we have to go further in terms of not write people off and think that they just need to be safe and be medicated. There are different levels of rehabilitation as possible. We can have social skills rehabilitation for the severely mentally ill where they can function, where they can perform simple tasks where they can communicate with each other, they can perform activities so that we can have some measure of quality of life even with severe mental illness. Wards 12 and 13 at St. Ann’s come to mind. I think the nurses are doing a fantastic job with what they have, but what we basically have are people who are just fed, kept safe with limited quality of life.

As we go down the continuum, for people who are high functioning, the vast majority of people with mental illness are not institutionalized. They are living, they are sitting, they are working, they are our neighbours, they are friends, they are relatives. So in terms of those services, they have to be able to access services within the community. A small percentage of people can afford to go privately but we need to have adequate public services for people and there is such a limit. So in the breakdown of the figures we submitted to the committee you will see that there are
no psychologists currently employed at Mount Hope. I work there but I am not employed by the RHA. I have clinical privileges, I supervise our students, I do some interventions, but there is no psychology clinic outside of what the programme offers.

What does that mean? People have very limited places to go. They go to Barataria Wellness Centre; there is one psychologist. So in terms of what they can offer, we use that as a practicum site. So there are two of our trainees there as well, but in terms of what they can offer it is very limited, you are cut off at the neck. In terms of whether it is assessment or when we think about therapy. Therapy is not a one shot. So what we are looking at is—you asked about attracting people to mental health for psychologists, we have no shortage of that. We have graduated and a number of clinical psychologists many of them cannot find jobs in the public sector. It is very simple. They cannot find jobs because there are no posts. So one of the strongest things I want to advocate for here is that we have a desperate need for psychology posts in the public sector. The Carenage Wellness Centre was recently opened; they have not yet appointed a psychologist there. So all of the psychologists in the public sector are overworked and what this does is it compromises the quality of service we could deliver.

**Mr. Chairman:** One clarification, doctor, and that is, do you have a professional body call professional body of psychologists where in order to practise you need to have certain certification and certain hours of practicum.

**Dr. Khan:** It is a very critically important point you are raising because we are working on that now. So the Trinidad and Tobago Association, while we are the representative body, there is currently no registration and licensing. And part of the reason for that has been in deciding what route we should go under, whether we should have our independent council or whether we should go with the professionals, like to the health sector and medicine.
Sixth Report of the Joint Select Committee on Social Services and Public Administration

So we are currently devising our scope of practice and what that document does is entail who is entitled to call themselves a psychologist, what qualifications and experience they need to do that and what remit they can operate in. And also as well, we currently have ethics guidelines but we are also devising our code of ethics. This will help with this process because then what we will need after, agreements and understandings with the hiring bodies and agencies with the Ministries that hire psychologists to work with us.

Currently, some of the Ministries do. So we do get requests from our members to get letters verifying that they are members of the Association because their employers have demanded this. So this has been a really positive sign for us because we do need to have the profession regulated.

With respect to the other services, just wrapping up, with what we need, currently mental health has been predominantly viewed under medical model. So the causes are biological genetic and therefore medical doctors need to deliver treatment. That has been changing and I think many people recognize the role of nurses, social workers, occupational therapists, speech pathologists and psychologists in playing a role, but there is inadequate multidisciplinary integration of treatment.

So we do not have a case where physiatrists and psychologists and social workers and occupational therapists are sitting down around a table and discussing treatment. We do not have established protocols of care. So, for example, schizophrenia, this is what we think is the best practice in terms of pharmacotherapy, in terms of psychological therapy, et cetera. So what we need is more integrated care across the disciplines. Very few organizations in Trinidad have multidisciplinary team. For example, the forensic Unit at St. Ann’s does—

Mr. Chairman: Clarification again.

Dr. Khan: Sure.
Mr. Chairman: Doctor, can you administer a drug such as Prozac. Do you have that?

Dr. Khan: No, psychologists are not in the business of administering drugs, we administer therapy, we administer assessment and other such interventions.

Mr. Chairman: Do you think you should as a clinical psychologist?

Dr. Khan: No, there is no need. We have perfectly competent psychiatrists who handle that aspect of it. But as we put in our paper, all of the evidence suggest that medical treatment can be augmented with psychological interventions and, in fact, for sub-clinical, for those population who are at risk, you need not intervene with pharmacotherapy. You can be treated with psychotherapy and it can be quite effective.

Miss Lewis: All right, there is one question, social media. I just want to find out how you can deal with persons coping skills, coping issues, with persons who are more inclined to use social media to communicate.

Dr. Khan: Social media is just part of a ton of research now, both in terms of how it can be used to promote mental health but also how it is a factor in peoples’ decreased coping skills. So I think looking at the positive, social media is certainly an incredible tool that can be used. In fact, our facebook page is one of our most popular tools. We share articles, we advertise events that are going on, we share what is going on with other agencies, so certainly in the consumption and because more and more younger people use it, at three and four they are very tech-savvy, so I think it is really important, where we need to go with it is to incorporate that into our campaigns.

So we have been trying to do that but we are limited by the resources of the organization, but certainly if there is some integrated campaign because—one of the things we have is we have so many little groups that are coming up. People are interested, they want to help, but that diffuses the resource and we do not have a
critical mass. So if we had an agency that would take the lead—and I think the state has to play that role and committees like yours have to play—that takes the lead in devising a campaign that other stakeholders now can just add on to and it becomes a synergistic effect.

So, for example, World Health Day, depression is the theme. So if we have this national theme of depression so therefore we have all of this energy from all of the different stakeholders talking about depression, it is on social media, we have advocates. I know the Ministry has done some videos with users, patient users and patient advocates, but I do not know where they are, so I cannot access them to be able to share them.

**Mr. Chairman:** I get the gist of the argument, there is, Ms. Cox wants to come in and then Brig. Antoine. Sen. Ayanna Lewis, are you finish with your questioning.

**Miss Lewis:** I have one more.

**Mr. Chairman:** Okay. One more. Let us give Ayanna Lewis an opportunity to pose the last question.

**Miss Lewis:** Yes, this is my last question and it is concerning Alzheimer’s, because we have been talking about mental health issues and we have not spoken about Alzheimer’s and I want to find out if it is that in your lined different fields, how do you treat with Alzheimer’s and is there some kind of collaborative work with the Ministry of Health and the persons with Alzheimer’s, what would you recommend if anything? I know it is very broad but—I leave it there for you to respond.

**Dr. Khan:** So as a nurse psychologist, I have had a lot of experience dealing with dementia, worked in memory clinics outside of Trinidad for a number of years, so it is a growing epidemic for a number of reasons. With respect to our treatment, I think we still—one of the biggest problems with Alzheimer’s disease is people present to health services when they are already at a moderate to severe stage and at that time there is very little you can do. Not even medication can help when you are in the
severe stages. So that has been one of the issues, that we need more awareness so that people can present at an earlier stage. So we need relatives, friends, caregivers to recognize the signs and symptoms. What we have is a lot of attributing it to old age. Well, you get forgetful when you get old and not recognizing that, no, if you are forgetting your route home, if you are forgetting your ATM PIN number, that is not normal. So we need to get people being seen earlier.

One of the initiatives they posed in the UK and I think it would be applicable to us here, is, they wanted to recommend that once you are over 65 that you are screened routinely for Alzheimer’s diseases and dementia. So with respect to—so there are two aspects: one, if it starts early, presentation and early diagnosis and then the treatment and management. Part of the treatment and management as we need a lot more care facilities for people, not only residential but day facilities. There are many families who are quite okay to take care of their member while they work. So during the day they need somewhere. So I know that we have one or two senior day facilities in the country but we need more of those with staff who can cater for patients with Alzheimer’s disease.

The other thing about Alzheimer’s disease is in its most typical presentation often they lack insight. They do not know they have a problem so therefore the burden is on the caregivers. The family members who have to deal with this changing person and all the support that they need. So we also need a lot of support for caregivers. One of the things I am currently working on, we have a research project that is currently going on where we are recruiting patients with memory problems and also normal healthy people to compare them to. We are looking to identify valid instruments to measure cognitive decline. Because if we cannot detect it then, as I said, when somebody is severe you do not need a test. You can interact with them for a few minutes and you know. So we are doing some of that research and I think—[Interuption]
Mr. Chairman: I just want to intervene—I am looking at the clock and I do wish to finish at a reasonable time. But before I proceed to MP Antoine, Ms. Cox, did you want to come in briefly?

Ms. Cox: Yes, briefly.

Mr. Chairman: So as you come in, then MP Antoine will have the floor.

Ms. Cox: Ms. Khan had offered, because we did not speak much about the facilities and one of the suggestions in our thrust for decentralization, having day centres just as she said there. It was well explained. Also, psychiatric inpatients units within the community near to the persons’ home. So instead of being in this central area or mental hospital, persons could come and bring food, they can visit their relatives, they can have their care for one week, two weeks and then go right back home, right there in the community. That is part of the thrust of decentralization. So we are talking about mental health and the adequacy of the practitioners. We realize that there is a shortage of psychiatrists. All research have shown in different countries that there is a shortage of psychiatrists but how have they dealt with it?

12.20 p.m.

We have looked at the Belize model, we have looked at Jamaica and some other foreign countries and we see the value of the Advanced Nurse Practitioner, who trains at a Master’s level and they have both prescriptive and diagnostic powers, and they are able to work along with, and under the psychiatrist and they can work independently in the community and they are able to do health promotion and prescribe and they have been working quite well. As a matter of fact, Belize, in the introduction of the Nurse Practitioner, they have been able to close down their mental hospital and they have complete community psychiatric care that is integrated into their general setting. So there is no centre—you can walk into a health centre and have assessment.

Mr. Chairman: Could you send, for the benefit of the committee, any information
you may have on community care for the mentally ill? I was not familiar that that was a model that existed in a Caricom country.

**Ms. Cox:** Yes, so we will.

**Mr. Chairman:** And finally, Brig. Antoine.

**Brig. Gen. Antoine:** I just want to touch on a negative stereotyping. Mr. Murphy mentioned the situation with demon-possessed vis à vis mentally ill patients. But in the communities and in the cultural setting there is a pendulum that swings between people who are mentally ill but are classified as having a “tabanca” because his wife went to the States and left him or the husband left her for another man, as the case may be. But also there is the other side of the pendulum and we experience this in the military where a person would show that he has his papers from St. Ann’s, so therefore the military may not discharge you, but then you are prevented from coming close to weapons as the case may be and you just carry on your life as, what we call, a barrack room assess soldier. So you just work in the barrack room. So there is a pendulum in terms of the communities.

My question is, as different organizations, what are we doing with the negative stereotyping of mentally ill patients? Is there any programme to deal with that, to educate the communities that these people are, in some instances, not violent as the case may be, but they would interact better if they are closer to their communities and their families as the case may be? Is there any programme afoot to deal with that?

**Mr. Chairman:** A brief response with respect to the profile, the behavioural profile of a mentally ill patient. Do you think there is a need for a public education programme to disabuse individuals that mentally ill people are behaving in a particular way; that they can look and behave normal? So who is looking to see—who should be doing that programme?

**Mr. W. Murphy:** Well, there is definite need and the first place we need to begin
is stop the labelling about “them” versus “us”, because any one of us can become mentally ill in the morning. In fact—

**Mr. Chairman:** Three of us here, statistically, perhaps will be suffering from a mental ailment.

**Mr. W. Murphy:** And you are correct.

**Mr. Chairman:** Fifteen of us, divided by five, would be three. I “doh” know which three, but—[Laughter]

**Mr. W. Murphy:** I do not know either but if we have to use the diagnostic and statistical manual on mental disorder for five, published in 2014, there are over 18 categories of mental illness. That works out to over 375 discreet diagnoses of mental illness, which means that the statement we made a while ago could very well be true, and in fact it is true. So we need to stop the labelling. It is not going to happen overnight. It requires public education programme; we have got to get into the social media; we have got to get into the traditional media; we must get some air time; we are going to send our best professionals in. We have been doing it, but I think we need to increase the numbers and the frequency.

**Mr. Chairman:** I will ask Sen. Ameen to come in and then MP Jennings-Smith.

**Miss Ameen:** Chair, I have several questions but they really just are very short answers—

**Mr. Chairman:** And I will want very short responses because we do want to finish at 12.30.

**Miss Ameen:** You indicated that there is no register of practising psychologists in your report to us. If you can briefly indicate the reason for the delay, and in the absence of such a register, what mechanism is currently utilized by the association to record and track practising psychologists?

**Dr. Khan:** Very briefly, why there is no register, I think the fact of deciding which route to go in terms of being independent or going under the current Act has been a
significant factor. Under my stewardship we were going to pursue going under the existing Act, so hopefully that should change. We are having a public consultation with stakeholders in a few months’ time to discuss that as well.

And the latter questions as to the breakdown of psychologists, based on what we know about who is graduating from the programmes—so from USC and UWI, which are the two programmes that graduate professional psychologists, counselling and clinical psychologists, so we have figures for those, and we also have figures for our historical membership. So 200 to 300 roughly over the time. So we can give further estimates of how many clinical counsellors are educational psychologists, school psychologists, work psychologists, et cetera.

**Miss Ameen:** And you also indicated that the legislation with regard to the Trinidad and Tobago Immigration Act, that it was so archaic and obsolete. Has the association been able to make any headway with its representation to the Ministry of National Security, to the office of the Attorney General to recommend that the Immigration Act be amended to reflect the contemporary views in terms of mental illness?

**Dr. Khan:** No, we have not, and it is something that we have to do. We are currently—most recently we have been in participation in the discussion on child marriages, so we have submitted our comments on that and we are going to re-submit based on the current discussion that is taking place in Parliament. So we have been tackling the Child Marriage Act and we are quite firm in our position that it should be 18 and no younger.

With respect to this Immigration Act, it is not one that is regularly discussed. I do not think many people even know that we have this statute on our law books. So yes, I think one of the barriers is because we are a voluntary organization, only supported by financial membership which varies. So something in that response we would want to have the assistance of a lawyer. So I think—so it is mitigating those.
But we will certainly start with just a letter to the AG’s office saying, this exists, we think it is negative for all these reasons. We hope something will be done about it.

**Miss Ameen:** My other question is with regard to the nurses and perhaps the—you spoke about the absence of posts for psychologists in the public sector. My question relates to nurses—psychiatric nurses—and in many other spaces in the public service there are a number of positions that exist but are vacant while you have a shortfall and those who are in the system are overworked. What is the situation in terms of the number of nurses, trained psychiatrist nurses, who are practising in public institutions? Are the positions generally filled? Are there shortages?

**Mr. Stuart:** Yes. Briefly, well, first to begin, I think we should start with the Chief Nursing Officer. That post has been vacant for the past two years. That post is supposed to be at the Ministry and that is where an association like myself and other parties would be making our recommendations too, to get to the Minister. So that post has been vacant for the past two years, so that has caused a number of problems.

With regard to psychiatric posts, from the minute the individuals would have graduated from the nursing schools, they are hired by the various regions to fill the gaps. Those are of the lower levels. But in terms of supervisory levels, there is a serious problem in terms of, for instance, in St. Ann’s Hospital, half of the nurses who are in roles of nursing supervisor, are retired persons who would have come back and now they are blocking the upward mobility of persons within that field. You would not get that situation in any other setting: in police, fire, what have you. But currently more than half are retired persons blocking the upward mobility.

In terms of—but what we will also like to see is—and it is in our recommendation—with regard to the mental health plan of 2000 by the Ministry of Health, where they speak to de-formalizing the establishment of the National Mental Health Committee which would incorporate the different professionals within this field to come up with the master plan instead of each organization just submitting
their different ideas. If we get that master plan coming out of this National Mental Health Committee, it would be more organized to suit.

**Mr. Chairman:** Thank you very much. Sen. Ameen, do you have any more burning questions? Could it be your last—very, very critical question?

**Miss Ameen:** My final question has to do with something that was mentioned earlier related to the safety of our nurses and medical personnel at St. Ann’s Hospital. When you have prisoners who are brought in for treatment, are prison officers posted on the wards to house them, so that those—

**Mr. Stuart:** No. And that has been another main issue with psychiatric nursing. You have persons—well, you have two categories of persons, basically; persons who would have really been convicted and because of their mental health status they are warded in St. Ann’s Hospital, and then you have the persons who would have been charged and the court would have sent them for 14 days for evaluation. So those two different categories of persons are within the St. Ann’s institution and there is no prison officer. The prison van will drop them and come back for them 14 days later, and nurses have to take care of these persons who, some of them are not mentally ill after the diagnosis by the doctor. Some of them cause a lot of problems. There have been a number of riots in St. Ann’s Hospital where we had to call the police. A number of nurses would have gotten injured over the years and there is no compensation, no avenue for redress.

