

# WHO-AIMS

WHO-AIMS REPORT ON  
**MENTAL HEALTH SYSTEM**  
**IN GUYANA**

2008



World Health  
Organization



MINISTRY OF HEALTH  
GUYANA

**WHO-AIMS REPORT ON  
MENTAL HEALTH SYSTEM  
IN GUYANA**

*A report of the assessment of the mental health system in Guyana  
using the World Health Organization - Assessment Instrument for  
Mental Health Systems (WHO-AIMS).*

*Georgetown, Guyana*

2008



Ministry of Health

Ministry of Health  
Guyana

*WHO, Guyana*

*Pan American Health Organization (PAHO), WHO, Regional Office for the Americas  
(AMRO)*

*WHO Department of Mental Health and Substance Abuse (MSD)*

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The project in Guyana was implemented and carried out by Bhiri Harry, National Psychiatrist, Mayda Grajales, Chief Psychiatrist National Psychiatric Hospital, and Sonia Chehil, technical expert from the PAHO/WHO collaborating centre at Dalhousie University.

Technical support was provided by Stan Kutcher Director of the PAHO/WHO collaborating centre at Dalhousie University, Hedwig Goede, PAHO Health System Advisor and Devora Kestel, PAHO Mental Health Regional Advisor.

The preparation of this study would not have been possible without the collaboration of the Ministry of Health, Health Canada, PAHO Guyana and Dalhousie University. This project was funded by Health Canada as part of the PAHO Biannual Project Budget.

The World Health Organization Assessment Instrument for Mental health Systems (WHO-AIMS) has been conceptualized and developed by the Mental Health Evidence and Research team (MER) of the Department of Mental Health and Substance Abuse (MSD), World Health Organization (WHO), Geneva, in collaboration with colleagues inside and outside of WHO.

Please refer to *WHO-AIMS* (WHO, 2005) for full information on the development of WHO-AIMS at the following website.  
[http://www.who.int/mental\\_health/evidence/WHO-AIMS/en/index.html](http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html)

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The WHO-AIMS project is coordinated by Shekhar Saxena.

## Executive Summary

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Guyana. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This will enable Guyana to develop information-based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

Although there is little epidemiologic data from Guyana upon which to base assessments of mental health service need, disease burden estimates have recognized the neuropsychiatric disorders as making a larger contribution to the burden of disease, measured in Disability Adjusted Life Years (DALYs), than other diseases such as HIV/AIDS, tuberculosis, and malaria combined. Unipolar depression alone has been identified as the fifth greatest contributor to disease burden in Guyana and suicide is estimated to be the third-leading cause of death among those 15 to 44 years of age, accounting for 13% of all deaths (PAHO; 2006, February 2003). Relevant studies in the Americas indicate there is likely a prevalence of 10 to 15% of the population with a mental disorder at any one time, with 3 to 5% of the population having a severe chronic mental disorder. Given a population estimate of 750,000, this would predict that 75,000 to 112,500 Guyanese suffer from mental disorders and require some level of mental health care services. Of these, approximately 22,500 to 37,500 would be expected to suffer from severe mental illness. These projections do not include the number of patients with epilepsy and mental retardation, which are not surveyed in typical psychiatric epidemiologic studies, but are included in the population serviced by mental health care services in Guyana.

The current mental health system in Guyana is fragmented, poorly resourced, and not integrated into the general health-care system. Care of the mentally ill is provided under the legislative framework of the **Mental Health Ordinance of 1930**, which is antiquated and fails to make provisions for the protection of the rights of people with mental disorders. Persons with mental disorders are reported to suffer discrimination in their communities, the workplace, educational institutions, judicial services and the health-care system. Safeguards to protect individuals with mental illness from involuntary admission and treatment and mechanisms to oversee treatment practices within health facilities are lacking. There are no independent review bodies established to protect the human rights of users of mental health services. Stigma against the mentally ill is reported to be pervasive and considered by stakeholders to be expressed by the public as well as by many health professionals, the police, and policy makers and administrators alike. It is considered to be one of the greatest barriers to the development of modern mental health services in Guyana.

Mental health services are inadequate and not available or accessible to the vast majority of the population. Although at least one medication from each class of psychotropic drug is available at all mental health facilities as well as most primary and secondary care facilities in Guyana, there are no guidelines or protocols for the use of psychotropic drugs, and few health or specialized mental health workers have received any training in the rational use of these medications. There are minimal

numbers of general health human resources with the necessary mental health competencies to provide mental health care services at any level of general health care services. In addition, few adequately trained specialized mental health professionals are available within mental health services. At the time of this assessment there were 3 psychiatrists in the public sector in Guyana, 2 based in Georgetown and one at the National Psychiatric Hospital. Besides these physicians, mental health staff has variable levels of training, and often lack the competencies required to provide adequate quality mental health care. Guyana's total of 3 full-time equivalent psychiatrists translates into 0.5 psychiatrists per 100,000 population (equal to 5 per million) significantly below the world reference average of 4.2 per 100,000 (WHO, 2005). By these standards, Guyana's mentally ill are markedly underserved.

Available public mental health services are predominantly institution-based. Tertiary level services are provided by one 240-bed mental hospital - the National Psychiatric Hospital - which provides both inpatient and outpatient services. Care provided at the mental hospital is primarily custodial and heavily reliant on pharmacologic intervention. The majority of mental hospital beds are filled by long stay patients who do not necessarily require institutional care. There is one 4-bed short-stay community-based psychiatric unit in the country's tertiary health care facility, the Georgetown Public Hospital Corporation (GPHC), which provides emergency and acute care services. There are few community-based services and minimal services available at primary care level.

There are no national or institutional standards for mental health care, facilities or human resources. The National Psychiatric Hospital (NPH) is in substantial disrepair and significantly below the standard of facilities that provide for physical health care, raising concern about equitable treatment of the mentally ill. There are no standards, protocols, policies or guidelines for the use of psychotropic medications; the assessment, treatment, monitoring, and ongoing evaluation of patients with mental disorders; the charting of patient information; or the maintenance of health records. There is little national mental health data available for mental health service monitoring and evaluation. As a consequence, datasets of sufficient quality are not available to inform service utilization or to provide quality assurance for mental health care.

