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
Ms. Mala Kowlessar	State Counsel III

Mr. Lawrence Jaisingh	Director, Health Policy, Research and Planning
Mr. Asif Ali	Health Sector Adviser

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 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 anaeesthetic 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 adjourne*d.