**Miss Ameen:** Just a follow-up on this. I am shocked at the response.

**Mr. Chairman:** This is the last question.

**Miss Ameen:** Chair, through you—thank you for your patience. This is a very alarming situation where the safety of the psychiatric nurses and the staff of St. Ann’s Hospital is concerned. Does the hospital itself have any mechanism to treat with the safety regarding these criminal people who are accused or convicted, who are brought to the hospital, to ensure the safety in the absence of prison officers being
posted—special security arrangements or staff?

**Mr. Stuart:** Well, let me just speak on it quickly for two points and I will just let Letitia Cox who is actually in the area right now. So, one, they utilize attendants, and basically the persons are untrained. They bring them into the facility to be the muscle, basically. So a violent incident is taking place on the ward, if the nurses cannot handle it they will call these attendants. They will come over and they will try. But they have no formal training in mental health. They have no formal training in managing aggressive patients and it is really up to the nurses themselves to really treat with issues like that. But in addition, the forensic ward, they recently rolled out camera surveillance systems to see what is happening. But that, basically, is the limit of it.

In terms of training in forensic nursing, there is none in Trinidad and Tobago. And in terms of compensation when nurses get damaged, I myself was damaged on the wards. Most psychiatric nurses would have been damaged at some point in their career on the wards and you have no compensation. In fact, we are dealing with a case right now at the Industrial Court where a nurse was injured. A nursing supervisor going on the ward to check on what is going on was tripped—

**Mr. Chairman:** Okay. Could we stay away—we tend not to interfere too much with court matters until there is a determination.

**Mr. Stuart:** Sure.

**Mr. Chairman:** But I will ask MP Jennings-Smith to pose her final question—final, final question.

**Mrs. Jennings-Smith:** I will be very short. I am going back to Lifeline and I am linking. Now, a lot of medical issues help in crime fighting, and with respect to suicide, the Ministry of Health had said they would be looking at implementing a suicide surveillance system. But with your interactions with persons, because you have seen suicides and where they would have murdered somebody before or
interfered with some members of their family and then went on to commit suicide, in your interventions or in your conversation, do you have a protocol that you follow in terms of when you get certain kinds of information for prevention of that kind of activity where you could put, maybe a stop, by having intervention? Did that ever occur from your interventions or from any other persons?

**Dr. Gabriel:** Could you explain to me what you mean by an intervention?

**Mrs. Jennings-Smith:** I mean your conversations, where you listened in to persons calling Lifeline and its relation to suicide, because you did say the number of calls increased to 80 per cent and you did talk about evaluating and assessing and determine how many suicides occurred, and things like that. Can you link it to the prevention of suicides in terms of its relationship to a person committing suicide but prior committing murder?

**Dr. Gabriel:** Yes, you can, because sometimes—

**Mrs. Jennings-Smith:** And what kind of intervention you have with the Ministry of Health?

**Dr. Gabriel:** It does not go to the Ministry of Health in that case. What you do have is a person who would ring and say that “I either commit suicide” or “I killed somebody”. And in talking to that person, in listening to that person, they would finally get to the stage where they say, “Look, I will do X, Y and Z instead”, and you then follow through with that person. But if they are really determined to do that, they will not tell you who they are or where they are. So they will make sure that you cannot track them. They would do that. The person has the right to anonymity and therefore we would—if you are talking about for the Ministry of Health, when it comes to somebody who says “I will kill somebody”, just the same as “I will commit suicide”, you do not let them go until they felt better. But to say, if they are determined to do that, they will make sure that you cannot track them.

**Mrs. Jennings-Smith:** Can you say from your experiences, because you would
have had the facts, that you could have linked it to any time when you saw a suicide committed followed by murders or a murder?

**Dr. Gabriel:** You cannot say because you would not have known who it was. The person would not tell you who they are.

**Mr. Chairman:** Thank you very much. We are past our time but as Chairman I do have some flexibility and I will exercise it. So what I will do at this time is ask members of the visiting panel to give us any brief closing comments they may like to leave with us that did not get discussed in the deliberations—a representative from the Nursing Association, a representative from Psychology and the Lifeline representative. So could we get a representative from Nursing to leave us with any closing comments that they may wish to have?

**Mr. D. Murphy:** At the level of the regulatory body, we are doing everything we can once persons would have applied, would have been qualified, so that we can grant them their licence to practise. But we must also do so in the context of not only qualification but to protect the public’s best interest.

As it relates to the advanced practice nurse that Ms. Cox spoke about, the regulation has been amended. We now have on the statute the advanced practice nurse, or nurse practitioner and the council is prepared to enrol, to register, persons as advanced practice nurses once they would have met the requirement. And one of the areas at the council we have discussed previously would definitely be in the area of psychiatry and mental health.

**Mr. Chairman:** Thank you very much. The Lifeline representative, any closing comments that you would like to leave us with?

**Dr. Gabriel:** Basically one, that I hope that out of this that you will take a very active role in breaking the stigma associated with mental health.

**Mr. Chairman:** Very well. Thank you.

**Mr. W. Murphy:** From my standpoint, there is a cliché that guides us: there is no
health without mental health. What we need in order to carry the process of mental
for both this generation and the one that is yet unborn is that so much more gets done
when nobody is too interested in getting the glory for what gets done.

Mr. Chairman: Thank you very much and well said. Yes, Dr. Khan.

Dr. Khan: Thank you for listening to us today, and I think, apart from all the
detailed comments we sent in, what I would like to see is after this, some continuity.
So TTAP is very willing to continue to partner. We are very willing to participate
wherever we are needed and I really do want to advocate for this committee having
a say in terms of extending or expanding the range of services that are available in
the public sector.

Mr. Chairman: Very well. Any other comments? Democracy reigns in our
committee. If there is any comment—Ms. Cox?

Mr. Stuart: I just want to pull something from the Welch Committee. One of the
findings and one of the things they are looking at is how to deal with the doctors
who pursue private practice while in Government employment, and one of the
solutions is increasing the scope of practice through the advanced practitioner nurse
so they would not have that stranglehold. Because basically what it is, the doctors
will walk out if you limit them to Government practice only, but if you have a cadre
of professionals who could take up that slack in psychiatry and in the general setting,
which is the nurse practitioner, which has been working successfully throughout
several countries, and even in the Caribbean, namely Jamaica, that problem that the
Minister has with rationalizing that system, could be solved.

Mr. Chairman: Okay. Could you elaborate on that just for my edification, how
will that work? Is it that you are saying that the nurse practitioners can also work in
the private sector?

Mr. W. Murphy: No, the nurse practitioners will take up the workload, because
there is currently a shortage of—
Mr. Chairman: Okay, very well.

Mr. W. Murphy: Not house officers, but consultants. But the nurse practitioner could—

Mr. Chairman: So freeing up the medical doctors to undertake private practice.

Mr. W. Murphy: Yes.

Mr. Chairman: And Ms. Cox, I know you wanted to say something.

Ms. Cox: Yes, Chair. Just as he said that there are—you know in the international community that nurse practitioners have nurse-led clinics. They are well trained, but they will collaborate. You see, we have to come back to the place where there is this camaraderie among professionals. We are not at war with each other. We are lending that support and education. So there are nurse practitioners internationally working in the private setting.

I would also like to say that just like Ms. Khan said, I would love for this to continue and we would be invited again so that we can really share and make an impact in the community, because it is in my heart for the children and the adolescent, especially the teenagers, to reach them. So I applaud this committee, this forum and I hope it continues and is successful.

Mr. Chairman: Thank you very much, Ms. Cox. As is customary, I start a committee hearing not knowing very much and I end it with knowing a little bit more. What have I learnt—and committee Members by extension—over the last couple hours of deliberations? We do basically need to consider having a special ward for children who need institutional care or hospitalization. We certainly need to encourage more individuals in the medical field to pursue the field of psychiatry and to look at whatever impediments may exist there. We need to work closer with the social workers and the school guidance officers in schools who are in contact with the school age population more frequently than the nurse practitioners so that they would be trained to at least identify, very early, children who are displaying
symptoms of mental ailments.

With respect to Lifeline, I was very surprised to learn that the private sector is not more heavily involved in financing this particular NGO. So it is something we need to be looking at, to what extent we can actually encourage the private sector. There are certain incentives which can be provided at the level of the Parliament which will encourage private sector to be more involved in NGOs such as tax concessions and so on, something that we can be looking at.

What has emerged is that there is a greater need for collaboration between the Ministry of National Security, Education and Health, because what. Sen. Ameen indicated was that we need to understand how national security with respect to prisoners, is impacting the nurses at the St. Ann’s institution, Ministry of Health. We need to look and sort out the problems with respect to the Ministry of Education. And a recommendation from Dr. Khan is that we need to place much more emphasis, and also Lifeline, on family life education. The breakdown of the family support unit seems to be a cause now for greater and greater mental problems and we need to be looking at how we could redress this situation via curriculum change.

We need to advertise more for psychiatric nurses. That seems to be something that ought to be part of policy, that specialist psychiatric nurses we advertise for. And what came out of the deliberations, at least for me, is that in addition to community mental health facilities and nurse practitioners helping medical doctors, is now a need—because mental health is so wide. It involves—we did not look at alternative treatments such as yoga and things like that, animal therapy. But I think there is a need for there to be an association of mental health workers in Trinidad and Tobago with its own social media pages made up of the medical professionals, the psychiatrists, the psychologists, the mental health nurses and individuals who may be engaged in alternative therapies, and with that association coming together maybe on an annual basis to interact, we should be able to determine what is the way
forward with respect to the assistance that each can give the other so that ultimately the health, the well-being and the wellness of the mentally challenged in Trinidad and Tobago can be addressed.

We have learnt a great deal and this will probably be the last public hearing of this committee which I have the honour of chairing for this particular session, but what has happened over the last little while is that we have now been alerted to the various multifaceted nature of mental health problems and we are going to be looking at what we in the Parliament can do with respect to legislation and also with respect to public policy on how we could provide to the national community an environment where mental health is treated on par with other aspects of health and where the mentally ill in Trinidad and Tobago can receive the kind of services that a developed country ought to receive.

At this time, 12.47, I call this meeting to a close. The conversation has now started and I want to thank all of our viewers, all of our listeners on radio, all of our participants on social media, the regular mainstream media and all our panellists for being here. It was a very edifying session.

I thank you and may there be an improvement in mental health in Trinidad and Tobago as we move forward. Thank you. And this meeting is now adjourned.

*12.47 p.m.: Meeting adjourned.*
Appendix VIII

EXCERPT OF VERBATIM
NOTES OF THE
EIGHTEENTH MEETING
OF THE JOINT SELECT
COMMITTEE ON SOCIAL
SERVICES AND PUBLIC
ADMINISTRATION
EXEMPLARY OF VERBATIM NOTES OF THE EIGHTEENTH MEETING OF THE JOINT SELECT COMMITTEE ON SOCIAL SERVICES AND PUBLIC ADMINISTRATION, HELD IN LEVEL 2 MEETING ROOM, (IN CAMERA), AND THE J. HAMILTON MAURICE ROOM (MEZZANINE FLOOR) (IN PUBLIC), OFFICE OF THE PARLIAMENT, TOWER D, THE PORT OF SPAIN INTERNATIONAL WATERFRONT CENTRE, #1A WRIGHTSON ROAD, PORT OF SPAIN, ON WEDNESDAY, NOVEMBER 15, 2017 AT 9.49 A.M.

PRESENT

Dr. Dhanayshar Mahabir, Chairman
Mr. Rohan Sinanan, Member
Brig. Gen. Ancil Antoine, Member
Mrs. Christine Newallo-Hosein, Member
Mrs. Glenda Jennings-Smith, Member
Mr. Julien Ogilvie, Secretary
Mr. Johnson Greenidge, Parliamentary Intern
Miss Ashaki Alexis, Parliamentary Intern
Miss Vahini Jainarine, Legal Officer

ABSENT

Mr. Esmond Forde, Vice-Chairman [Excused]
Miss Khadijah Ameen, Member [Excused]
Ms. Ayanna Lewis, Member

10.30a.m.: Meeting suspended.

10.38a.m.: Meeting resumed.
MINISTRY OF EDUCATION

Mrs. Lenore Baptiste-Simmons       Permanent Secretary
Mr. Kurt Meyer                     Permanent Secretary
Mr. Harrilal Seecharan             Chief Education Officer
Ms. Amanda Pedro                   Guidance Officer II
Mrs. Leticia Rodriguez-Cupid      Special Education Teacher II
Ms. Darlene Smith                 Guidance Officer II
Mrs. Sharon Francis-Gaines         Social Work Specialist

TRINIDAD & TOBAGO ASSOCIATION OF PSYCHOLOGISTS

Dr. Margaret Nakhid-Chatoor        President, TTAP
Dr. Katija Khan                    Past President, TTAP
Dr. Krishna Maharaj                Sr. Clinical Psychologist & Health Administrator, TTAP

CHILDREN’S AUTHORITY OF TRINIDAD & TOBAGO

Mr. Hanif E.A. Benjamin            Chairman, Board of Management
Ms. Safiya Noel                    Director
Ms. Christalle Gemon               Dep. Dir. Care, Legal & Regulatory

MINISTRY OF HEALTH

Mr. Richard Madray                 Permanent Secretary
Dr. Roshan Parasram               Chief Medical Officer
Dr. Indar Ramtahal                 Medical Chief of Staff,
                                     St. Ann’s Hospital
Dr. Jaqueline Sharpe               SMO, Child & Adolescent Psychiatrist
Prof. Gerard Hutchinson            Head Psychiatry, UWI
Dr. Celia Ramcharan               SMO, Psychiatrist, SWRHA
Ms. Ashvini Nath                   Manager, Mental Health Services
Mr. Chairman: Good morning and welcome to this the Eighteenth Meeting of the Joint Select Committee on Social Services and Public Administration. This is the third public hearing pursuant to our enquiry on the state of mental health services and facilities in Trinidad and Tobago.

I would like to welcome the officials from the Ministry of Health who are here with us this morning; the Ministry of Education, the Children’s Authority of Trinidad and Tobago, Trinidad and Tobago Association of Psychologists, the Association of Psychiatrists of Trinidad and Tobago.

This morning we are here to focus on the mental health services and facilities provided for children and adolescents in Trinidad and Tobago. The reason for focussing on children this morning is that our Committee has been looking at mental health issues in Trinidad and Tobago. We have undertaken site visits to institutions and we have found that there is something or some questions to be answered with respect to the facilities available for children who are experiencing mental illness. By that I mean, I will refer under the laws of Trinidad and Tobago, Chap. 46:01, it defines a child to mean a person under the age of 18 years. There was a view by Committee members upon our enquiry and our investigations that we needed to delve further into the facilities available for the mental care of children, citizens of Trinidad and Tobago under the age of 18.

I would like to welcome again our loyal listeners on the Parliament radio, our viewers on the Parliament Channel, members of the public who follow us on the various social media sites that are the platforms available for them to communicate with us, and I want to welcome all the officials who are here with us this morning.

We have a very full house. We have a number of agencies interested in this particular problem. So it appears that there is a problem with respect to the care for the children who are experiencing mental illness. And for members of the public who have been following the work of our committee, we were also looking at an
issue of school violence and bullying amongst children in the under 18 group, and these are issues which are now culminating in our investigation on how it is the children of Trinidad and Tobago are coping with the various stresses of being children and what kind of treatment facilities are available by the State to handle mental illnesses of children.

I would at this point ask the following representatives to offer brief introductions, because we would like to give all participants an opportunity to inform the Committee on what their views are on the way forward with respect to the mental health of the children of our Republic.

So I would ask the following officials to offer brief opening remarks: the Permanent Secretary of the Ministry of Health first, a familiar face to this Committee; Permanent Secretary Ministry of Education, second; the Director, Children’s Authority of Trinidad and Tobago, third; the President Trinidad and Tobago Association of Psychologists, fourth; a representative of the Association of Psychiatrists of Trinidad and Tobago.

I would ask you to offer brief opening remarks, introduce yourself at the same time, and we proceed in the questioning members who are going to respond will introduce themselves at that point in time. Once you are done, members of the Committee we will introduce ourselves, and we will proceed with the enquiry. So Permanent Secretary, Ministry of Health.

Mr. Madray: Good morning, Chairman and members, I am Richard Madray, Permanent Secretary Ministry of Health. Thank you for the opportunity to appear before you to discuss this important issue of child and adolescent mental health services.