Informal mental health services are poorly developed and limited to substance abuse ambulatory support and counselling services for male individuals with substance abuse problems provided by two non-governmental organizations (NGOs) in the capital city of Georgetown. There are no mental health consumers/users, volunteer, family or advocacy groups in Guyana. This is unfortunate as these groups can play valuable roles in prevention/promotion, advocacy and rehabilitation efforts within the mental health care system. However, there are many non-health professional and non-professional groups in Guyana, including teachers, community leaders, traditional/spiritual healers, herbalists, religious leaders, law enforcement (police), ambulance attendants, NGOs, and the media, who could potentially play a role in the promotion of mental health in their communities.

Despite the continued challenges and resource constraints noted above, there have recently been substantial efforts made to improve mental health in Guyana. The Government of Guyana has demonstrated a strong commitment to improving the

mental health of its population. In Guyana, mental health has specifically been identified as an essential component of health reform. In the Ministry of Health's National Health Plan 2003-2007, mental health was highlighted as a priority area for development. The profile of mental health has been raised further in the recently drafted Health Sector Strategy 2008-2012 in which mental health is identified as one of the seven priority health areas.

The National Health Sector Strategy identifies 7 priority programs selected to facilitate the achievement of comprehensive, accessible health services in keeping with the Ministry's commitment to the Millennium Development Goals, National Development Strategy and Poverty Reduction Strategy programs. The priority programs are Family Health; Chronic Non-Communicable Diseases; Accidents, Injuries and Disabilities; HIV, TB and Malaria; Communicable Diseases including neglected diseases and emerging diseases; Mental Health; Health Promotion and Risk Reduction. The specific targets identified in Mental Health are the development and implementation of prevention and management services for suicide, depression and substance abuse in first contact (primary) clinical care.

*"...Improvements (in Mental Health) will be achieved through prevention and management of suicide, depression and substance abuse in first contact clinical care (i.e. at the primary health care level)... the number 1 priority of the mental health program will be the movement of mental health into the primary health care system."*

Guyana Health Sector Strategy 2008-2012

National Health Sector Strategy 2008-2012 Mental Health Indicator:

*"Mental health care services for the identification and treatment of common mental disorders including substance use disorders are available at first contact health facilities with at least 10% of primary health care facilities offering such services by the end of 2009."*

Guyana Health Sector Strategy 2008-2012

In addition to the profile given to mental health in the Health Sector Strategy, the Ministry's commitment to the development of mental health care in Guyana is clearly demonstrated in recent initiatives undertaken by the Ministry to improve mental health services:

Mental Health Policy: The Ministry of Health actively supported and participated in the development and completion of their Draft Mental Health Policy, which was completed as a component of the first Pan American Health Organization/Health Canada Biennial Programming Budget project, with Dalhousie University and PAHO.

Mental Health Plan: The Ministry of Health actively supported and participated in the development and completion of their Draft Mental Health Plan, which was completed as a component of the second BPB project with Dalhousie University and PAHO. In addition, the Ministry of Health actively promoted and participated in the development and submission of a successful proposal to International Development Bank for funds to help support the implementation of the Mental Health Plan.

Mental Health Financing: The Ministry of Health has secured an annual budget for mental health to support the functions of the Mental Health Unit and has sourced funding to support the implementation of priority programs in mental health.

Health Human Resource Development: Over the past 2 years the Ministry of Health has actively promoted and supported initiatives to develop local capacity to provide mental health care services at the community and primary care levels. In 2005-06 a program to train Medex in basic mental health competencies was launched through the embedding of a mental health training curriculum within the Medex health professional school training program provided by the Department of Health Sciences Education. In 2006-07, this initiative was expanded to include the development of mental health training materials for all health professional school training programs of the Department of Health Sciences Education. Both of these initiatives were supported by the two previous BPB projects with Dalhousie University and PAHO.

Mental Health Leadership: In 2006-07 the Ministry of Health established a Mental Health Unit (MHU) within the Ministry of Health and secured an annual budget to support the functions of the unit as well as a position of National Mental Health Coordinator. In addition, the Ministry of Health appointed a Mental Health Technical Advisor to the MOH to provide ongoing technical guidance to the development of the Mental Health and Substance Abuse Program. A multi-sectoral Mental Health Advisory Committee (MHAC) to the MHU has also been appointed. The MHAC is accountable to the Minister of Health and is responsible for overseeing the development of priority mental health areas in line with the directions set by the Ministry in the Draft Mental Health Policy and through the strategies identified in the Draft Mental Health Strategic Plan.

Improvement of Services: In 2006 the Ministry of Health supported the completion of an Operational Review of the National Psychiatric Hospital in order to initiate the process of refurbishment of the existing facility and to inform the development of a long-term functional plan for the institution that promotes the deinstitutionalization of mental health care and the rehabilitation and recovery of persons suffering from mental illness. Subsequently the Ministry has initiated and supported repairs to the existing physical plan.

Collaboration: The Ministry of Health has actively engaged directorates within the Ministry of Health, other government ministries (including but not limited to Human Services, Education, Home Affairs, Youth Sports and Culture), the private sector, NGOs, Faith leaders from Christian, Muslim, Hindhu, Baha'I, and Rastafarian faiths (FBOs), international institutions, civil society organizations and communities in the promotion of mental health and the development of the mental health program.

Address of Priority Public Health Concerns: In 2007 the Ministry of Health in collaboration with the Ministry of Human Services led the development of a Homeless Initiative to promote access and availability of therapeutic mental health and general health care, nutrition, shelter and security to homeless persons. Also in 2007, the Ministry of Health established a multi-sectoral National Suicide Prevention Committee to develop a National Strategy for Suicide Prevention in Guyana and established a focal point for substance abuse within the Adolescent Health Unit of the

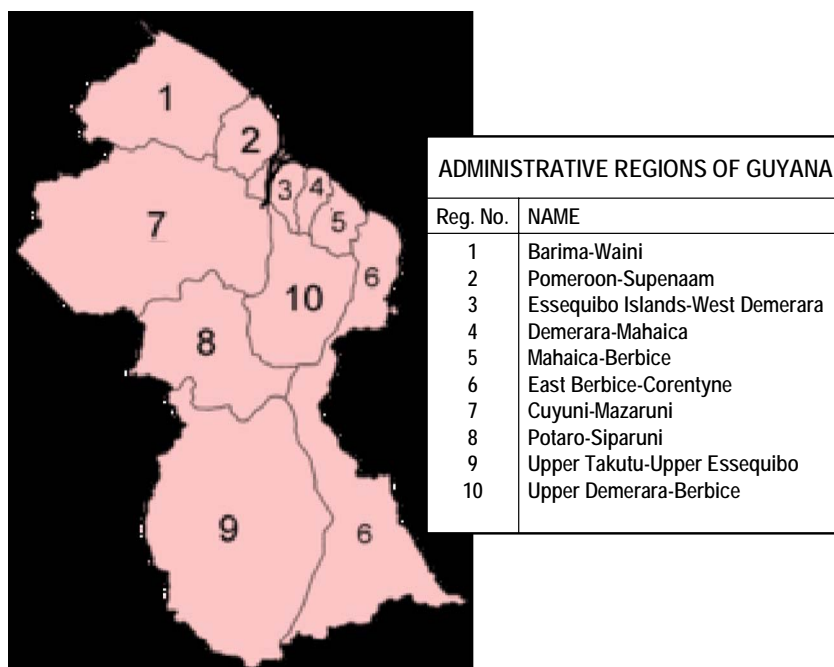


MOH. In 2008, the Ministry of Health actively supported the development and implementation of a training program to embed the competencies necessary for the early detection and treatment of anxiety and depressive disorder in primary care health facilities. This program will be completed as a component of the third BPB project with Dalhousie University and PAHO in 2009. In addition, the Ministry of Health has embarked on an initiative to develop guidelines for the treatment and management of anxiety and depression in primary care (to be completed in 2008) as well as guidelines for the treatment and management of psychosis (to be completed in 2009).

# WHO-AIMS COUNTRY REPORT FOR GUYANA

## Introduction

The Dutch originally settled Guyana in the 15<sup>th</sup> century. It became a British territory in 1815, attained political independence on May 26<sup>th</sup> 1966 and became a republic in February 1970. It is formally known as the Republic of Guyana. Guyana is located on the northeastern coast of South America bordering the Atlantic Ocean and nestled between Brazil, Venezuela, and Suriname covering an area of 215,000 km<sup>2</sup> with a population estimate of 761,510. Guyana is the only English-speaking country in South America and is culturally closer to the Caribbean than South America with an ethnically mixed population of approximately 43.5% East Indian, 30.2% Afro Caribbean, 9.2% Amerindian, 16.7% Mixed Heritage, 0.3% Portuguese, and 0.2% Chinese. Christianity, Hinduism and Islam are the dominant religions in Guyana. Approximately 50% of the population is Christian, 30% is Hindu and 15% is Muslim.



Over 70% of the population lives in rural areas, the vast majority of whom live in the coastal strip. The country is divided into 10 administrative regions that are managed by regional democratic councils. Each regional council is administratively responsible for the delivery of public services within its boundaries. Regions 1, 7, 8, and 9 are classified as the interior regions - rural and remote, with small populations. Regions 2, 3, 4, 5 and 6 are the coastal regions, and region 10 has one moderate sized town and a large rural area. Of these, region four includes Georgetown, the capital, and represents the largest concentration of population. Regions 2, 3, 5, and 6 are predominately East Indian. Region 10 is predominately Afro-Caribbean. Regions 1, 8 and 9 are predominately Amerindian, and regions 4 and 7 are mixed.

The economy is based mainly on the export of agriculture (rice and sugar), gold, bauxite and timber. Although rich in natural resources, Guyana remains one of the poorest countries in South America and the Caribbean. The 2007 Millennium Development Report for Guyana showed a Gross Domestic Product (GDP) per capita of \$1082 USD (2006) placing Guyana's GDP on par with countries like the Congo, Honduras and Nicaragua. The proportion of the population living below \$1 per day was 35 percent in 1999 (most recent available statistics). However in 2007, Guyana's ranking increased by ten places over the previous year to 97 out of 177 countries in the UNDP Human Development Index.

Women make up 51 percent of the Guyanese population and 53 percent of the population over 60. Life expectancy for women is 67.4 years, exceeding the rate for men by more than 6 years. Approximately 37 percent of the population is under the age of 15. Education indicators remain relatively high for a developing country. An additional 3.9 percent of the population is over 65 years. The maternal mortality ratio for Guyana in 2005 was 161 per 100,000 live births. The estimated infant mortality rate in 2007 was 42.9 per 1,000 live births. Life expectancy has increased to 66.8 years overall, with women living slightly longer than men.

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Guyana. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This will enable Guyana to develop information-based mental health plans with clear baseline information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

This study was carried out by Dr. Bhiro Harry, National Psychiatrist, Dr. Mayda Grajales, Chief Psychiatrist National Psychiatric Hospital, and Dr. Sonia Chehil, technical expert from the PAHO/WHO collaborating centre at Dalhousie University. Technical support was provided by Professor Stan Kutcher Director of the PAHO/WHO collaborating centre at Dalhousie University, Dr. Hedwig Goede, PAHO Health System Advisor, Dr. Devora Kestel, PAHO Mental Health Regional Advisor, and the WHO's Mental Health Evidence and Research Team in Geneva: Dr. Shekhar Saxena, Coordinator, Dr. Jodi Morris, Technical focal point, and Maria Grazia Motturi-Gerbail, Technical assistant.

The preparation of this study would not have been possible without the collaboration of the Ministry of Health, Health Canada, PAHO Guyana and Dalhousie University. This project was funded by Health Canada as part of the PAHO Biannual Project Budget.

Data was collected in 2008 and is based on the year 2007-2008.

## **Domain Summary**

### **Domain 1: Policy and Legislative Framework**

#### **Policy, plans, and legislation**

The Ministry of Health in Guyana identified mental health as a crucial part of health reform on the Ministry of Health's five year National Health Plan from 2003. Mental health programming was further elaborated in the 2008, Health Sector Strategy, where it was identified as one of the priority health programs. The Ministry of Health, with the establishment of the National Mental Health Working Group, has been advancing toward the creation of a national mental health policy and plan since 2005. In 2007, a completed draft mental health policy and plan was submitted to the Ministry of Health for approval. Although the mental health policy and plan have not yet been formally endorsed, the framework provided by the policy document and the strategies for implementation outlined in the mental health plan are guiding the development of the mental health program. The draft mental health policy and plan was developed according to the WHO Mental Health policy template by the Ministry of Health Guyana with the support of PAHO, Health Canada, and Dalhousie University. Currently there is no disaster/emergency plan for mental health.