At present, the Ministry of Health through our Regional Health Authorities has the mandate to deliver mental health services to the population. This is achieved through the following: three national services, these are located at the St. Ann’s
Psychiatric Hospital, the Substance Abuse Prevention and Treatment Centre and the Arima Psychosocial Rehabilitation Centre; three acute inpatient psychiatric units and wards; two extended care centres; three child and adolescent outpatient clinics; 27 adult outpatient clinics.

As the Ministry of Health seeks to continue the improvement of mental health services, a new model of care for mental health is being developed, that is client-centred and promotes recovery. This model will consider evidence based protocols and practices for mental health such as early intervention, respect for human rights and the integration of mental health into the general health care system.

Our Ministry recognizes the complexities and vulnerabilities of the child and adolescent population, and the Ministry of Health seeks to provide comprehensive integrated and responsive mental care with a special emphasis on rehabilitation and recovery in community-based settings, rather than institutionalization ultimately.

Mr. Chairman: Thank you, Permanent Secretary.

Mrs. Baptiste-Simmons: Good morning, Chairman and members. The Ministry of Education is pleased to be invited and to contribute at this meeting of the Joint Select Committee with a special focus on the state of mental health services and facilities for children and adolescents in Trinidad and Tobago.

The establishment of the Student Support Services Division within the Ministry of Education was aimed primarily at providing and giving support for all students to maximize their full learning potential and to develop holistically within the school setting.

In fulfilment of this objective, the Ministry continues to develop internal synergies and collaborations. In this regard, the Divisions of School Supervision and Student Support Services work collaboratively to implement systems of referrals from the classroom to professional internal staff and, where necessary, direct referral from our Ministry out to specialist care by the relevant health authority or
The Divisions of Educational Planning, Education Facilities Planning and Procurement, and Curriculum Planning cooperate along with Student Support Services to plan and improve accessibility for students diagnosed with special needs.

The Ministry of Education also works collaboratively with internal partners and agencies to establish protocols for effect client service delivery. These include the Ministry of Gender and Child Affairs, the Children Authority and the Child Guidance Clinic at the Ministry of Health.

In providing an equitable quality and accessible education system for all learners, the Ministry is guided by our national laws, policies and several pieces of legislation. We also look at international conventions which include, inter alia, the 1989 United Nations Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities. We identify with and are fully cognizant of the challenges of attaining education for all as outlined in the United Nations SDGs. We specifically refer to Goal 3 which speaks to ensuring health and well-being, as well as Goal 4 which looks at including and ensuring inclusive quality and equitable quality education and promotion of lifelong learning opportunities for all.

As we endeavour to expand our inclusive education system at every level, the Ministry continues to develop, contextualize and implement initiatives that meet national objectives, but seek to develop our students as 21st Century citizens and learners within an ever evolving and continuously changing, learning and working environment.

In this regard, particular emphasis is placed on nation building, self-actualization, spirituality, mental and physical health, happiness and emotional wellbeing.

Mr. Chairman: Madam PS, the remarks are supposed to be brief at the opening.

Mrs. Baptiste-Simmons: I am finished.
Mr. Chairman: Very well, thank you very much.

Mrs. Baptiste-Simmons: So we look forward to the morning’s proceedings.

Mr. Chairman: You will be given an opportunity to elaborate as the hearing proceeds.

Mrs. Baptiste-Simmons: You intervened at the right time; that is it.

Mr. Chairman: May I ask the Director of the Children’s Authority to offer brief opening remarks to us.

Ms. Noel: Good morning Chairman and members of the Committee. My name is Safiya Noel, Director of the Children’s Authority. Chairman, please allow me to introduce Mr. Hanif Benjamin our Chairman, who is actually the one that is carded to bring the remarks on behalf of the Authority.

Mr. Benjamin: Good morning, Mr. Chairman and members of the Committee, and thank you for allowing us the opportunity to delineate this morning’s most important topic as it relates to our children, more so because in less than a week we will be looking at the world’s Children Universal Children’s Day, and I think it is fitting that we have this conversation in relation to our children and mental health.

For far too long there has been a stigma regarding mental health, and often families are ostracized. For far too long our children have been labelled as bad child, delinquent or beyond control, and unfortunately our response has been to those different labels. We have been looking at mental health and what is going on in Trinidad and Tobago, and we have seen in various reports where one in four persons are living with mental illness. There is also a report of our children living with mental problems in our nation’s schools, homes and communities. Unfortunately, we also see our inability to adequately manage and treat the high numbers of children living with said mental illnesses. The article also notes that there is one mental hospital, the St. Ann’s Psychiatric Unit and 31 outpatient facilities. Notwithstanding that, however, we see in-patient care woefully lacking for our children. I beg the question
then for us to delineate here what about our children.

Since the Children’s Authority of Trinidad and Tobago has been delivering services to children and their family, we have noted a significant number of children presenting with mental health illnesses. It is truly worrying for our staff as they see children without a place to go. So while the Authority is working closely with other entities, we welcome the opportunity to have this conversation with the Committee and other colleagues this morning, as we forge a way forward.

Mr. Chairman: Thank you very much. We will continue the conversation. The opening remarks are supposed to be brief, two/three minutes, because the opening remark is just like the opening over, it is not the full 10 overs you have in limited cricket, just the first few balls of the over.

Could I ask the President of the Trinidad and Tobago Association of Psychologists to offer us brief remarks as well?

10.50 a.m.

Dr. Nakhid-Chatoor: Good morning everyone, Dr. Margaret Nakhid-Chatoor, president, clinical and educational psychologist. We believe that many children with mental health needs are not receiving the required professional help, and although the likelihood of receiving care increases with clinical severity, seriously emotional disturbed children are yet to receive any kind of mental health care unless from an outside provider.

One of the key players we believe in the provision of mental health services is the education sector, and for many children in this country this continues to be the sole source of care as the general health care system plays a relatively minor role in service provision for children.

In our proposals today, one must review the types of providers involved, the forms of clinical interventions delivered, how effective these services are, and
the relationship between cost and outcomes.

In conclusion, we at TTAP cannot fail also to consider the continuing stigma that is attached to mental health in this country, the need to better understand the dynamics underlying help seeking by parents and caregivers, and the availability of sector choice patterns for children with mental health concerns. Thank you.

**Mr. Chairman:** Thank you very much for your brief remarks President of the Trinidad and Tobago Association of Psychologists. And now finally, a representative from the Association of Psychiatrists of Trinidad and Tobago.

**Dr. Ramtahal:** I do not think anybody is here representing that Association.

**Mr. Chairman:** Okay. Well then, we can then ask members of the Committee to introduce themselves briefly before we open the Committee to full hearing. On my right.

[Introduction of members]

**Mr. Chairman:** And I am Sen. Dhanayshar Mahabir, Chairman of the Committee, Independent Senator. May I first of all thank the participants here for their opening remarks, a lot was said, and I really would like to focus on, and it is open now to anyone, maybe the PS of health or a representative of the Association of Psychologists.

Under the Children Act, 2000, section 30, it says, where a child has been received into the care of the Authority and:

…subsequently that child is determined to be mentally ill, under the Mental Health Act, and such determination results in the admission of the child to a psychiatric hospital…

That is what the Act says. What I want to get from members of the panel now is whether it is that this child can be admitted to any psychiatric hospital or are there
special facilities available within the health care system of Trinidad and Tobago to treat someone under the age of 18 with mental illness in dedicated facilities or facilities dedicated for children? The question is a simple one: is there any dedicated mental health facility for the under 18 population of Trinidad and Tobago; if there is not, should there be? And should there be—the “is” there is for individuals in the Ministry of Health; “should there be” is for the professionals in the field. So maybe the Permanent Secretary in the Ministry of Health you can answer the question: is there a dedicated facility for the treatment of children who are experiencing mental health issues, mental health problems?

Mr. Madray: All right. Thank you for the question. I will ask either Dr. Sharpe or Dr. Ramtahal to respond to that.

Mr. Chairman: Okay. And Dr. Sharpe and Dr. Ramtahal, you can also indicate the positions you hold within the Ministry of Health.

Dr. Sharpe: Good morning, I am Jacqueline Sharpe, I am a Specialist Medical Officer child licenced psychiatry in the Ministry of Health. I work with the North-West Regional Health Authority.

Mr. Chairman: Thank you.

Dr. Sharpe: The answer to your first question is, no, there are no dedicated in-patient psychiatric facilities for children under the age of 18.

To address the second part of your question: yes. Obviously we need services, in-patient services included for children and adolescents who have serious mental health issues that need to be addressed. There have been various arrangements in the past that have worked, and of course, we have children now who are in need of psychiatric care.

At this point if the children are evaluated by a psychiatrist and they need admission, if there are children under the age of 16 and the behaviours are as such...
that they can be accommodated on one of the wards at the paediatric hospital, then you try to make arrangements for their admission to the paediatric hospital. If they are over the age of 16, you try to make arrangements for them to be admitted either to the psychiatric unit at the Mount Hope Hospital that is run by Prof. Hutchinson’s team or the children may be negotiated to go to the St. Ann’s Hospital usually to the LFE Lewis unit which is a unit that is for acute care. Those are the arrangements. And in San Fernando, I believe, children may be admitted to the San Fernando General Hospital.

**Mr. Chairman:** Yes. I see Mrs. Newallo-Hosein wants to come in, but if she could just hold, may I ask Dr. Chatoor to answer my second question from the perspective of the psychologist. Should there be—and the reason I ask this is simple. Children I imagine have different needs from individuals who are adults and they have different coping mechanisms and different problems in coping with the stresses of life, but that is just prejuring. In your view, professional opinion of the psychologist, is there a need to treat children in their own dedicated facilities?

**Dr. Nakhid-Chatoor:** All right. So current data—to answer that question, you have to consider is the need of children sufficient enough to provide these facilities. Data suggest that up to 20 per cent of children and adolescents suffer from a disabling mental illness. Suicide is the third leading cause of death among adolescents and up to 50 per cent of all mental disorders have their onset in childhood and adolescence. So with these glaring statistics, Sir, you are asking the question, is there a need? And I would just answer, of course, there is.

**Mr. Chairman:** Okay. You are giving a statistic of 20 per cent of children estimated internationally—

**Dr. Nakhid-Chatoor:** Yes.
Mr. Chairman:—can be experiencing or have experienced some form of mental illness. So that if—the population of Trinidad under 18, do you have any idea how much, what is the population of Trinidad and what 20 per cent of that could be?

Dr. Nakhid-Chatoor: I have no idea.

Mr. Chairman: Okay.

Dr. Nakhid-Chatoor: But based on my own clinical experience I would imagine that the numbers are quite great for children coming in for clinical evaluation. And many of these children, again, eh these problems go unnoticed because they always feel, again, understanding the developmental period of the adolescents, feeling that this is a phase that they are passing through and, you know, it will correct itself when it does not.

Mr. Chairman: Okay. To get the numbers in perspective, I think, around 1,800 children write the SEA exam every year, so 20 per cent of that would be close to 4,000 children. Would you say 4,000 children in Trinidad in say the SEA cohort year are experiencing some kind of mental problems on average which should be addressed?

Dr. Nakhid-Chatoor: And to answer that I would break that down into what are some of the mental issues, because you have from very mild to very severe. All right. And I would say for a rough estimate, I do not doubt that figure because especially you mentioned SEA, Mr. Chairman, you have a host of mental issues coming out of just that exam before the exam and after when people want to address these issues, the trauma associated with failure, so just that alone. Yes.

Mr. Chairman: Thank you very much. And MP Newallo-Hosein will come in and a follow-up question by Brig. Ancil Antoine.

Mrs. Newallo-Hosein: Thank you, Chair. Just to follow up on the question from
Chairman. Is there an adequate number of mental health professionals to care for children under 18 years old? And if you can identify how many professionals are there in Trinidad and Tobago? Who can answer, probably you can, Dr. Chatoor? The PS Ministry of Health.

**Mr. Chairman:** And while you are contemplating who will answer, MP Antoine has a follow up on that question as well.

**Brig. Gen Antoine:** And this is to the Ministry of Health: Is there any data of children with mental illness being referred by the courts; and if so, where are they set if the courts refer them because of mental health?

**Mr. Madray:** Again, with respect to the first question, I will ask Dr. Sharpe to respond.

**Dr. Sharpe:** The question relates to the total number of available personnel in Trinidad and Tobago or the number of personnel who are employed by the Ministry of Health and the Government?—because they are two different questions really.

**Mrs. Newallo-Hosein:** We have an Act, the Children’s Authority Act which speaks to children receiving the requisite mental health care. I am asking: is there an adequate number of professionals, mental health care professionals who can treat with children under 18 years old? And if the answer is no, therefore, are we in breach of the Children’s Authority Act because we are unable of provide the proper mental health care for our children?

**Mr. Chairman:** Yes. The question is: Are the requirements of the Act being adhered to with the personnel that you have or do you need more personnel to comply with the requirements of the Act? Simple.

**Dr. Sharpe:** The personnel in the Ministry of Health, it is not adequate because we do not have enough child licensed psychiatrists. We certainly do not have
enough clinical psychologists, and we absolutely have no speech and language therapists, no occupational therapists, no people doing—

Mr. Chairman: Could you send in writing from your technical perspective what are the requirements, the professional requirements, the professional staff requirements of the Ministry of Health?—so that you in your unit will be able to comply with the Act quoted by my colleague. We would like to get that in writing. Because you are saying we have a number of therapists, but I do not know the amount that you would require. And if you quantify that we need so many therapists of this type, so many psychologists, then I think that would certainly guide the work of the Committee when it makes its recommendations.

Mr. Madray: We will certainly do so.

Mr. Chairman: Yes, please. That, I think, is critical information because what your technical officer is saying is that there is an Act, the Ministry of Health is charged with complying with the Act, but there are certain limitations, staff limitations that you have which will not allow you to discharge your functions efficiently, and given the numbers quoted by Dr. Chatoor, it means that there is certainly a critical mass which warrants treatment which is not really receiving it. So, PS, we would like to get what ideally, from your perspective as an administrator, you would like to see with respect to the professional complement of that unit which is charged with complying with the Children’s Authority Act.

Mr. Madray: All right. Certainly, Chairman and member, I could also add that with respect to certain fields it is not just Trinidad and Tobago that has the challenge. The field of child psychiatry, there are global shortages in that field, and therefore, we as part of the global environment we are also affected by that. What we have done is placed before the National Scholarship Programme our areas of priority including the field of child psychiatry, and it is our hope, if not
expectation, that over the next few years there would be people who seek out those scholarship awards, and we can presumably make some difference.

**Mr. Chairman:** Thank you very much. PS, we are moving in the right direction of finding and crafting solutions now, because if we are short in certain areas clearly we need to be planning to ensure that we find the professionals, we cultivate them, we promote them so that they could provide the complement of staff that you need in the Ministry of Health. But MP Antoine had a question. MP, maybe you would want to raise your question again for a response, after which MP Jennings-Smith has a follow-up question on this same important matter.

**Brig. Gen. Antoine:** I am enquiring any data on children with mental illness being referred by the courts? And if they are referred by the courts, where are they sent or what is done with these children when they are referred by the courts?

**Dr. Sharpe:** The children who are referred to the courts who might get sent to St. Ann’s Hospital usually these are young men and women who may be over the age of 16 who are remanded for psychiatric evaluation by the forensic unit. That is one group of children, I do not see those children, they go to St. Ann’s Hospital. We also get referrals to the Child Guidance Clinic. I imagine it happens with Dr. Ramcharan in San Fernando and possibly in Tobago as well, children are referred to the outpatient services, they are evaluated and reports are written to the court. I cannot tell you the numbers off the top of my head. I do not have that information.

**Brig. Gen. Antoine:** But are they sent separately to a children’s ward or are they put together with the adults?

**Dr. Sharpe:** The people who are sent to St. Ann’s I think Dr. Ramtahal might be able to tell you what happens with that.

**Dr. Ramtahal:** Well, there is no separate children’s ward for any such thing, so
they are sent together with the adults in the adult forensic unit whether it is a male or female ward and they are seen there. So there is no separate children’s ward for forensics or general psychiatry.

Mr. Madray: I would like to add that there are proposals that are currently being tabled for consideration to establish at the Wendy Fitzwilliam Paediatric Hospital four beds for children and adolescents as a first initiative and possibly with a ward later on. Those discussions are currently in train.

Mr. Chairman: With respect to the timeline, Permanent Secretary, the Committee is one that sets timelines because discussions can continue for quite a while without things being done. Is there a timeline at which a determination can be made for that?

Dr. Parasram: The timeline which we put forward in our submission, I believe, is June 2018—

Mr. Chairman: Okay.

Dr. Parasram:—for completion of—we are allocating in the first instance four beds within the paediatric ward, so it is an integrated service. We want to get away from the whole idea of institutionalization as PS had indicated. So, we are looking at June 2018 in the first instance.

Mr. Chairman: Yes. Thank you very much. In June 2018, you may be invited and we may replay the record. Dr. Chattoor has to come in, but then after Dr. Chattoor has made her contribution, I want to raise an issue that was initially made by Dr. Sharpe. But Dr. Chattoor.

Dr. Nakhid-Chatoor: I just wanted to say that I would like Dr. Maharaj to comment on that question since he is the health administrator at St. Ann’s. Thank you.

Dr. Maharaj: No. Just a correction, I not the health administrator, I am senior
Clinical Psychologist at the St. Ann’s Hospital. Prior to one year ago children were seen at the forensic unit of the St. Ann’s Hospital. A decision was taken by the psychiatrist in charge then Dr. Vince that he would not be accepting any more children referred to his unit by the court. Prior to that year, children coming out of the court system to the St. Ann’s Hospital were free to mingle with adult psychiatric patients. So at this time we do not have children coming into the forensic unit at St. Ann’s Hospital.

Mr. Chairman: Dr. Maharaj, I need clarification. The forensic department, the forensic unit at St. Ann’s is the one with all the barbed wires and so on that I saw when I visited. Is that where you house the criminally insane, I think they call them, and you put children in there in the past?

Dr. Maharaj: Let us not describe them as criminally insane. The children would be assessed there at times, but they would go towards elsewhere—

Mr. Chairman: Okay.

Dr. Maharaj:—which may seem to be less threatening.

Mr. Chairman: Okay. Right. Before Children’s Authority comes, Dr. Sharpe I need clarification again on a point. You said that children between the ages of 16 and 18 are sent and are largely treated as adults, but according to the Children’s Act a child means a person under the age of 18. Is it that under certain administrative conditions you treat 16 to 18 differently from under 16?

Dr. Sharpe: Excuse me, Sir, I did not say that children between the ages of 16 and 18 were treated as adults. I said that in some circumstances children who are remanded by the courts for psychiatric evaluation might get sent by the courts to the St. Ann’s Hospital. And the people who are remanded by the courts for psychiatric evaluation and sent to St. Ann’s Hospital are then seen by the forensic psychiatrists.
Mr. Chairman: Okay. It would appear to me then that you have children 16 to 18 because that is the definition of the Act, who will be basically treated with individuals, adults who are experiencing mental illness, so that is something we need to address. The Children’s Authority wanted to come in at this point.

Ms. Noel: Yes. I just wanted to share with the Committee some emerging trends that the authority has seen even as it started operations two and a half years ago. So, we would have conducted some multi-disciplinary assessments which included a full psychological assessment, and we would have developed treatment plans out of those assessments. And out of the 360 treatment plans that we have been able to complete, 137 of the children out of those 360 have presented with some sort of mental illness, but that is 38 per cent of the children that we have completely assessed. Assessments are still ongoing, some referred by the courts, some through the process of our investigations we determined require assessment.

And so what we have seen in the initial trends, I mean, they cannot be established as trends as yet, but certainly emerging, it is more than 20 per cent. We have seen 38 of them particularly the children that we have found to be in need of care and protection, those that are living with mental illness are more vulnerable and many times will come to the attention of the Children’s Authority.

Mr. Chairman: Okay. Thank you very much. MP Jennings-Smith, I think you had a follow up?

Mrs. Jennings-Smith: What I want to request, what I want to follow up: could I have you repeat what you just said in terms of the numbers of children that came to your attention?

Ms. Noel: Right. So, what I was saying is out of the 360 full multi-disciplinary assessments that the Children’s Authority conducted in the last two and a half
years, which includes a full psychological assessment, we have found that 137 out of those 360 children are living with some sort of mental illness.

Mrs. Jennings-Smith: So could we get a definition of children displaying beyond control behaviour and acute mental illness? Can you tell me what is the difference?

Mr. Benjamin: Children beyond control it is a term given by the court, based on my knowledge. It is one where a parent cannot handle and they would therefore, bring the child before a court where he will be deemed beyond control. And in instances gone by they would have been sent to a place or they would have come under supervision.

Now, when you talk about acute care in terms of mental illness, you are speaking about a child who might be experiencing some type of mental breakdown or an episode which can, in most instances, come across as an emotional or behavioural instability or dysregulation. And as a result of that, that child or those children would require acute care, and that acute care will come in the form of our hospitals or ERs.

Mrs. Jennings-Smith: So, are you saying that children who are classified as beyond control, what happens next to them?—they are separated from those that you have just described as those suffering with acute mental illnesses symptoms. So, could you tell us, what are some of the acute mental illness symptoms that you would have experienced?

Ms. Noel: Before Chair answers, I just want to indicate that we no longer refer to the children as beyond control, they are children in need of supervision, because children that present with uncontrollable behaviour they have so many different reasons for it, it is not always that they have a mental illness, and so we associate things that are not really associated which are some of the stigma that we spoke
about and the association that the psychologist spoke. So the two are not synonymous, there are various reasons why a child may present as beyond control. So, I will allow Chair now to expound on that.

**Mr. Chairman:** Before he does that, MP Antoine has a follow up on the same issue. MP Antoine.

**Brig. Gen. Antoine:** Yes. I need to get a definition on the interpretation of beyond control behaviour as it relates to children. Because you as the Children’s Authority is saying that you no longer classify it that way. But then you also said that it is the courts that say beyond control behaviour. But I also want to find out who determines this categorization?—is it the parent or assessment by some sort of professional?

**Ms. Noel:** Right. So, what would have happened before is if it is that parents are having difficulty with their child, before they had an opportunity to come to the court and say, “I cannot control my child” and the court will deem the child as beyond control. With the passage of recent legislation the Family and Children Division Act that has since changed, which was passed in May 2017, they are now referred to as children in need of supervision. So when they come before the courts, the courts then have to assess the reason for the children’s behaviour and then make recommendations to treat with whatever the catalysts for those behaviour instead of just deeming the child beyond control without any type of assessment by all the professionals that the child may need to see. So that is what happens now, that is the transition period that we are in right now.

**Mr. Chairman:** Thank you very much. A follow up now from MP Newallo-Hosein.

**Mrs. Newallo-Hosein:** Just a follow up on that comment that you made. You have the courts assessing the child, but does anyone assess the home to determine
whether the problem emanates from the home?

**Ms. Noel:** Well generally from me understanding, in order for a child to be assessed you have to assess the child’s home, the child’s environment, where the child frequents, the persons who have care and control for the child. So in assessing a child, you cannot assess a child by themselves. So in assessing a child to come to a particular conclusion, you must evaluate the child’s home and all the other factors and elements and the means of the child.

**Mrs. Jennings-Smith:** So, could you tell us the final evaluation? Okay. So, you have determined that a child is beyond control, what happens to that child, where is that child sent to?

**Ms. Noel:** Okay. Again, if it is the child is found to be unable to be controlled by their parent, we then have to determine why, and that could be anything, and based on that you make the determination.

**Mr. Chairman:** Thank you very much. The Chair has to come in here, and I would like to shift. The things are getting very interesting, but really we need to get some solutions crafted. It is determined that there is a problem in Trinidad and Tobago with respect to the mental health and well-being of children. It is determined, as certainly from Dr. Sharpe and Dr. Chatoor that we may not have the adequate quantity of professionals that will be required to treat with the issues for the 20 per cent of the children who may be so affected. It is determined and the assurance has been given by the Ministry of Health, by the Permanent Secretary and the Chief Medical Officer Dr. Parasram that maybe by June of 2018 if the plans are implemented, we can see a dedicated ward at the Mount Hope facility for the treatment of children. *[Crosstalk]* Well it is going to be a start. It is not yet determined that the St. Ann’s Hospital is unsuitable for children or may not be the best environment for the rehabilitation. So, I need to get the...
professionals to let me know why the St. Ann’s Hospital may not be the best.

But to redirect the line of questioning now and I want to bring in the Ministry of Education after the professionals come in. For the professionals, the psychiatrists and the psychologists, I would like if you give certainly me and members of the Committee a breakdown of the types of problems you see in Trinidad and Tobago which are experienced by the children population?

And to the Ministry of Education, the law says that everyone under the age of 16 should be in school, and we are dealing with your members, we are dealing with your charges. Within the school system you have the guidance officers, the school counsellors, the social workers, what kind of input do these guidance officers provide in assisting the professionals in Trinidad and Tobago with detecting any mental health issues which children in the school system may be experiencing?

But from the professional perspective, the psychiatrists and psychologists, I need to get an understanding of the types of problems you commonly see when you evaluate children in need of care, mental care. The psychologists first, Dr. Chatoor.

\textbf{11.20 a.m.}

\textbf{Dr. Nakhid-Chatoor:} All right, so I am looking at priority disorders here and I would like just to break the children down into early, middle and late childhood, because they are disorders prevalent to these developmental periods. So, in early childhood we see a lot of disorders as regard learning disorders. So that children who are not doing well in school and who are brought in, let us say, for assessment, dyslexia, et cetera, they would have associative trauma connected with failing in school. So we have those learning disorders and also hyper-connected disorders like ADHD, et cetera. In middle childhood we see a lot of behavioural problems, conduct
Sixth Report of the Joint Select Committee on Social Services and Public Administration

disorders and so, and in adolescents—that is why I had to break it down into three—we see a lot of depression with associated suicide, substance abuse here, and a lot of psychoses which are resulting in a lot of maladaptive behaviours. So, dependent on the developmental cycle, I would say that there are different mental disorders associated with that.

Mr. Chairman: Can I get the people from the psychiatrists as to the various types of problems you deal with regularly?

Dr. Sharpe: They psychiatrists currently use the Diagnostic Statistical Manual 5 of the American Psychiatrist Association. So, our patients would be diagnosed according to that format. I agree with doctor in that, you know, some disorders are more common at different times of the years, but certainly disruptive and the more impulse controlled disorders are common in mid and later childhood and early adolescence. We have children who have neuro developmental disorders which include things like attention deficit cycle hyperactivity disorder, which is very common and which typically represents in mid childhood, but can sometimes now be diagnosed until later depending on whether the child has been labelled “beyond control” because of the behaviour. And when I say labelled “beyond control”, quite often by their parents or by their teaching, not necessarily by the school system. Children who have mood disorders, and mood disorders can occur in mid and early childhood as well as in adolescence, so that one of the big problems in adolescence is non-suicidal self-harm as well as children who are, in fact, making suicidal attempts.

We also have children who have anxiety disorders, and anxiety disorders come across the age groups, children whose disorders are the result of trauma and stress, and at the moment we have a lot of children in Trinidad and Tobago who are not even recognized as being traumatized because they are the children of murder victims and children who are the victims of domestic violence. We know that maybe
68 per cent of children who are living in households where there is significant domestic violence will also be physically abused, or certainly may be neglected, and we also have to deal with the issue, although it is not a formal psychiatric diagnosis, it certainly in the DSM is recognized as a condition that needs psychiatric attention, and children who are abused and neglected and these are a large segment of the population, and that includes all kinds of abuse and negligence including child sexual abuse. All those children need care and attention.

Mr. Chairman: Thank you very much, Dr. Sharpe. So that they need care and attention and they will need it from professionals, so I await the response from the Ministry of Health with respect to the professional needs which the Ministry of Health currently requires to address these issues so that we can make some progress in mitigating this problem.

Now, but very important to the Ministry of Education—the Ministry of Education is discharged with the education of children, but teachers act in loco parentis when the children are in school, and I would like to know from the Ministry of Education, as the first responders—the Ministry of Health is the second, of course—are teachers at all trained? Are they given any kind of training to recognize whether a child may be experiencing some of the problems raised by the professionals? Are social workers trained to do that? And do they do it? Are the school guidance counsellors trained to recognize a child who is at risk and who may need some kind of professional counselling? Is that done? And if it is not done, should it be done? Ministry of Education.

Mrs. Baptiste-Simmons: Chair, I would like to ask Ms. Amanda Pedro to lead off with respect to the response.

Ms. Pedro: Good morning, Chairman, and all members, I am Amanda Pedro, Guidance Officer II, presently assigned the duties of manager of the Student Support Services Division. As the PS indicated at the beginning, the Student Support
Services Division was instituted or established so as to provide that support for students for holistic development. Listening to Dr. Sharpe, we hear the list, the numeration of all the possible concerns. I would just put a context that at the Ministry there may be as many as over 400,000 students that we have in our care. And at Student Support Services we have various models to prepare for the need, and one of the models we used is that perhaps 15 per cent would be at risk, those that Dr. Sharpe has indicated. And 5 per cent with really—5 per cent of targeted need for counselling or therapy.

You asked about the training, the Student Support Services provides training sensitization for teachers. The Teacher Development Division also provides more intense training opportunities during the July/August, and the staff at Student Support Services, that is the guidance officers, the school social workers, and what was not mentioned, the term, special education teachers, all provide in the districts, the educational districts and at the school level, opportunities for sensitization for the needs to detect and refer to the internal staff at SSSD. We also have clinical psychologists. We have five clinical psychologists and a team of behavioural specialists to assist us internally.

Mr. Chairman: Okay. Thank you very much, but we need the professionals who deal with children on a daily basis with these mental issues to indicate—we know that the courts refer children to you, but are you satisfied that the referrals for the other group of children who may not be involved in criminal behaviour or with any infractions of the law, whether the school system can play a greater role, or is it that you are satisfied with the role of the guidance officers and the school staff in referring the students to you? Professionals at the psychologists/psychiatrists, do you think that they could do more, or is it that there is nothing more they can do? Yes, Dr. Chatoor.

Dr. Nakhid-Chatoor: I was just going to say, in response to your question I think
that the education sector provides a lot of services for children with mental disorders and mental health care needs. And one of the things I had mentioned before is that whilst we see the referrals coming to the paediatric doctors and so to these for the provision of services, there is no follow through.

You quoted a study in 2000, Dr. Mahabir, about an action plan, and that is kind of archaic and outdated, because we have 17 years and into that mix we have the advent of social media which has brought its own issues and its own concerns with children, cyber-bullying, online bullying, things like that. So, it is a kind of cocktail mix. So, I think that children implode, they implode a lot, and a lot, as Ms. Pedro said, a lot of these disorders and these mental issues go undetected and unnoticed. When we look at facilities however, I believe that there are not enough facilities, let us say for day care, treatment of these children. Whilst there are services and whilst I think the Ministry of Education provides a lot of services, because we have guidance officers, we have the psychologists, we have the child guidance unit, things like that. We do not have places where children can go just to talk about issues.

As a psychologist, I have found what works well with children and adolescents, are services like group therapy sessions, because children sometimes do not want to talk with one on one only, they want to talk with their peer group, and I think this works well. I just want to mention here that, for example, the Ministry of Education have something like learning centres or homework centres, and these, I think, could be an excellent base if they are brought back for group therapy sessions with children. But we do not have facilities and enough personnel to deal with this.

**Mr. Chairman:** Okay. So to answer the question that I had posed, is that the support staff at the school system, the guidance officers, the social workers, do you think that they are doing an adequate job in identifying at-risk students so that there can be treatment at an early level? Because at one point in the discussion it was indicated...
that many children go undiagnosed, and if it is that they go undiagnosed, clearly they have been slipping through, there are professionals who not seeing them. The question is, can the school system do more since all children are mandated to be in school? And if they cannot do more what could be done to ensure that they actually do more in sending the at-risk students for the treatment that they need at an early stage?

Dr. Nakhid-Chatoor: And I do not think this has to do with the quality of service provided by school personnel, because many of them are professionals. I think it has to do with the understaffing and the lack of sufficient personnel to determine. Because you said they slip through the cracks, and children do, because you have—and I think the Ministry of Education is better poised to give you that here. You have one psychologist or one guidance officer dealing with two and three schools and, again, it is the understaffing or the lack of personnel within schools to deal with the issue.

Mr. Chairman: Ministry of Education, is it possible for you to send to the Committee information on the number of students over the last five years—I do not know if you collect that data—who were identified by your guidance officers and social workers, and referred to the various agencies for assistance with mental illness?