#### **Financing of mental health services**

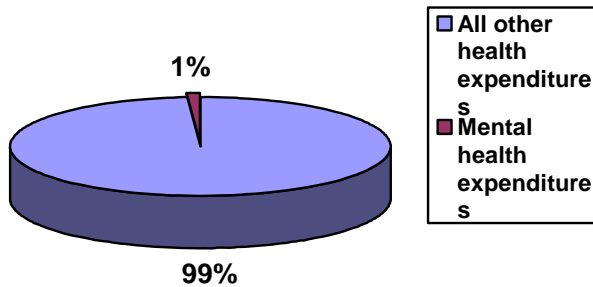
Out of the total of health care expenditures by the government health department, 1% is directed towards mental health. Of all the expenditures spent on mental health, 61% is directed towards mental hospitals.

At present, 100% of the population has free access to mental health care services as well as essential psychotropic medicines provided by the public sector and all mental disorders and all mental health problems of clinical concern are covered in the social insurance scheme (see Domain 5: Legislative and financial provisions for persons with mental disorders).

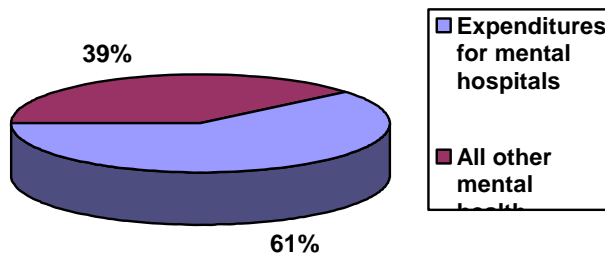
There is a dedicated budget for mental health in Guyana to support the development of the mental health program. Recurrent costs for the inpatient units at the Georgetown psychiatric ward and for the National Psychiatric Hospital (NPH) come from annual global budgets allocated to the Georgetown Public Hospital Corporation (GPHC) and the Region 6 Health Authority respectively. Recurrent expenditure for the NPH is approximately 240,000.00 USD/year. Annual recurrent budget for the GPHC Psychiatric Department, excluding drug costs, is approximated to be 190,000.00 USD/year. An additional 60,000.00 USD is allocated to the NPH by the government health department, summing up a total expenditure on mental health of 490,000.00 USD.

Graph 1.1: Expenditures on mental hospitals as a proportion of total mental health care spending

**GRAPH 1.1 HEALTH EXPENDITURE  
TOWARDS MENTAL HEALTH**



**GRAPH 1.2 MENTAL HEALTH  
EXPENDITURE TOWARDS MENTAL  
HOSPITALS**



**Human rights policies**

A regional human rights review body exists which has the authority to: (1) review complaints investigation processes, and (2) impose sanctions (e.g. withdraw accreditation, impose penalties, or close facilities that persistently violate human rights).

Neither the national mental hospital nor the community-based inpatient facility has had a review/inspection of human rights protection of patients in the past year and none of the staff of either mental health facility have had at least one day training, meeting, or other type of working session on human rights protection of patients in the year of assessment.

The Ministry of Health's Standards committee is mandated to review all existing health facilities annually. Although there has been no formal inspection of the national mental hospital or the community-based inpatient unit in the year of assessment, the Ministry of Health completed two comprehensive facility reviews of the mental hospital in the past 5 years with technical assistance provided by PAHO.

In Guyana, the right to health is assured through the constitution. Development of health legislation is being addressed through general health reforms within Guyana

which has recently included the completion of the drafting of a Patient's Code of Rights – this has not yet been enacted.

An outdated mental health law - The 1930 Mental Health Ordinance - exists, but it fails to include many basic elements of protection in legislation. Areas with insufficient protection include those related to confidentiality, informed consent, conditions in mental health facilities, safeguards to protect against abuse, appropriate and accessible care within communities, and equality in opportunities for access to care, to employment, to shelter and to justice.

Awareness of mental health legislation and its purpose is low. Legislation specifically addressing the needs of the mentally ill is currently inadequate. Future legislation, which takes into account the needs of the mentally ill, is likely to be included as a part of legislation for those with disabilities.

## **Domain 2: Mental Health Services**

### **Organization of mental health services**

The Ministry of Health has established a Mental Health Coordinating Unit within the Ministry with a mandate to provide informed advice on, and be involved in the development and implementation of, mental health policies and legislation, service planning, service management and coordination, as well as monitoring and quality assessment of mental health services. An annual operational budget to support the functions of the Mental Health Unit (MHU), a position for a National Mental Health Coordinator, as well as administrative support for the MHU has been secured. In addition, a multi-sectoral Mental Health Advisory Committee to the MHU to oversee the development of priority mental health areas in line with the directions set by the Ministry of Health has been established.

Mental health services are organized in terms of catchment/service areas. Service areas are organised by regions. Currently, mental health services are concentrated in the most heavily populated areas along the coastal strip and are not currently available in all regions. Regions in which there are current mental health services include the following: Region 6 (also services region 5); Region 4 (also services region 5); Region 3 (also services region 2); and Region 10. The National Psychiatric Hospital (region 6) is the only mental hospital in Guyana and provides inpatient acute, sub-acute and chronic mental health care services at a national level.

### **Mental health outpatient facilities**

There are 2 outpatient mental health facilities available in the country, of which none are exclusive for children and adolescents. One is provided by the only mental hospital in the country - the National Psychiatric Hospital (NPH) - and the other is provided at the country's tertiary care centre - the Georgetown Public Hospital Corporation (GPHC) - by the GPHC Psychiatry Department in the country's capital city. The NPH outpatient facility has been recently physically relocated from the NPH to the New Amsterdam Regional Hospital. Both facilities provide mental health care

services to persons across the lifespan and the GPHC Psychiatric Unit provides a twice monthly multidisciplinary outpatient child and adolescent clinic.

Two weekly satellite clinics are provided from the GPHC Psychiatry Department by a mobile team consisting of a staff psychiatrist, nurse, and social worker to Regions 10 (Linmine Hospital complex Linden) and 3 (Parika Health Center). In addition, the GPHC Psychiatry Department provides outpatient follow-up care in the community for persons discharged from hospital requiring additional supports.

In terms of available treatments, both outpatient facilities offer limited psychosocial treatments and both have access to at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) year round.

There is no computerized data entry system in the National Psychiatric Hospital or the GPHC Psychiatric department. Diagnostic information, based on the DSM-IV classification system, is recorded on the patient charts but is not a component of the mental health data set submitted to the Ministry of Health statistic department. Together, the outpatient facilities provide care to an estimated 2062 persons in Guyana. Outpatient services at the GPHC and NPH provide care to approximately 1200 users/year, and 862 users/year respectively. Of all users treated in mental health outpatient facilities 60% are female and 4% are children or adolescents.