Mr. Seecharan: Yes, Chair, we will do that. But if, with your permission, you spoke about whether the service provided by the Ministry is adequate in terms of identification of students in the context of those who may be falling through. We have recognized that one of the challenges we have is in terms of that initial screening which can highlight challenges students have and those who need support, and we are actually currently working systemically towards—it is our intention within the next two or three years to have all students in primary schools undergo that first basis screening.
We also recognize that there are some issues related to staffing and the number of persons who could adequately address some of those needs, and we are actually addressing that, but financial constraints given. But we are trying to complement the screening and the service that we provide by looking at staffing issues within the Ministry. So that we are aware that there are some gaps, and there are a number of students, as you indicated, who we miss. One of the areas where we can certainly benefit from additional support is in terms of those students who we identified for following up services. That is an area where we have some challenge in terms of once we identify, and usually it is the ones with the more severe symptoms. That service I think is important for us.

**Mr. Chairman:** Thank you very much, Ministry of Education. According to Ms. Pedro, your Guidance Officer II, I think she indicated that some 5 per cent of the school age population may be experiencing some acute mental disorder. Now, if the figure you told me is 400,000 students within the school system, 5 per cent would be about 20,000?

**Mr. Seecharan:** Can I just correct that?

**Mr. Chairman:** Yes.

**Mr. Seecharan:** The primary and secondary schools based on our data that we currently have it is more in the vicinity of 225,000, and the ECC centres we have about 36,000 to 38,000 students.

**Mr. Chairman:** So, maximum 250,000?

**Mr. Seecharan:** Yes.

**Mr. Chairman:** So if we are taking 5 per cent of that, that would be about what, 5,000 children?

**Mr. Seecharan:** It could be in that vicinity. However, as I said, we recognized currently that the numbers we are getting based on either diagnosed or suspected, may not be picking up all the students. So that as we move ahead in terms of
strengthening our initial screening process and putting systems in place we expect
to get a truer reflection of what exists.

**Mr. Chairman:** Okay. Let us just assume numbers, 10,000 students, according to
the 5 per cent, whatever the population is, I simply would like to know of the 10,000
students within the Ministry of Education, how many of these? And these are
students not with the mild disorders that Dr. Chatoor spoke about, but they have
serious problems. I would just like to know whether your officers are trained, or
should they now be subject to some kind of training? Preliminary training so that
they can identify the bulk of this 10,000 students. These, of course, because what
Dr. Chatoor said is that some of these students suffer from disorders that can lead to
some really serious outcomes. So that I would like to know how many of these
students were referred and whether in fact there is a gap there between what your
officers are doing and what in fact they can do to identify the 5 per cent seriously
at-risk students within the school system.

**Mr. Seecharan:** Chair, you spoke about training first, and that is an ongoing process
within the Ministry of Education. We have leverage and various training
opportunities, top skill—our staff, and as I said, that is ongoing. One of the things,
and the area that we are addressing currently is, I guess, financial constraints force
you to optimize and maximize efficiency. So, we are currently looking at how we
can reorganize services that we provide so that we can become more efficient. In
terms of giving you a figure, I am not in a position at the time to—

**Mr. Chairman:** I perfectly understood. You see we are trying to identify the source
of a problem which has existed in Trinidad and Tobago for quite a while, and what
was indicated to me at another committee is that the people who are suffering, not
only children, with mental illnesses are usually identified by lay people who think
that maybe a person should be—it does not have to be a psychiatrist or a psychologist
who will suggest that this is an individual who needs treatment, the people they live
with, and in the case, and that is why I mentioned teachers and the officers in the school act as parents in situations where parents may not be identifying the problems, I simply was inquiring as to whether the Ministry of Education sees a role in this area so that it can pick up the 5 per cent indicated by Ms. Pedro.

**Mr. Seecharan:** Absolutely, Chair. I just wanted to comment, because in an earlier contribution we tried to establish numbers of specialists, those persons who would provide the service. In the Ministry of Education, mental health is one area along the spectrum that we treat with, and there was a whole list of areas that we saw. So that a layered approach—so when we spoke to basic screening it is really starting from the level of the teachers at the schools and parents in terms of providing them with ongoing training and support in terms of that early identification. We have established school-based teams who will then look at these cases that teachers may identify or suggest there is a problem, and then we have another layer where depending on that discussion, we have what they call special education persons or student support services personnel who can now intervene and determine whether—some of the things, as I said, lie along a continuum, and therefore suggested strategies and intervention can take place from the level of the teacher in the classroom. Really, it is those cases which require professional treatment are brought forward, and therefore in the consideration of the number of persons and the personnel required, I think it has—so we have to look at it in terms of the strategy at what level do we need the specialists, and we refer students outside the system as opposed to those who we need within the system.

**Mr. Chairman:** Yes. Thank you very much Chief Education Officer. [Crosstalk]

We have two follow ups.

**Mrs. Jennings-Smith:** I really want to ask some serious questions here. Because, you see this morning we have been talking a lot about 5 per cent and world standards and stuff like that. I want to be real here. I asked a question to Ms. Noel about the
number of cases that were brought to you, and you told me 360 persons over two and a half years. I want to ask the Permanent Secretary and the Chief Education Officer, tell me what systems you have in your schools? Because I asked a question before, eh, and I want you remember these questions I asked. I asked what is the definition of beyond control, and then I heard you speak, and you quite correctly spoke about the continuum of behaviour with children, and I want you to tell me, tell me in numbers, 100, 200, 300, do not give me no percentage. Give me in hundreds, how many children in your school system have been identified as mentally-ill children, or sent to the Children’s Authority, or sent to the courts and have been determined mentally-ill children? I need to get that figure in numbers.

Mr. Chairman: The question is a simple one from the member, she wants to know the amount in terms of a number that was evaluated.

Mrs. Jennings-Smith: And I can make it easier. Separate children who have been determined beyond control and children who were deemed mentally ill? The numbers.

Mrs. Rodriguez-Cupid: Okay, I am Leticia Rodriguez-Cupid, special education teacher, currently assigned duties of coordinating special education services. From the current—just to be very direct, the current referral data, this is students who are currently referred to student support services, the cases falling under mental health issues would be about 243. The numbers I have exactly is 243 students who we are currently treating with in terms of mental health. A large percentage of those have been diagnosed with ADHD. Fifty-four of them at this time have been diagnosed with various emotional behavioural disorders. We do have a number of other students who may have what we call, home morbid disorders, which will include ADHD, emotional behavioural learning disabilities. That number is not disaggregated, but that number is a lot larger, 476.

Mrs. Jennings-Smith: Mr. Chairman, so, therefore, I want to be practical and real,
because we are in Trinidad and Tobago today and we are in a particular situation financial-wise, and I heard the Chief Executive Officer make mention of that. Chief Education Officer, sorry. And I also heard reference being made to, we had to maybe wait until 2018 when we could advertise positions, to fill positions to deal with the situation at hand, and I want to know, bearing in mind what we have right now, because are we certain 2018 could facilitate the paying of salaries for these additional staff? Bearing in mind who we have and what we have right now, what plan is being made to deal with the situation at hand now? Because this is not a situation which is beyond doing. It is a very doable situation. But how are we looking at the situation at hand and making an effort or an attempt—or do not tell me a study, because that would be the next two years—to deal with this situation with these numbers at hand? Because Safiya said she had 360 and she ended up with 137 needing attention, the school system gave me even a more realistic figure. So now I am talking to the heads. I am talking to the President of the TTAP, I am talking to the Chief Medical Officer, and I am talk now also to the Chief Education Officer, tell me what can we do now to deal with the situation at hand given our present economic challenges in this country?

**Dr. Nakhid-Chatoo**: I would like to address that, MP Jennings-Smith, and I want to be real here. You have asked a lot of questions that I do not think there is sufficient data. Only because for a lot of these action plans to be implemented there has to be policy, there has to be law, and that is where you people come in. Dr. Mahabir has talked about an action plan 2000, 17 years have gone by, and according to Dr. Maharaj, nothing, hardly anything has been implemented. We are here to review mental health care amongst children and adolescents, hopefully to devise action plans, and hopefully so that some kind of policy and laws are implemented. The bottom line, and I am being real here, we do not have people to document. Documentation is important. Secondly, we do not have personnel in the schools and
in I imagine other professional services to provide the kinds of services needed for children. That is the real situation. I do not know if anyone else can.

**Mr. Chairman:** But here is something that has just come to hand. We are seeing a major slippage between the data presented by MP Jennings-Smith, and the fact that Ms. Pedro has indicated—MP Jennings-Smith, that 5 per cent of the student population may be in need of some major intervention. The 5 per cent amounting to 10,000 or 20,000. I am wondering from you Dr. Chatoor, whether in your opinion a module can be prepared by you and people in your profession, to train the social workers and the school guidance counsellors in early detection. This is a troublesome issue, but in the medical field there are paramedics who are there to deal with a patient on accident, and a doctor looks after him afterwards. Is there a module of training that you can offer to the school guidance officers and to the teachers of Trinidad and Tobago so that they can identify at an early stage the children who may be most at risk so that there is early diagnostic and early treatment, and in that way the problems do not exacerbate and continue into adulthood? Or is it that you cannot do that, such a training module cannot be created?

**Dr. Nakhid-Chatoor:** In 2011, Dr. Mahabir, the Association of Psychologists proposed a plan to deal with all that you have said. The reality was that no moneys were allocated and no approval given for trauma centres or anything where children were concerned. In 2011, six years have gone by, and you are asking us now, can we come up with a plan? A plan that we have done before, a plan that we have proposed the Government before—

**Mr. Chairman:** I am not asking you to come up. I am asking you as a professional.

**Dr. Nakhid-Chatoor:** Yes, we can.

**Mr. Chairman:** So, you can—

**Dr. Nakhid-Chatoor:** Give us the money and we can.

**Mr. Chairman:** You can take the psychologists—the school guidance counsellors
and have them in a session for two hours, and you can train them to identify—
[Crosstalk] I am looking at practical things. In two hours you can give a module.
You see, as an old educator myself, I know what is possible and what is not possible,
but can you offer that rudimentary training so that having undertaken that course
with you they would be better prepared to identify. There may be one guidance
officer in their school population, they may be in a better position simply to identify.
Because you see, MP Jennings-Smith raised a very valuable point, only 300 students
or so seemed to have been diagnosed, and clearly there is a problem. I am seeing Dr.
Sharpe coming on, but I would ask Dr. Chatoor to co—
cept and then the psychiatrist, Dr. Sharpe, to come in afterwards.

**Dr. Nakhid-Chatoor:** I am hearing my colleagues around the table. These people
are professionals, Dr. Mahabir. They have been trained in techniques. I think they—
whilst we can do a good job—can also train their staff.

**Ms. Pedro:** Yes, we do.

**Mr. Chairman:** But if it is that that is the case, why is it only MP Jennings-Smith
numbers are coming up, 300 and something patients. You see, the question that is
coming to me is this, according to Ms. Pedro, 5 per cent of the students may be at
serious risk, are we picking them up? If we are not, why?

**Mrs. Jennings-Smith:** But, Mr. Chairman, based on what is she saying that? What
is the evidence to say that?

**Ms. Pedro:** Excuse me? Excuse me?

**Mrs. Jennings-Smith:** Yes.

**Ms. Pedro:** The model I am explaining suggests that the students, 5 per cent may
have serious needs that require intervention. They may not be all mental health care.
Some are environmental situations but they require our intervention. So I am saying
that when the student support services was set up, it was set up for us to have that
awareness of sensitization to teachers and parents to be able to meet those needs. So
there will be a discrepancy, but it is, to my mind, a very important figure to be aware that they are children under environmental factors, social challenges that require intervention.

**Mrs. Jennings-Smith:** May I ask a question?

**Mrs. Baptiste-Simmons:** I am going to ask the senior social worker to intervene as well.

**Mrs. Newallo-Hosein:** Before you intervene, I just want to ask a question. The low figures that we are seeing here, is it that parents must give consent?

**Ms. Pedro:** Yes, privacy. Correct.

**Mrs. Newallo-Hosein:** So, therefore, is that reflective of the low figures, because parents have not been consenting?

**Ms. Pedro:** Now, we cannot say for sure, but certainly that is a factor because there are privacy concerns.

**Mrs. Newallo-Hosein:** Okay. And the next thing is that, understanding that teachers are being trained and so forth, but understand they are there obviously, but what initiatives have been taken by the Ministry of Health and other stakeholders to improve public awareness of mental health illnesses affecting children and adolescents, so that even the public could be aware and they could bring it to the forefront? You know, what is being done to bring public awareness?

**11.50 a.m.**

**Ms. Pedro:** Sen. Newallo-Hosein, if you would allow the social worker to address it because we have been taking a social marketing approach and she would have some valuable insight there.

**Mrs. Francis-Gaines:** Good morning, Chair and Committee members, Sharon Francis-Gaines, Social Work Specialist. During the period of 2012 to presently, the social workers have been receiving referrals from students. We have received approximately 563 referrals from students with behavioural, sorry, self-harming
behaviours and I have the data available. It is broken down between self-mutilation, suicide ideation and suicide by stress and it is broken down into the districts. When we saw the data, we recognized that a greater percentage of the data represented suicide ideation. As a result of that, we took an initiative where we decided to develop a strategy, an intervention because we recognized that it is a community approach as much as it is a mental health issue.

In providing a community approach we reached out to Ministry of Health, a number of our stakeholders, members from the OPM, Office of the Prime Minister, Gender and Child Affairs, we met with a couple of the stakeholders and we discussed the gap that has been identified, questions as to why our students are not reaching out. Why are they not talking? Why are they remaining among themselves, they are searching the Internet and they are getting information on self-harming behaviours. What can we do to intervene?

As social workers we have gone into the community, we have met with the parents, we have done home and family intervention and assessment, and we also felt that the parents were also keeping a lot of issues to themselves because they were unable to share. In some cases, they were challenged within terms of getting assistance; in some cases they really did not know how to. As a result of that, when we recognized that a percentage of the students were actually using the social marketing we decided to run a Social Marketing Campaign at the Ministry of Education as one of the outline strategies. With the Social Marketing Campaign, it began on November 25, 2016 and out of the data we identified approximately 25 schools—I need to check the data exactly of the number of schools—and from the schools we identified students who were willing to share preventative measures with their colleagues through social marketing and art work.

Mr. Chairman: A follow up on that, because something is very unclear to me. What is unclear to me is this, you see Ms. Pedro indicated that—and it is an international
law I would imagine, 5 per cent of the student population experiences some major mental illness or some major—

**Ms. Pedro:** Not mental illness, but challenge.

**Mr. Chairman:** Some major challenge, yes. And I just would like to know of the 5 per cent experiencing this challenge, how much of the 5 per cent is identified by the social workers and the school guidance officers in the school system. Is it 1 per cent, 2 per cent or do you identify the full 5 per cent?

**Mrs. Francis-Gaines:** It is an integrated approach in the sense that the initial screening begins at the level of the school with the guidance officers because there are guidance officers present at most of the schools in terms of the ratio. When the screening begins the referral comes to the MDT, Multi-Disciplinary Team, in most cases and it is different for primary and it is also different to the secondary in terms of the treatment. We meet and at the meeting, through the conferencing the assessment is done and a decision is made as to the persons responsible for certain aspects of the intervention. If it is home and family—

**Mr. Chairman:** That is your process; that is your procedure. I would like to know of the 5 per cent, really, the 5 per cent, let us say would be 100 students in a school, it is a large school. Of the 100 students who are experiencing that major problem, mental or problem, how many of them are picked up and how many of them are undiagnosed, because that to me seems to be the problem. If you are able to identify every one of the 5 per cent then you have been able to identify and then it goes through the process. But if you are only picking up 1 per cent then it means 4 per cent of your acute patients are undiagnosed and I really would like to know, what is the rate, realistically, you think that you are able to identify from the practice that you have? Because that is going to then flow, you see, to the Ministry of Health; from the Ministry of Education to the Ministry of Health to the Psychology Department to the various services. So I need to get that figure. Are you identifying
your full—I am not talking about the other 15 per cent who have mild problems, the critical 5 per cent, how much, 1 per cent, 2 per cent or is it that you are satisfied that you are identifying the full 5 per cent of those students with major challenges? Straightforward question, I need a straightforward answer.

**Mrs. Baptiste-Simmons:** Chair, I understand that you need definitive, you need data and you need for us to be clear. But looking at the information provided, it has been disaggregated but when I looked at it there are gaps.