### **Day treatment facilities**

There are no day treatment facilities in the country.

### **Community-based psychiatric inpatient units**

There is one 4-bed community-based acute care psychiatric inpatient unit at the GPHC for a total of 0.53 beds per 100,000 population. None of these beds are reserved for children or adolescents. This small unit functions as a short-stay acute care unit for crisis intervention, assessment, and stabilisation. Patients are admitted for 24-72 hours. The vast majority are admitted as involuntary patients and many require physical restraint on admission. Patients who are stabilised within 72 hours are discharged home with community outreach and follow-up care provided by the mental health staff of the GPHC outpatient department. Those patients requiring a higher level of in-hospital care are transferred to the National Psychiatric Hospital. Forty-six percent (46%) of admissions to community-based psychiatric inpatient units are female and none are children/adolescents. The most frequent admission diagnosis is psychosis (86%) followed by substance-related disorder (14%). The average length of stay is 2.75 days. Treatment is highly focused on acute symptom management with psychotropic medication followed by focused psychosocial interventions and mobilisation of patient supports to facilitate hospital discharge back into the community. The GPHC has consistent access to all psychotropic medications listed in the National Formulary, which includes at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines).

### **Community residential facilities**

There are no community residential facilities available in the country.

### **Mental hospitals**

There is one 240-bed mental hospital – the National Psychiatric Hospital - available in the country for a total of 32 beds per 100,000 population. The NPH is organizationally integrated with mental health outpatient facilities and the number of beds has not changed in the last five years. None of the beds at the NPH are reserved for children and adolescents only. The patients admitted to mental hospitals belong primarily to the following two diagnostic groups: schizophrenia and delusional disorders (45%) and others such as epilepsy, organic mental disorders and mental retardation (19%).

The number of patients in mental hospitals is 33.73 per 100,000 population. The average number of days spent in mental hospitals is 206: 15% of patients spend less than one year, 4% of patients spend 1-4 years, 14% of patients spend 5-10 years, and 67% of patients spend more than 10 years in mental hospitals. Between 51 – 80% patients in mental hospitals received one or more psychosocial interventions in the last year.

The National Psychiatric Hospital has at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

### **Forensic and other residential facilities**

There is no forensic psychiatric facility and no designated forensic mental health beds in Guyana. However, within the correctional facilities there are designated areas where inmates suffering from mental disorders reside. Mental health care services are provided to these inmates by the psychiatry staff from the GPHC psychiatric unit and the NPH. Forensic cases are sent to the NPH where they are admitted to the general wards on order of the court for psychiatric assessment and treatment. As the NPH is not equipped to provide secure facilities, forensic cases admitted on order of the court are provided assessment and acute stabilization treatment and are then discharged to the prison system.

There are 38 residential beds available for male persons affected by substance related disorders in the country's capital city, Georgetown. These beds are provided as a part of the substance abuse and addiction residential treatment services of 2 NGOs: the Salvation Army (24 beds) and Phoenix Recovery (14 beds).

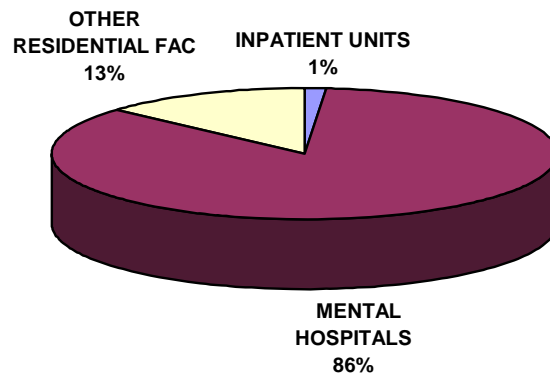
### **Human rights and equity**



Two percent of all admissions to the national mental hospital are involuntary. Between 11-20 % percent of patients were restrained or secluded at least once within the last year in the mental hospital.

Out of the 244 psychiatric beds available in the inpatient unit and in the mental hospital, the vast majority (98%) are in the national mental hospital, while the remaining 2% are in the inpatient unit located in the largest city in the country, Georgetown. Inequity of access to mental health services for much of the country's population is a significant issue. The major minority group in Guyana are the indigenous peoples who are substantially under represented in both inpatients and outpatients mental health services.

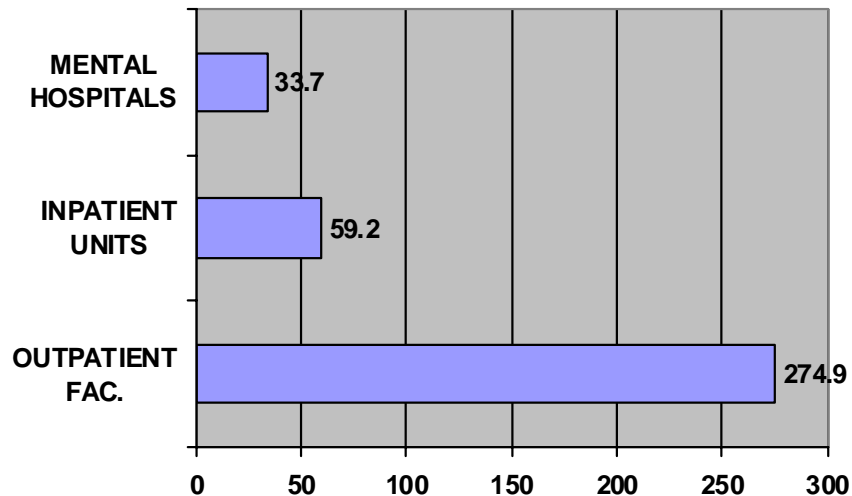
**GRAPH 2.1 - BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES**



Summary for Graph 2.1:

The majority of public sector beds in the country are provided by the mental hospital.