**Mr. Chairman:** Yeah.

**Mrs. Baptiste-Simmons:** Yes. We have quite a lot of gaps. In certain areas because—for example, if it is in the Port of Spain area, because it is a referral and it is a case basis, you find that the data may be more reflective of what is happening in our school system. As we go down, for example, if I pull a district, North-Eastern, I am not seeing the type of information that will—right—because whilst this is provided across a category there are too many gaps. So at this point what it needs is that, we need to be able to definitively see, as the CEO would have indicated, the screening must be done because most of our students support is by referral. It is not where we screen and we detect or we have teachers who are referring the information. It is those cases that come up to us and we see a need to respond, we respond. So it means that our system needs to be relooked at and our data collection has to be—

**Mr. Chairman:** Thank you very much Madam PS. That is certainly, certainly, I think the practical way to go. The first responders in my mind ought to be the employees of the Ministry of Education and the question that I had posed to Dr. Nakhid-Chatoor I did not get a clear response and I like clear responses to my very clear questions and that is, do you think now as PS that your teachers, the teachers who are employed by the Ministry and who deal with the children on a daily basis, the social workers and the guidance officers will benefit from some kind of exposure
where they would be able as part of their job description and they are trained now to
discharge that function, to identify so that we can screen as early as possible the
majority of the critical 5 per cent and hopefully with the progress of time we will be
able to catch maybe more and more of the 20 per cent? Do you think your officers
will benefit from that? If not, well they would not, then we find another mechanism.
If they can, then maybe that is a solution that we could start to implement without
looking at any grandiose plans; certainly things we can do at the school level on the
ground so that we have a throughput that we send to the Ministry of Health because
the Ministry of Health would be preparing itself to deal in time with the throughput
but you cannot have all the professionals in the Ministry of Health and the people
who are in need are not being identified at an early stage.

So I would like to know what your plans are and maybe you can put it in
writing, you can discuss with your technical officers, discuss with your social
workers, your school guidance officers as first responders, the teachers on whether
in fact this is a programme, because what Ms. Pedro has indicated to me is a
worrying statistics. Twenty per cent in general suffering from some kind of disorder
or some kind of problem, but 5 per cent being acute and we want at least at the
beginning to pick up the 5 per cent. And I think we cannot rely on others outside the
school system only. I think the school system should play a role because in law—in
law, as you know the education Act says, the teacher and the principal will act as
loco parentis in the absence of the parents when the children are under their charge.
So I think it is something that I direct to the Ministry of Education, how you are
going to address this issue of identifying more and more the 5 per cent that is at risk.

Mrs. Jennings-Smith: Mr. Chair, I just want to say as you are on the 5 per cent, you
see it is a danger when we play with statistics and percentage and numbers and before
we present and we generalize after based on a basic assumption, on a part study, we
run into wrong calculations and assumptions. That is why I am concerned this
morning when I saw the submission by the Ministry of Health and I want to really question, you know, what was the population used to come up with this particular—

Mr. Chairman: Okay. MP Jennings-Smith, I have to intervene here. We will look at the statistics and look and see whether they conform with international norm, but MP Newallo-Hosein has to leave and once she leaves we will not be quorate but we will continue taking evidence, of course, with the leave of committee members, we will continue with the taking of the evidence. So, MP Newallo-Hosein you can pose your final question before you leave and then we will continue taking the evidence.

Mrs. Newallo-Hosein: Thank you, Chair. My apologies that I do have to leave early, but just to ask the question and that is, Dr. Mahabir had indicated earlier in the statement that the children are taken to—who are being evaluated, they are taken to the forensic department in St. Ann’s. And I am wondering, is there a psychiatrist or psychologist on site at all times, 24 hours a day? And if not, how long would the child be required to wait to be evaluated? So that determines really how long the child remains in an environment that is not healthy. And if there is a case of concern, would the Ministry consider looking at the Couva Children’s Hospital as a facility for the treatment of children with mental illness.

Mr. Chairman: Dr. Maharaj you can come in, yes.

Dr. Maharaj: Yes. Member Newallo-Hosein, I think she called me Dr. Mahabir. It is Dr. Maharaj, rather.

Mrs. Newallo-Hosein: Sorry, Dr. Maharaj. My apologies.

Dr. Maharaj: The employ of forensic personnel, like forensic psychologist is not at all 24 hours. It is usually 8.00 to 4.00 and we try to get an assessment done two weeks or less once the child is admitted. So that is how we have been operating in the past.

Mrs. Newallo-Hosein: So therefore, the child is in an environment that is basically unhealthy because the child is among adults.
Dr. Maharaj: I think you said it correctly, yes.

Mr. Chairman: Very well. I see Dr. Ramtahal wants to make a contribution.

Dr. Ramtahal: Yes. When the child is admitted—we have doctors on call 24 hours at St. Ann’s. So the child will be seen on admission by a house officer, a junior doctor and then by the next day or morning he will be seen by a specialist. But as Dr. Maharaj said, we have been reluctant to accept the children since Dr. Vince had decided—he has resigned now—but he had decided that we had no child psychiatrist there now. As such we were not in a good position to write reports on children to the courts. So at this stage, we have not been doing the children sent by the courts. We have asked them to not send them there. But to answer your question, yes, they have been mixing with the adults in previous years, yes, and that is not ideal.

Mr. Chairman: Okay, very well. Thank you, MP Newallo-Hosein. You are excused.

[Ms. Newallo-Hosein exits the Committee room]

Mr. Chairman: MP, do you have a further question.

Mrs. Jennings-Smith: Well, I really just made a statement because I find that, you know, we are going along a line of the 5 per cent and generalizing a study into another population and I feel it could be dangerous. So I think I just wanted to make a statement.

Mr. Chairman: Right, very well. Okay. Yes.

Mr. Seecharan: You asked earlier about training and whether the Ministry and the school personnel will benefit. Simple answer to that is, yes, and that is an ongoing thing that we have, but any support there will be welcomed. The other question you asked is about trying to close that gap between those we diagnose and those we miss. And the Ministry is in fact working on a strategy right now where the intention is after three years we will be down to screening every child at the level of Standard 1 in a primary school. So we are doing it on a phased basis starting with two levels at
a time. But the design is that, after we go through that and make our assessments that going forward every child at the level of Standard 1 will be screened and that will certainly impact on our ability to, first of all, assess the students who are coming through and any support that is needed that is going through the system. So there is a plan within the Ministry.

**Mr. Chairman:** Just to follow up with respect to the screening. The screening has to be done by individuals, of course, trained in screening. And are you satisfied now that if you get your full complement of school guidance officers and social workers that with the current skill set that they have they will be able to identify the at-risk students or do you think you need to consider how they are going to be further trained to evaluate these particular at-risk cases?

**Mr. Seecharan:** Ongoing training is certainly one of the things we are looking at, but you mentioned and I think we agree with you, that there is also a big role for teachers and school personnel to play in that initial screening. The current staffing we have and if we get all the positions filled will certainly augment so that if there are symptoms or signs detected in the classroom and those could manifest in many ways. It could be student performance, it could be behavioural, once that happens then there is a next level so that the student support services personnel do not necessarily have to, but we can train school personnel to do that early detection.

So we are looking at it in a systemic way so that some of those early detection, as I say, because it is along a continuum we can put strategies in place from that level, those who need further support from persons within the student support services or the clinical and behavioural and if it requires referral outside of the Ministry then we take it. So it is a multi-step, multi-layered approach that we are using. Certainly, we are looking at training. Currently, we have done some training so there are some persons within the system who can do that at the school level but we intend to have that training on a consistent and ongoing basis so that we have
enough persons at the school who can be involved in that process.

**Mr. Chairman:** Okay. To the PS of Education and the Chief Education Officer, I know there is always a close association between the Ministry of Education, the school principals and the community police where children who are displaying anti-social behaviour or unacceptable behaviour are referred to the community police for some kind of guidance before they take them to the court system. The Children’s Authority may be involved here, but I am simply wondering, is there scope for closer collaboration between the Ministry of Education and the Ministry of Health where one of the first professionals you call in is a psychologist at the Ministry of Health to have some kind of interaction with the child. Does it currently exist or does it not exist?

**Mr. Seecharan:** Let me deal with the community police. The community police and that partnership whether through the programmes that they run is one that we have been working with for some time and we are continuing to strengthen. I do not want it to be misconstrued that we are using the community police to address. We have persons within the student support services who would do that initial assessment and support. We work in partnership because there is a role for the community police—we are in fact working towards strengthening the relationship between the Ministry of Health and the Ministry of Education, not just in terms of mental health, for example, healthy life style, physical fitness. So that is ongoing and we will continue to engage and collaborate if there is need. So, for example, some students where we diagnose who may require psycho-eds, we may refer to Child Guidance Clinic or psychiatric support or in some cases we are trying to also utilize—we have some provision within our budgetary allocation to outsource some of these. So we do that when it is needed.

**Mr. Chairman:** So I am trying to get the process clear. There is a child who has been identified as at risk and in need of treatment. The school guidance officer or
the social worker will inform the school principal and does the school principal then inform the professionals at, say, Mount Hope psychology unit that we would like for you to evaluate this child, we think this child is at risk or does it go through a different—? You see I am looking at the collaboration, if any, which exists between the Ministry of Education and the Ministry of Health. Children suffer from these mental traumas all the time and going through the court system is one route, but going through the support system you have and a closer collaboration with the Ministry of Health,, do you think you would be able to minimize time and maybe secure treatment in a quicker way if the school guidance officers and the social workers are empowered to inform the principal that I think you should talk to the psychologist as soon as possible on this one?

Mr. Seecharan: Just to clarify, in terms of referral to the courts—

Mr. Chairman: Yes. Dr. Sharpe you will come in after.

Mr. Seecharan: There are incidents which require us to report—make reports to and those would go. However, in terms of the engagement with the student support services personnel it is a collaboration with—an incident may happen at a school or there may be certain observations the principal or staff member from the school will make a referral to the student support service, the guidance officer or the special-ed person. They will then do their assessment if required, they may intervene or if required they are the ones who really take it to the next level. So there is a clearly defined referral process with the Ministry.

Mr. Chairman: Okay. Very well. Dr. Sharpe wanted to make a contribution at this point.

Dr. Sharpe: I would like just to refer to the issue of referrals. Child Guidance Clinics, there is one in San Fernando, there is one in Tobago and there is one in Port-of-Spain. The one in Port-of-Spain serves the North-West, the North-Central and the Eastern Regional Health Authority. Children who have psychological problems
identified in schools are referred to those clinics. At those clinics the children have full psychiatric evaluations and treatment if indicated.

In 2017, the Child Guidance Clinic had 386 referrals from all over. Of those 386 who were interviewed for a preliminary interview, 284 of them returned for their psychiatric evaluation. Adolescent psychiatry, like psychiatry in general, is governed by medical ethics and therefore we have to have consent to do treatment. So parents can refuse the consent. Children, for the Child Guidance Clinic, we had referrals from the Ministry of Education, the Student Support Services Division and the Child Guidance Clinic work closely together and we have a system where children in primary schools who are referred to student support services, we then collaborate. It is not every child who is identified with a psychological difficulty that needs to have a full psychiatric evaluation.

**Mr. Chairman:** Okay. One follow up. Are you satisfied that the 386 students/children who were evaluated represent the best percentage you can find of the acute cases? Are you satisfied with that number or do you think—given your professional experience the number can be more?

**Dr. Sharpe:** That 386 include children who are not at school. And I want to really raise the issue that there are several children in Trinidad and Tobago who are not in school. They are not in school because they are underage or they are not in school because they have disabilities or they are not in schools because—they are not in public schools, they are in private schools because they have developmental difficulties that the general education system does not provide for.

**Mr. Chairman:** Right. That is understood.

**Dr. Sharpe:** And they are—excuse me, Sir, they are a part of a population that has significant mental health needs. That includes several children who are on the autism spectrum and there are institutions, not government institutions that are working with that population of children, but many of those children’s parents cannot afford these
services. There are private psychiatric services in Trinidad and Tobago that provide some service for some of the population.

**Mr. Chairman:** Okay. As a professional now, yes, it is my turn to speak, as a professional, I am asking you, of the number, very simple question, 386 identified, I know they may have been identified elsewhere, do you think that we are identifying the majority of students who need the care and the treatment or do you think we need to make much progress in identifying and detecting the children who are in need of this care? The question is, your experience is wide and it is vast, you have picked up 386 within a particular population, is that, do you think it is the optimal number or do you think we are missing a good bit? The answer is, either you agree we are missing or we are doing very well.

**Dr. Sharpe:** Yes, I think we are missing a segment of the population, but just to say that we need then to figure out why we are missing that.

**Mr. Chairman:** So then we will have to identify why we are missing.

**Dr. Sharpe:** Part of the population that needs to be screened are the children who attend the public health facilities. So there is developmental screening happening at the health offices. Part of the difficulty there is that there is a lack of professionals at the level of doing the diagnostic work.

**Mr. Chairman:** Right.

**Dr. Sharpe:** And if you screen and you do not have facilities to do anything more than screen well two things happen, people think, well why you are wasting my time.

**Mr. Chairman:** Currently you see, when I see a figure of 386 I think it is a really low figure and it does not justify the additional staff that you are speaking about. So clearly, could we get something in writing as to what the population of at-risk students who remain undiagnosed might be that will justify the increase in the staff that is warranted by the Ministry of Health. Dr. Nakhid-Chatoor you wanted to come in?
Dr. Nakhid-Chatoor: Yes, I wanted to say as I said in my opening remarks one of the key players in the provision of mental health services in this country I think it is the education sector. Teachers have become the line of defence by default. They are the ones who recognize, they are the ones who can recommend. So to that end, because still in Trinidad and Tobago there is a stigma attached to mental health. How many parents who know that their children have mental issues would seek help, all right, because, of course, it would be stigmatized? So I do believe that because of that, teachers have become first line of defence and they should be trained as you suggested to identify, because you said 5 per cent, let us look at that figure, I think it is less than 1 per cent that we are recognizing.

Mr. Chairman: Your experience is that we are identifying less than 1 per cent and that there is scope of further identification.

Dr. Nakhid-Chatoor: Yes.

Mr. Chairman: Your recommendation is that teachers can be trained to identify up to the 5 per cent.

Dr. Nakhid-Chatoor: At least to recognize and refer because they are not trained to deal with the issue—

Mr. Chairman: To recognize—

Dr. Nakhid-Chatoor: To recognize and refer.

Mr. Chairman: And you think that there can therefore be closer collaboration between the Ministry of Health—

Dr. Nakhid-Chatoor: There has to be.

Mr. Chairman:—and say your profession in identifying the at-risk students.

Dr. Nakhid-Chatoor: Yes, and in my opening I said there needs to be service integration between the education sector and the mental health services. That is a need.

Mr. Chairman: Okay. And right now you are saying that that collaboration does
not exist. What will you recommend therefore to the Committee as a possible solution, because you see my concern is the identification of all the students who are in need of care must be identified, well not all but the majority of them and you say that it is not necessarily happening. What is your recommendation to us and to the Ministry of Education?

**Dr. Nakhid-Chatoor:** The first thing we know is always public health education to decriminalize the stigma attached and that is necessary. I know the public health sector, I think stated this morning, that some campaigns are being done but I think that if we are looking at the first step that is a first step. We need also to really devise a child and adolescent mental health action plan. We need that, not a general action plan, but specifically geared towards children to establish our approach to care, to utilize all our means of treatment and to put that as a priority.

**Mr. Chairman:** Okay. Very well. There is a follow up and then Dr. Ramtahal will come in.

**Mrs. Jennings-Smith:** I have a question that I want to put to the Chief Education Officer. Are you satisfied that your institution is failing in its activity to identify children beyond control, mentally challenged children or are you satisfied that you have a promising programme that seeks to deal with the reality of the conditions and the economic challenges of our country? Tell me, are you satisfied? Are you satisfied that you are getting sufficient assistance from professional bodies, external professional bodies in your plan to deal with the situation at hand given our economic circumstances?

**Mr. Seecharan:** You have thrown a few curve balls at me. We recognize in the Ministry and I recognize, I guess it is something that we agree with within the Ministry that there are gaps in terms of students we are picking up. Based on that we have identified a strategy that early basic screening which we believe and if it can be rolled out the way we have it planned at least every child coming into the primary
school system at Standard 1 will be exposed to that initial screening and therefore we strongly believe that can contribute to closing that gap we have identified.

12.20 p.m.

The approach that is used by the Ministry of Education is not one which deals with mental health alone but with a whole spectrum, and therefore our approach to that early screening will throw up students who have symptoms associated with mental health to other learning disabilities or challenges.