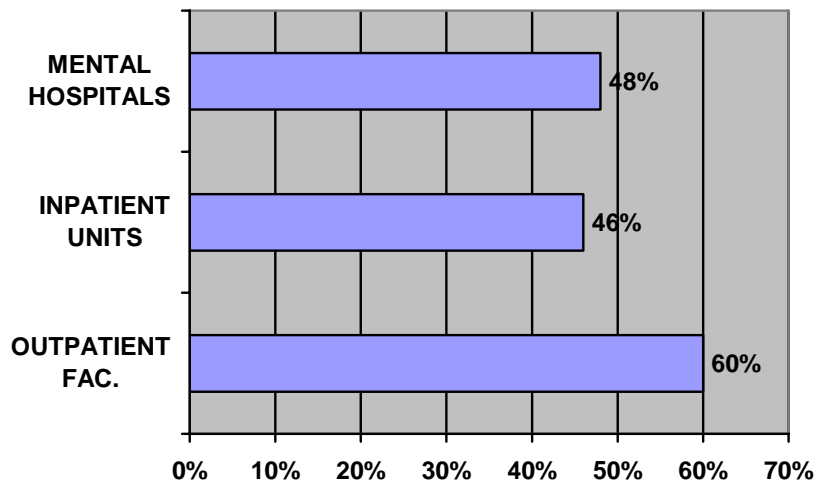
**GRAPH 2.2 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES (rate per 100.000 population)**



Summary for Graph 2.2:

The majority of users are treated in outpatient facilities followed by the community inpatient unit and lastly the mental hospitals. There are no day treatment, residential or forensic facilities in the public sector.

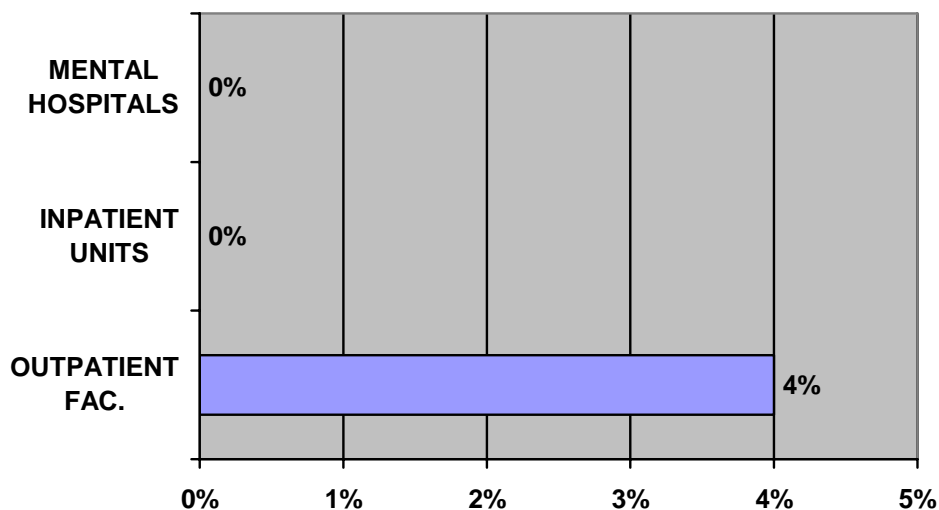
**GRAPH 2.3 - PERCENTAGES OF FEMALE USERS  
TREATED IN MENTAL HEALTH FACILITIES**



Summary for Graph 2.3:

The proportion of female users is highest in outpatient facilities. Approximately 50% of users of mental hospitals and 46% of inpatient units are females.

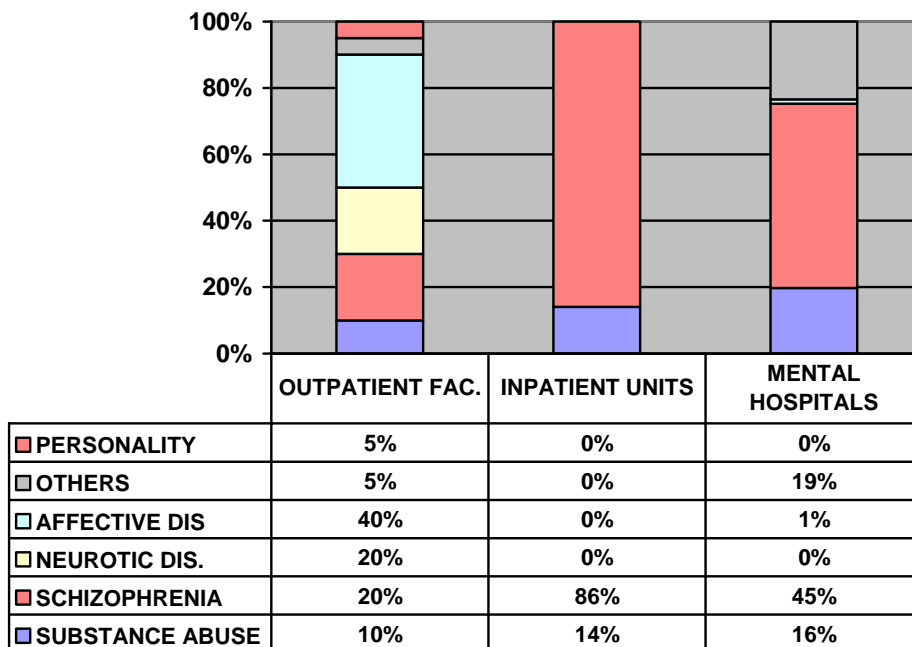
**GRAPH 2.4 - PERCENTAGES OF CHILDREN AND ADOLESCENTS TREATED IN MENTAL HEALTH FACILITIES**



Summary for Graph 2.4:

There are only outpatient facilities for children and/or adolescents.

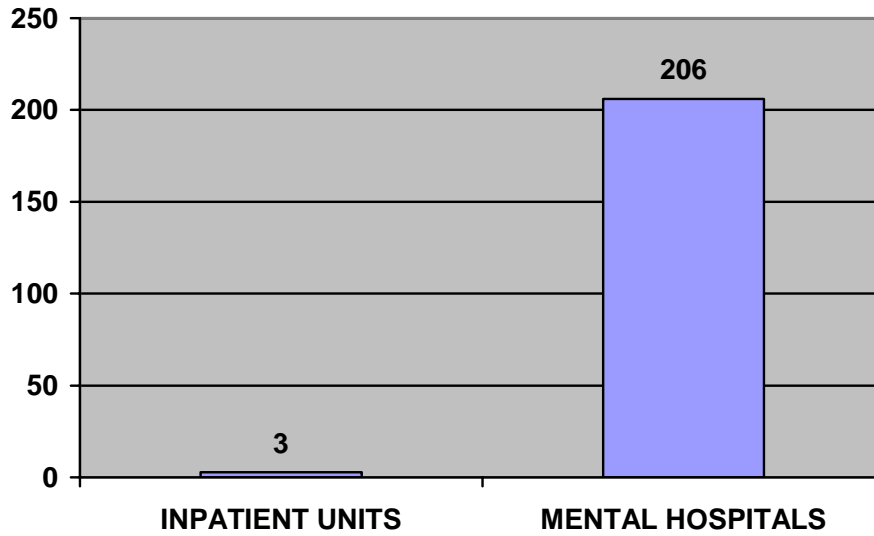
**GRAPH 2.5 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS**



Summary for Graph 2.5:

The distribution of diagnoses varies across facilities: in outpatients facilities affective disorders are more prevalent, the majority of patients admitted to the community inpatient unit have a diagnosis of psychosis, and in mental hospitals schizophrenia and "other" diagnoses are most frequent.

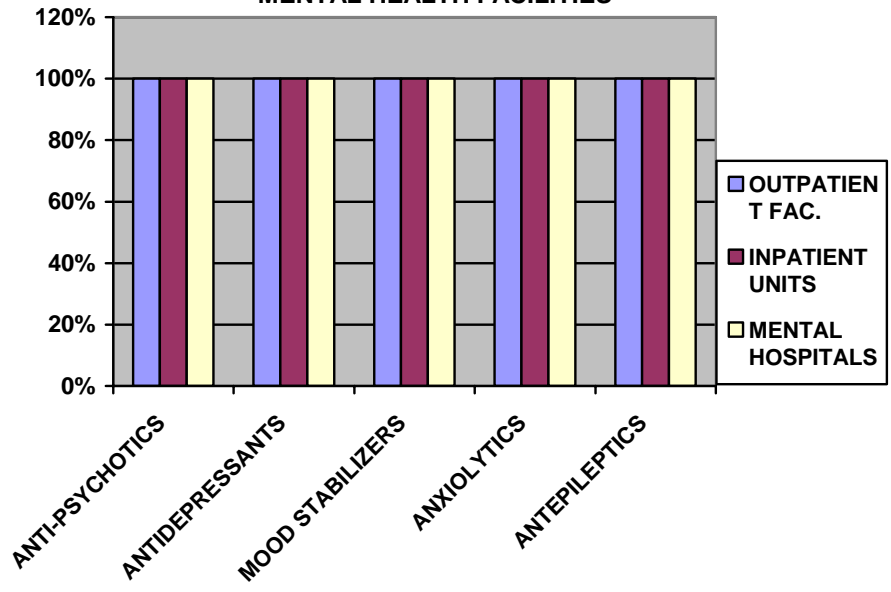
**GRAPH 2.6 - LENGTH OF STAY IN INPATIENT FACILITIES  
(days per year)**



Summary for Graph 2.6:

The average length of stay in the mental hospital is 206 days. As the community-based psychiatry inpatient unit is an acute short-stay service the length of stay for each admission is targeted to be less than 72 hours.

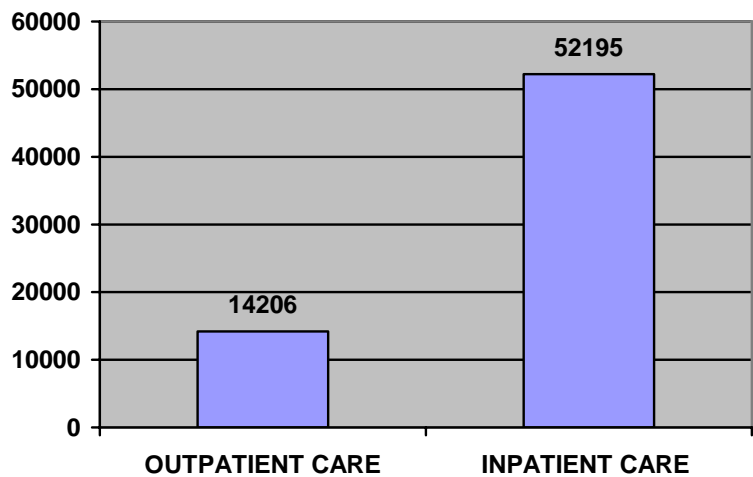
**GRAPH 2.7 - AVAILABILITY OF PSYCOTROPIC DRUGS IN MENTAL HEALTH FACILITIES**



Summary for Graph 2.7:

At least one medication from each class of psychotropic drugs is available in all inpatient and outpatient facilities in Guyana.

**GRAPH 2.8 INPATIENT CARE VERSUS OUTPATIENT CARE**



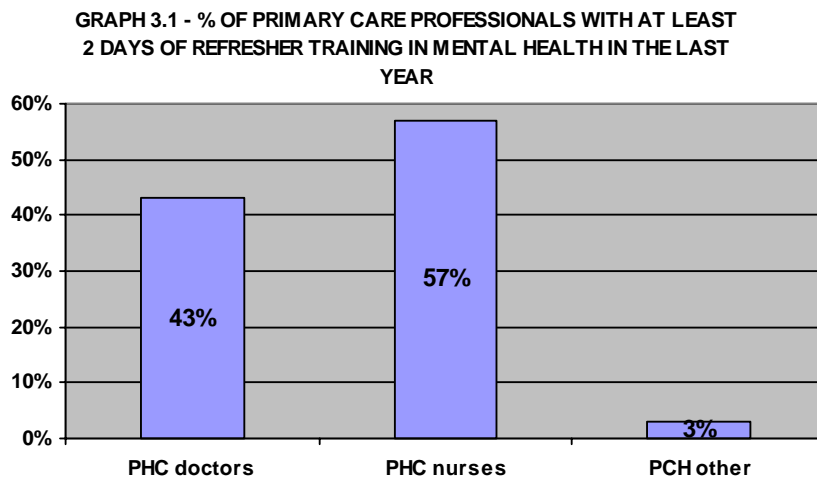
Summary for Graph 2.8:

The ratio between outpatient/day care contacts and days spent in inpatient facilities (mental hospitals and community base units) is an indicator of extent of community care: in this country the ratio is 4:1.