I think we have a strategy that can certainly significantly improve our ability to provide the service that we are being asked to provide. I also am convinced in terms of the support that we need, because there is also—I think several speakers spoke to the follow-up, and there is certainly the need for us to get that additional follow-up in terms of students where we may not be able to treat with directly but who may benefit from another layer of intervention. Some of the specialists and experts may be outside of the Ministry.

One can always argue that additional resources and maybe if we increase numbers, will certainly contribute, but as a Ministry we have to plan within the budgetary constraints we have, and I think certainly, what we have on the ground now with the current reality will significantly improve what we are doing.

**Mr. Chairman:** Thank you very much, Chief Education Officer. You indicated to us that screening is going to start relatively soon from Standard 1 all the way up to the SEA exam level. We do not know when that is going to be rolled out, or implemented. The question that was posed—and I want to reiterate from MP Jennings-Smith—is, are you now satisfied that your staff is doing all it can to identify the students at risk? Or do you think that the staff in the Ministry of Education will now need to place some kind of priority on the mental illness of children, so that the numbers identified can be more realistic and reflective of the population of students at risk, I would imagine, in Trinidad and Tobago?
Mr. Seecharan: There are two things here: one, in terms of what we currently do and how we do it, certainly we can improve in terms of the detection and all of that. I think that with what we are planning to do, not separating, I think, and that is something that we need to look at in terms of strategy. It may not be practical for the Ministry of Education to focus on the needs of students by truncating mental health and the areas under that: special needs; learning disabilities. In other words, we have to start broad and identify the spectrum, the next level. And the next level of intervention as required can then put students into—so for example, ADHD, our strategy will identify students with ADHD or some other area.

So I do not think we need to change strategy in terms of how we are proposing to go forward but, certainly, that strategy will contribute to a higher level of identification of students who may need mental health support.

Mr. Chairman: Thank you very much. Dr. Ramtahal has one comment to make.

Dr. Ramtahal: I think some of these questions are difficult to respond to because I do not know of any country-wide epidemiological data on prevalence rates, or incidence rates of mental illnesses in children and adolescents in Trinidad and Tobago. So what is the benchmark? What are we measuring? How could we ask if somebody is succeeding at something if we do not know what are the baseline prevalence rates of these conditions in the first instance? So some of the questions are difficult to answer, really. In addition, we should be cautious about the figures we are hearing in the absence of those studies.

Mr. Chairman: Right. So we should start collecting the data. We should start collating the information because there are resource implications. The resource implications for the Ministry of Health, as indicated, is that there is the need for a number of professionals and we need to know that there is going to be the demand for them. So that it comes back to the initial position. It has to be that ground level staff are collecting the necessary information, doing the basic rudimentary
evaluations so that we could at least send for further evaluations to the professionals charged with that responsibility, the people who are most in need. Because what is of concern to me, clearly, is that there is a question on the figures provided by, say, Ms. Pedro, but without any contra-position that the figures may, of course, be less than that, or more than that.

So we do need to collect the data. We need to start at the school level since children are supposed to be in school, in my mind, and once we are able to get the professionals in the Ministry of Education to do the basic screening, as Chief Education Officer indicated, then, of course, we will understand and appreciate at the parliamentary level, the needs of the Ministry of Health and the needs of the Permanent Secretary and his Chief Medical Officer on how they have to gear up for this particular problem.

So may I just recommend, before I ask for closing comments, that the Ministry of Education seems to be the first line here. Children have to be in your institutions by law. The under 16, we ought to be in some form of education. Certainly under 12, we ought to be in primary school. That is what the law mandates. And therefore, we should be able to identify that captured group. Our professionals in the school system ought to be keenly aware of what to look for. I am not sure that they are.

Dr. Chatoor has indicated that they can be subject to some kind of treatment to make them a little bit more aware, so that they are able to identify more and more students who may be in need of care. And once we are able to do that, we will be able to address the concern of Dr. Ramtahal, and MP Jennings-Smith, that we need to get the data—the statistics—right.

We do have international standards, international norms. We hear one in five persons suffering from mental illness. Maybe one in five children are also experiencing that problem. This is just casual observation, so I think we do need to start collecting the data. And more important than the data, behind each datum point
is a person, a child in need and we need to identify those children in need because, as rudimentary as they are, facilities exist in Trinidad and Tobago. Once we are able to identify the children in need—and I think I look forward to the Ministry of Education starting their screening so we would be able then to really capture the group that is in need and ensure that the problems they are experiencing are not exacerbated.

So at this point in time I will ask in this particular order, closing remarks from the panel and then I myself will close with a few words. So may I ask the Permanent Secretary, Ministry of Health, to offer some brief closing remarks on the subject under inquiry?

**Mr. Madray:** Thank you, Chair, and Members. The Ministry of Health commits to continuing to work with the Ministry of Education, as we already do, with respect to the training and in respect of the referrals that we have received from the Ministry of Education and the services that we provide there. We will continue to work with them to more fully integrate with that Ministry, as well as other agencies, to ensure that the quality of our services improve.

**Mr. Chairman:** Ministry of Education?

**Mrs. Baptiste-Simmons:** The Ministry of Education recognizes as first responders that we are responsible for the data in terms of understanding, as was said earlier, in terms of the baseline prevalence rate; that we also need to disaggregate the data in terms of what was said in terms of primary, ECC; the learning disorders or conduct disorders that are at primary, ECC and mid-childhood into teenagers; that we need to understand what exactly we are treating with when we refer to mental health. We recognize again the collaboration that needs to—that we ensure collaboration between the various ministries as well as the Children’s Authority; that when we identify our children who are at risk that there is follow through; that clearly we cannot continue with the referral. We need to detect and screen and we need to have
an understanding within our system and plan effectively, as well as the resource allocations.

**Mr. Chairman:** Thank you very much, Madam Permanent Secretary. Director, Children’s Authority of Trinidad and Tobago?

**Mr. Benjamin:** Chairman, Hanif Benjamin. We want to take the opportunity to thank this Committee for allowing us—from the discussion it is clear that greater collaboration is a must. We believe that the people sitting in this very room can, in fact, solve the challenges that we are addressing today. There is a great crisis on our hands in terms of adequate placement for our children with mental illness and we need to come up with an immediate solution for those children. At the Children’s Authority there are a number of children in need of placement today and we need to collaborate to find a permanent solution to get this addressed. Thank you.

**Mr. Chairman:** Thank you very much, Children’s Authority. The President, Trinidad and Tobago Association of Psychologists?

**Dr. Nakhid-Chatoor:** Many of our policies and laws are not fully in line with international human rights instruments. Implementation is often weak and persons with mental disorders and their family members are frequently marginally involved in their development. The Trinidad and Tobago Association of Psychologists will continue to work with these groups of children and family members. However, let us put into place a mental health action plan for our children and adolescents, because after all, they are the most important asset of our society. Thank you.

**Mr. Chairman:** Thank you very much, Psychology Association. I have come away from this hearing/knowing more than I knew before, and the reason we conducted this public inquiry is that we looked at, in the past, the mental illnesses of people in Trinidad and Tobago and then as we inquired we found out that children provided a special case—a special case, because we did a public inquiry prior on bullying in schools and it came out at that inquiry—it is now on the public record—that bullying
can lead to serious mental problems, sometimes even suicide. The curriculum of the school, sometimes can, in fact, cause much anxiety. So this is for the Ministry of Education to address, that we do have within the school system itself, schools can be a stressful place and we would want to ensure that children are able to cope and to handle the stress.

In that context, I think as first responders, as Madam Permanent Secretary indicated, there is a need for the first three first responders: social workers; school guidance officers and the teachers who are on site for the entire day with the children, be trained to monitor and evaluate simply as observers so that they will be able to identify, as first responders, children who may be having some kind of problems. It was indicated by Dr. Chatoor that is possible. That is a solution. It is possible to catch as many of the children who are at risk, as possible. I think that is the interest of the Children’s Authority. Let us try to catch as many of the children in need so that we will able to have early detection and we then provide the necessary treatment as we go along.

Once we catch, then we know that the demands will be placed on the Ministry of Health for the professional staff complement as indicated by Dr. Sharpe. But we cannot know unless, as Dr. Ramtahal and MP Jennings-Smith indicated, what the numbers are. So all will go back to the Ministry of Education to a large extent to indicate to the general population what they are picking up in the school system and the referrals that they are sending to their health professionals in the Ministry of Health. From the Permanent Secretary and the Chief Medical Officer in the Ministry of Health, it was indicated that by June of 2018 discussions are underway.

We have been able to secure many things in this Committee by putting timelines, and you will find that you would not get away with this Committee when we are vague and nebulous. We want a timeline on things which are reasonable.
Things like life certificates, and so on, for the elderly, we are putting timelines to get rid of them. But with respect to a dedicated ward, I think the health professionals: Dr. Maharaj, and Dr. Sharpe, and Dr. Chattoor and the Psychologist Ramtahal, have all indicated that children with mental issues should not be mingling with the adult population. They form a separate and distinct community and we should be able to treat with them in an environment that is more amenable to their health and well-being.

So, by June of 2018, we expect maybe at the Mount Hope facility, maybe at the Couva facility—there are many facilities out there, the professionals will determine what the best site is so we have a dedicated facility for children. People may say four beds may not be adequate, but it is four more than currently exists. So that let us start and see whether we can have a dedicated facility, since it is accepted that the St. Ann’s facilities may not be the best available for the treatment of children.

Dr. Sharpe has indicated that there really is a need for more professionals. We would need to identify what they are. Knowing that the problem exists, we would need to identify what these professionals are and we can start the process of manpower planning so that maybe five years down the road it would take—maybe in the medical field—about six years to get a specialist on service. So maybe six years down the road we should gradually have the complements that we need.

And we know that there is a need for closer collaboration between the Ministry of Health, the Children’s Authority, the Psychology and the Psychiatrist professions, and once we have that collaboration, maybe this forum might be an ideal way to exchange email addresses so that you will be in contact with what is happening on the ground in the various sub-units that you have, and therefore we will be able to ensure that we share the information to treat.

At this point in time before I close, I would like to advise that the Committee’s Fourth Report on an Inquiry into the prevalence of sexually transmitted diseases
(STDs) among school students and into the general services administered to treat STDs in Trinidad and Tobago, will be presented in the House of Representatives this Friday, November the 17\textsuperscript{th}. The Report will be available for review on the Parliament’s website after it is presented in the House. So out of the deliberations of today’s meeting, a report will be presented, tabled in Parliament and you could be sure that there will be follow ups with respect to the progress.

This morning has been a learning experience for me and Committee members, I am sure. It has been one where we are seeing a problem and we are recommending solutions. We cannot fix all the problems at one time but I think there are certain problems which we can fix. Early diagnosis, to my mind, is the first stage in solving this problem and I leave it to the professionals who are charged with this particular—solving this problem—to handle this issue so that when we have a follow-up meeting we would be able to issue progress reports on where we are with respect to at least diagnosing and then treating the children of mental illnesses in Trinidad. So that the Parliament of Trinidad and Tobago, while the Members are voted by those who are 19 and over, the Parliament will be responsible for those who are 18 and under, and we are sending a message to the next generation that we are here to serve them as well.

This meeting is now adjourned. I thank you all for your participation. I thank members of the public, members of the media and all those who take a keen interest in the deliberations of the work of this Joint Committee on social services.

I thank you. Good afternoon.

\textbf{12.37p.m.:} Meeting adjourned.
Appendix IX

Disaggregated data on children recorded by the Children’s Authority with mental disorders/illnesses
The following overall and disaggregated data was extracted from these 360 treatment plans. Table 3 shows the age groups and Table 5 indicates the disaggregated data that was provide by the Children’s Authority in their submission as it relates to the prevalence of mental illnesses amongst children and adolescents.

**TABLE 3: AGE GROUP OF CHILDREN RECORDED BY THE CHILDREN’S AUTHORITY WITH MENTAL DISORDERS/ILLNESSES**

<table>
<thead>
<tr>
<th>Demographics</th>
<th>0-3 years</th>
<th>4-6 years</th>
<th>7-9 years</th>
<th>10-13 years</th>
<th>14-15 years</th>
<th>16-17 years</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>4</td>
<td>7</td>
<td>5</td>
<td>26</td>
<td>11</td>
<td>10</td>
<td>63</td>
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<tr>
<td>Female</td>
<td>0</td>
<td>4</td>
<td>7</td>
<td>12</td>
<td>33</td>
<td>18</td>
<td>74</td>
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<tr>
<td>Total</td>
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<td>11</td>
<td>12</td>
<td>38</td>
<td>44</td>
<td>28</td>
<td>137</td>
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**TABLE 4: DISAGGREGATED DATA PROVIDE BY THE CHILDREN’S AUTHORITY ON PREVALENCE OF MENTAL ILLNESSES AMONGST CHILDREN AND ADOLESCENTS**

| Demographics | Depression | Anxiety | ADHA | Conduct/oppositional disorder | Intermittent Explosive Disorder | Conduct/oppositional disorder | Borderline Personality Features | Antisocial Personality Features | PTSD/Trauma/Stressor related | Suicidal ideation | Self-Harm | Psychosis | Developmental Delay | Substance Disorder |
|--------------|------------|---------|------|--------------------------------|---------------------------------|--------------------------------|---------------------------------|--------------------------------|-------------------|------------------|-----------|----------|-----------|-------------------|------------------|
| Male         | 20         | 10      | 17   | 25                             | 2                               | 2                              | 1                               | 7                              | 2                 | 2                | 0         | 10       | 2         | 4                  |
| Female       | 28         | 20      | 9    | 19                             | 4                               | 3                              | 1                               | 2                              | 1                 | 7                | 2         | 10       | 3         | 3                  |
| Total Presenting with diagnosis | 48         | 30      | 26   | 43                             | 6                               | 14                             | 3                               | 30                             | 12                | 12               | 2         | 15       | 5         | 7                  |
| 0-3 years    | 3          | 0       | 0    | 0                              | 0                               | 0                              | 0                               | 0                              | 0                 | 0                | 0         | 0        | 0         | 0                  |
| 4-6 years    | 3          | 0       | 2    | 0                              | 0                               | 0                              | 0                               | 0                              | 0                 | 0                | 0         | 0        | 0         | 0                  |
| 7-9 years    | 3          | 2       | 4    | 1                              | 0                               | 0                              | 0                               | 0                              | 0                 | 0                | 0         | 0        | 0         | 0                  |
| 10-13 years  | 14         | 10      | 13   | 17                             | 1                               | 0                              | 1                               | 7                              | 2                 | 2                | 0         | 0        | 0         | 0                  |
| 14-15 years  | 18         | 13      | 6    | 13                             | 0                               | 2                              | 9                               | 8                              | 8                 | 8                | 2         | 2        | 2         | 2                  |
| 16-17 years  | 13         | 5       | 1    | 12                             | 5                               | 4                              | 0                               | 6                              | 2                 | 2                | 1         | 2        | 1         | 5                  |
Appendix X

Total number of patients admitted at St. Ann’s Hospital for 2015-2016
### Table 6: Admission to Mental Health Facilities for 2016

<table>
<thead>
<tr>
<th>Month</th>
<th>NWRHA (St George West/Central)</th>
<th>NWRHA (St George East)</th>
<th>NCRHA (Caroni)</th>
<th>ERHA (Mayaro/St David/St Andrew)</th>
<th>SWRHA (St Patrick/Victoria)</th>
<th>NWRHA &amp; TRHA (Port-of-Spain/Tobago)</th>
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<td>Jan</td>
<td>29</td>
<td>31</td>
<td>42</td>
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<td>May</td>
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<td>34</td>
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<td>17</td>
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<td>June</td>
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<td>28</td>
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<td>32</td>
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<td>16</td>
<td>28</td>
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<tr>
<td>Aug</td>
<td>33</td>
<td>27</td>
<td>47</td>
<td>17</td>
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<td>24</td>
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<td>23</td>
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<td>Oct</td>
<td>29</td>
<td>31</td>
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<td>31</td>
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<td>41</td>
<td>15</td>
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<td>22</td>
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### Table 7: Psychiatric Outpatient Clinic Attendance for the Period 2016

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<tr>
<th>Month</th>
<th>Carenage Mental Health &amp; Wellness Centre</th>
<th>Barataria Mental Health &amp; Wellness Centre</th>
<th>Tacarigua &amp; Arima OPCs</th>
<th>Chaguana OPC</th>
<th>Sangre Grande, Rio Claro, Mayaro, Toco</th>
<th>Pembroke Street Mental Health &amp; Wellness Centre</th>
<th>NWRHA</th>
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<td>196</td>
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<td>Sept</td>
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Appendix XI

The organizational chart of the Psychiatric Unit, Scarborough General Hospital
Appendix XII

The process to be followed by all parties involved in the student re-integration process
**FIGURE 2: THE PROCESS TO BE FOLLOWED BY ALL PARTIES INVOLVED IN THE STUDENT RE-INTEGRATION PROCESS**

1. **START**

2. Parent makes a formal request to the Principal to re-admit student in school

3. Principal reviews request

4. **Request approve**
   - **NO** Principal rejects parent's request for re-admission
   - **YES** Principal readmits student into school

5. Principal rejects parent's request for re-admission

6. Parent makes a formal request to the Education District's School Supervisor (Secondary/Primary) to re-admit student in school

7. School Supervisor contacts the principal to obtain the grounds for the rejection of the parent's initial request
School Supervisor reviews the request for re-admission

Request approved?

NO

School Supervisor rejects parent's request for re-admission

Parent makes a formal request to the MOE Head Office to either the Director of School Supervisor or to SSSD Head Office to re-admit student in school

School Supervisor rejects parent's request for re-admission

DSS Office or SSSD Head Office contacts the Principal to obtain grounds for the rejection of the parent's initial request

YES

School Supervisor consults with Guidance Officer II / Senior School Social Worker for the Education District to provide intervention & support for student
Parent is facilitated through alternative placement where possible (eg. Wharton Patrick)
Appendix XIII

BREAKDOWN OF STAFF AT THE ST. ANN’S PSYCHIATRIC HOSPITAL
**TABLE 9: BREAKDOWN OF STAFF AT ST. ANN’S HOSPITAL**

<table>
<thead>
<tr>
<th>POSITION TITLE</th>
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<tr>
<td>HOUSE OFFICER</td>
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<tr>
<td><strong>NURSING</strong></td>
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<tr>
<td>HEAD NURSE</td>
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## BREAKDOWN OF STAFF AT ST. ANN’S HOSPITAL

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**BREAKDOWN OF STAFF AT ST. ANN’S HOSPITAL**

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<td>HOSPITAL ATTENDANT I</td>
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<td>MAID I</td>
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Appendix XIV

The names and designations of the members of the implementation committee
<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Dr. Edwin Bolastig</td>
<td>Advisor, Health Systems and Services</td>
<td>PAHO/WHO</td>
</tr>
<tr>
<td>2. Dr. Katiya Khan</td>
<td>Immediate Past President</td>
<td>Trinidad and Tobago Association of Psychologists</td>
</tr>
<tr>
<td>3. Dr. Varma Deyalsingh</td>
<td>Secretary</td>
<td>Association of Psychiatrists of Trinidad and Tobago</td>
</tr>
<tr>
<td>4. Mrs. Keisha Lewis</td>
<td>General Manager, Mental Health Services</td>
<td>North West Regional Health Authority</td>
</tr>
<tr>
<td>5. Mr. Bertrand Moses</td>
<td>Coordinator, Child Development Unit</td>
<td>Office of the Prime Minister, Ministry of Gender and Child Affairs</td>
</tr>
<tr>
<td>6. Ms. Darlene Smith</td>
<td>Guidance Officer II, Port of Spain and Environ Education District</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>7. Ms. Sharon Francis-Gaines</td>
<td>Social Worker Specialist, Student Support Services</td>
<td>Ministry of Education</td>
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<tr>
<td>8. Mr. John Lopez</td>
<td>Prisons Supervisor</td>
<td>Trinidad and Tobago Prison Service</td>
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<tr>
<td>9. Ms. Veda Roach</td>
<td>Manager, Community Mediation Programme</td>
<td>Ministry of Community Development, Culture and the Arts</td>
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<tr>
<td>10. Dr. Jennifer Rouse</td>
<td>Director, Division of Ageing</td>
<td>Ministry of Social Development and Family Services</td>
</tr>
<tr>
<td>11. Dr. Lucretia Gabriel</td>
<td>Chairperson</td>
<td>Lifeline</td>
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<tr>
<td>12. Mrs. Beverly Baksh</td>
<td>Health Education Division</td>
<td>Ministry of Health</td>
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<tr>
<td>13. Ms. Ayana John</td>
<td>Health Education Officer, Health Education Division</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>14. Ms. Carla Ruiz</td>
<td>Research Officer, Health Policy, Research and Planning</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Name</td>
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</tr>
<tr>
<td>Ms. Cherry-Ann Jones</td>
<td>Coordinator, National Alcohol and Drug Abuse Prevention Programme</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Ms. Karline Brathwaite</td>
<td>Mental Health Planner, Mental Health Unit</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Mrs. Ashvini Nath</td>
<td>Manager, Mental Health Unit</td>
<td>Ministry of Health</td>
</tr>
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Appendix XV

Costaatt intake and the graduating figure for Psychiatric Nursing within the last three years
**TABLE 11: COSTAATT’s intake and the graduating figure for Psychiatric Nursing for the period 2014-2016**

<table>
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<td>3</td>
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<td>Totals</td>
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<td>11</td>
<td>8</td>
<td>20</td>
<td>15</td>
<td>34</td>
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Appendix XVI

Training offered by the Student Support Services Department
This training includes training in the following assessment instruments:

- Administration of Screening and screening tools for students with ADHD and other mental health disorder;
- RBPC - Revised Behavioral Problem Checklist;
- Connors - Assessment of ADHD and comorbid conditions for adolescents and youth;
- ASCA - Adjustment Scale of Children and Adolescents (normed in Trinidad and Tobago);
- Psychosocial assessment and intervention for treating with students with disabilities and mental health disorders (USC);
- Adolescent Suicide Intervention (UWI);
- Home and family intervention and support; and
- Motivational Interviewing.
Appendix XVII

Interventions provided by the Children’s Authority for children for whom placement into mental health facilities is not required
Children in Need of Placement

- **If a child presents as severely behaviorally or emotionally dysregulated**, the child is sent to the Emergency Department of the nearest health facility where she/he can benefit from an immediate psychiatric screening and subsequent referral to the Mt. Hope Psychiatric Unit or the St. Ann’s Psychiatric Hospital for further evaluation as necessary. This may also result in the child being warded at the Mt. Hope Psychiatric Unit or the St. Ann's Psychiatric Hospital for assessment and necessary treatment. This is not a long-term solution as neither Mt. Hope nor St Ann's Hospital has specific accommodation for children. As such children placed on the ward are accommodated alongside adults with severe presentations, the exposure to which may negatively impact or traumatize the child. By its very nature hospitalization at such institutions for children with mental illness suggests that opportunities for adequate stimulation and, in some cases, basic exercise is not available, which is a violation of the basic rights of the child according to the United Nations Convention on the Rights of the Child. Such accommodation for children with mental illness is far from ideal as there may present opportunities for absconding. There is also the possibility of further mental health complications such as depression and suicide ideations resulting from the exposure on the ward to other patients with similar presentations. Individual care and supervision, as well as access to education, for the children who are warded on a long-term basis in these facilities, are simply not available due to restrictive hospital staffing and resources. Additionally, children face the risk of developing an inability to cope outside of institutional placements thereby making future integration into alternative placements and society as a whole challenging.

- **Placement with a caring relative or Fit Person**: This is done after careful assessment using a Suitability for Placement Assessment whereby the persons' willingness and ability to care for the child with a mental illness are carefully considered. The investigation also includes a thorough exploration of the circumstances and background of the potential Fit Person especially in light of the presenting challenges of the child for which placement is being sorted.

- **Foster Care Placement**: In cases where a relative or Fit Person cannot be identified, based on the presentation of the child as well as the medication regimen prescribed for the child, a Foster Care can be engaged. This is referred to as Specialist Foster Care. In the existing register of Foster Care providers, there is very limited availability of such Carers and as such Foster Care has not been a viable placement option for children living with mental illness. There are however some children living with mental illness in Foster Care. These children are very closely
monitored by the Foster Care Unit and the necessary referrals are made to Child Guidance Clinic to have these children assessed and a plan for further treatment established. The implementation of the plan for treatment is monitored and supported by the Foster Care Unit and shared with the Foster care and the Authority. While the interest in Specialist Foster Care has been The Authority has also launched a massive campaign to attract Specialist Foster Carers with whom children with special needs including mental illness can be placed. This recruitment is ongoing through a targeted approach whereby social workers, psychiatric nurses and other professionals are being directly engaged.

- **Community Residences (CRs):** Placements of children with mental illness in Community Residences (CRs) have been exceedingly challenging as the needs of such children require that the CRs have special staff, equipment and in many instances, infrastructure to meet their needs. As such, in most instances when approached to provide placement of children with mental illness, CRs are unwilling to do so. The CRs that are the most viable options for children with mental illness are the Lady Hochoy Home and St. Dominic’s Children’s Home. For the Lady Hochoy Home, however, a child must have a developmental disability before being considered for admission. As such, a child with mental illness but who do not have a developmental disability will not be considered for admission. Lady Hochoy has also indicated challenges with staffing and accommodation. These challenges include the need for specialist training of existing staff or the recruitment of staff already in possession of the skills and training needed for this population. The resources for such recruitment and training are not readily available to Lady Hochoy. Additionally, the children currently accommodated at Lady Hochoy have long-term care needs which do not allow them to be easily reintegrated with their families. Therefore, with few children leaving the facility there is little space that can be allocated to the accommodation of new residents, particularly those with mental illness. St. Dominic’s Children's Home has a dormitory equipped to cater for boys with mental illness. This facility can only accommodate six boys. A similar dorm for girls is intended to be developed but has not yet been initiated.

- **Convalescent Homes:** Convalescent and geriatric homes have been utilized for the placement of children with mental illness, who have been in urgent need of placement. The Authority has entered into agreements with a few of these Homes to place children with mental illness and physical disabilities. These institutions are paid on a per child basis ranging from $3,500 to $5,000 per month. The availability of nurses and specially trained staff make these institutions more
willing to accept children with mental illness. However, the mixing of adults and children is not ideal. As such, increased monitoring is necessary when such placements are made.

Support
In cases where children present with mental illness, the Authority works to provide a range of interventions and support systems to ensure that the child’s needs are met. The interventions provided include the following:

- **Caseworker:** A Children’s Services Associate is assigned to the child’s case to provide continuous assessment of the child’s needs and progress.
- **Regular monitoring visits:** The Children’s Services Associate conducts regular monitoring at the child’s designated placement and school. These visits include conducting interviews with the child’s primary caregiver, consulting doctor, principal, teacher, therapist and any other key persons working with the child.
- **Therapeutic interventions:** Specialized therapeutic intervention (such as play therapy, art therapy, occupational therapy) is provided based on the recommendations made during psychiatric and psychological evaluations.
- **School Enrolment & Remedial Assistance:** The Children’s Services Associate assists children who require enrolment at specialized academic institutions and also assist with a wider range of academic needs. This may include vocational training. Many of these special schools are private and as such funding is needed for school fees.
- **Medication:** The Children’s Services Associate ensures that all medications are obtained from pharmacies or hospital dispensaries (when available) and are delivered to the child’s place of residence.
- **Supervised Access:** Supervised access visits are facilitated by staff of the Authority who accompany the children to their scheduled visits with their families.
- **Personal Care Items:** Children with mental illness who are hospitalized require weekly replenishment of personal care items and laundry services. These services are coordinated by staff members who conduct weekly visits to deliver the necessary items.
• **Appointment Coordination and Transportation**: The Authority ensures that all children in care are provided with holistic care by coordinating medical, psychiatric, psychological and legal appointments. This includes financing the appointments as necessary and providing supervised transportation, where necessary.

• **Psycho-educational Assessments**: These assessments are provided to ensure that the academic needs of the child are identified and met by enrolment at an institution equipped to meet these needs.

• **Psychiatric Assessment**: Continuous assessment is often required to ensure that clients’ psychiatric needs are attended to as well as to facilitate the close monitoring of medication and the child’s progress.

• **Family Case Conferencing**: The Authority engages in family case conferencing in an effort to coordinate the planning of the child’s wellbeing with concerned and involved family members.

• **Training**: The Authority also makes referrals to a range of training such as Parenting Skills for Children with Conduct Disorder/ADHD to assist caregivers with the necessary skills in dealing with children with mental health concerns.

• **Exploring Alternative Placement**: In the event that the child’s placement is not ideal, the Authority continues to engage family members and seek alternative placement.

• **Crisis Intervention**: The Authority is on call to respond to critical situations. These include placement breakdowns, suicidal or homicidal threats, and psychiatric or psychological breakdowns.

• **Hospitalization Supervision**: In cases where children are hospitalized, the Authority ensures that staff provides supervision, where necessary. In some cases, 24/7 supervision is required as instructed by various hospital policies.

• **Care Staff**: The Authority ensures that children who require specialized supervision and care are provided with such. This includes Psychiatric Nurses, Caregivers and other staff as needed.

As mentioned earlier, it is important to note that the Authority only treats with children who have come to its attention as being in need of care and protection. Support is not long term.
as it is important to transition the children to a permanent place. If a child is placed in a CR however, the Authority will continue to be involved by virtue of its monitoring role.
Appendix XVIII

Placement of Children with Mental Illness by the Children’s Authority
<table>
<thead>
<tr>
<th>NO.</th>
<th>CHILD</th>
<th>AGE</th>
<th>MENTAL ILLNESS DIAGNOSED / OBSERVED</th>
<th>PLACEMENT IN FORMAL CARE</th>
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<tr>
<td>1</td>
<td>JB</td>
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<td>Cerebral Palsy</td>
<td>Casa de Corazon</td>
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<td>JM</td>
<td>9</td>
<td>Attention Deficit Hyperactive Disorder</td>
<td>St. Mary’s Children Homes</td>
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<td>3</td>
<td>TJ</td>
<td>10</td>
<td>Attention Deficit Hyperactive Disorder – Impulsive Type Conduct Disorder Intellectual Disability</td>
<td>Couva Children’s Home and Crisis Nursery</td>
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<td>4</td>
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<td>11</td>
<td>Unspecified Communication Disorder Developmental Delay</td>
<td>Ezekiel Home for Abandoned Children</td>
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<td>Unspecified Disruptive Impulsive Control &amp; Conduct Disorder Unspecified Intellectual Disability Neurodevelopmental Disorder</td>
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<td>Christ Child Convalescent Home</td>
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<td>9</td>
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<td>St. Mary’s Children’s Home</td>
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<td>10</td>
<td>NB</td>
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<td>11</td>
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### TABLE 14: Placement of Children with Mental Illness in Non-Alternative Care

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<td>1</td>
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<td>Cerebral Palsy</td>
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<td>Augusta Home</td>
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<td>JM</td>
<td>13</td>
<td>Prader-Willi Syndrome</td>
<td>Children’s Authority's Child Support Centre</td>
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<td>4</td>
<td>TC</td>
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<td>Intellectual/Developmental Delays</td>
<td>The Allison Lynch Senior Citizen’s Home</td>
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<td>5</td>
<td>TA</td>
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<td>Major Depressive Disorder</td>
<td>Mt. Hope General Hospital – Adult Psychiatric Ward</td>
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<td>Mrytle’s Place</td>
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<td>16</td>
<td>Conduct Disorder</td>
<td>Mary Care Centre</td>
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<td>8</td>
<td>NB</td>
<td>16</td>
<td>Adjustment Disorder with disturbance of Emotion and Conduct, Neurodevelopmental Disorder</td>
<td>Mrytle's Place</td>
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<td>9</td>
<td>SSF</td>
<td>17</td>
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<td>St Ann's Psychiatric Hospital</td>
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**FAMILY-BASED ENVIRONMENTS**

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<tbody>
<tr>
<td>1</td>
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<td>Mother’s care</td>
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<td>3</td>
<td>AM</td>
<td>10</td>
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<td>Family’s care</td>
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</table>
|4  | AH | 12 | Attention Deficit Hyperactivity Disorder  
Mild Autism  
Legal Guardian’s care |
|5  | DH | 12 | Conduct Disorder  
Paternal uncle’s care, |
|6  | JJ | 13 | Autism Spectrum Disorder (ASD)  
Father’s care |
|7  | IB | 15 | Attention Deficit Hyperactivity Disorder  
Paternal grandparents’ care |
|8  | LE | 15 | Major Depressive Disorder (Mild)  
Fit Person’s Care |
|9  | SIAS | 16 | Schizophrenia  
Mother’s care |
|10 | SJ | 16 | Schizophrenia (Suspected)  
Mother’s care |
|11 | SS | 16 | Conduct Disorder  
Intellectual Disability  
Attention Deficit Hyperactive Disorder  
Mother’s care |
|12 | JS | 16 | Conduct Disorder  
Family’s care |