## Domain 3: Mental Health in Primary Health Care

### Training in mental health care for primary care staff

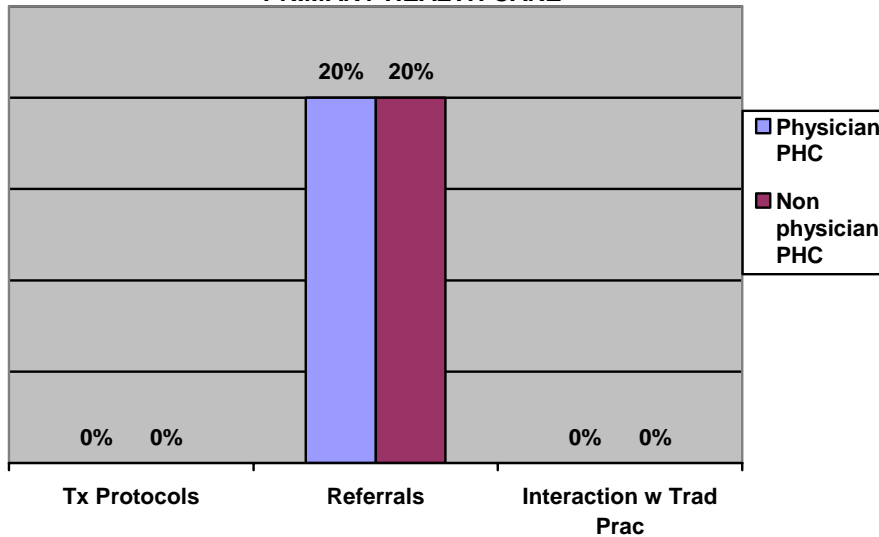
Only 20 hours of the 4-year training program for medical doctors is devoted to mental health. Approximately 2% of the training for nurses and 4% of the training for non-doctor/non-nurse primary health care workers is devoted to mental health. In terms of refresher training, 43% of primary health care doctors have received at least two days of refresher training in mental health, while 57% of nurses and 3% of non-doctor/non-nurse primary health care workers have received such training.



### Mental health in primary health care

Both physician based primary health care (PHC) and non-physician based PHC clinics are present in the country. Neither have assessment and treatment protocols for key mental health conditions. A few physician-based primary health care clinics make on average one referral to a mental health professional, which is the same as non-physician based primary health care clinics that make a referral to a higher level of care (e.g. GPHC or NPH). As for professional interaction between primary health care staff and other care providers, between 1 and 20% of primary care doctors have interacted with a mental health professional at least once in the last year. There is little contact between either the physician-based PHC facilities or non-physician-based PHC clinics with complimentary/alternative/traditional practitioners. The same is true of the mental health facilities.

**GRAPH 3.2 - COMPARISON OF PHYSICIAN BASED  
PRIMARY HEALTH CARE WITH NON-PHYSICIAN BASED  
PRIMARY HEALTH CARE**



**Prescription in primary health care**

Primary health care doctors are able to prescribe all psychotropic medication. The Medex - non doctors/ non nurse primary health care worker in Guyana – has restricted privileges. No other primary care health worker, including nurses, is able to prescribe psychotropic medications. As for availability of psychotropic medicines, all physician-based PHC clinics have access to at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic).

**Domain 4: Human Resources**

**Number of human resources in mental health care**

There is a dearth of specialised mental health human resources in Guyana. The majority of health professionals currently providing mental health care services within the public health sector are non- mental health specialised health providers. Categories of non-mental health specialized human resources currently providing mental health care services in the public health sector in Guyana include the following:

1. General Doctor
2. Medex (see below for a description of the Medex health worker)
3. Registered Nurse (RN)
4. Licensed Nurse Practitioner (LPN)
5. Nurse Assistant
6. Nurse Aid

7. Midwife
8. Community Health Worker (CHW)
9. Social Worker

The Medex health worker provides general health and mental health care at primary and secondary care levels in Guyana where a general doctor is not available. The Ministry of Health introduced the Medex health worker into the pool of available HHR in 1979. The Medex program was designed to provide health practitioners, such as registered nurses, additional training to perform specific public health functions (such as community health promotion and prevention of common diseases, and community surveillance) and to provide first contact medical care (such as first-line medical assessment, diagnosis and management of common conditions, perinatal and newborn care; and prescription of a limited number of medicines) particularly in rural and interior regions of Guyana where access to medical services is poor and there are no general doctors. The purpose and functions of the Medex health worker were codified in law by the Medex act in 1978. The Medex are governed by the Medical Board established under the Colonial Medical Services Ordinance 1953 and are registered by the Ministry of Health to practice within the public service.

The total number of human resources working in mental health facilities or private practice is 9.6 per 100,000 population. There are no psychologists or occupational therapists working in mental health facilities. The breakdown of available professionals per 100,000 is as follows:

Psychiatrist	0.5
General Doctor	0.3
Nurse	0.4
Social Worker	0.4
Other Worker	8.0

(These include Medex, nurse assistants, nurse aids, midwives, and community health workers.)

One quarter of the psychiatrists in Guyana work only for government administered mental health facilities, one quarter work in the private sector, and half work in both the public and private sectors. There are few other health human resources providing private mental health care services in Guyana.

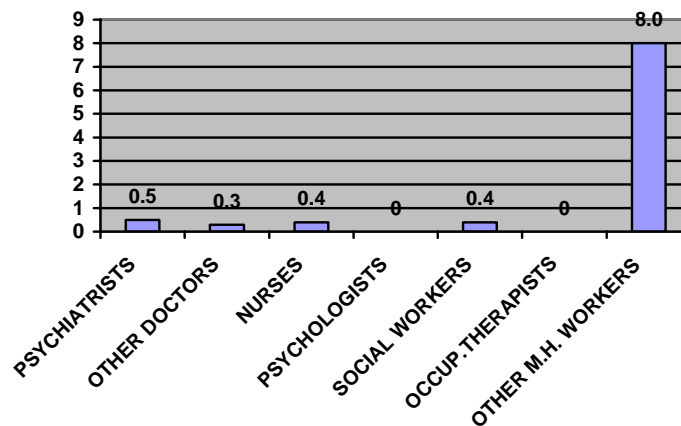
Regarding the workplace, one psychiatrist works in the national mental hospital, and 2 psychiatrists split their time working in outpatient facilities and in the community-based psychiatric inpatient unit. In terms of non-specialised doctors, although there are no general doctors working at the national mental hospital, there are 2 general doctors working in outpatient facilities and in the community-based psychiatric inpatient unit. As for nurses, one works in the national mental hospital, and 2 work in the outpatient facilities and in the community-based psychiatric inpatient unit. In addition, there are 3 social workers working in outpatient facilities, 2 in community-based psychiatric inpatient units and 1 in the national mental hospital. As regards to other health or mental health workers, one works in outpatient facilities, 19 in the community-based psychiatric inpatient unit, and 40 in the national mental hospital.



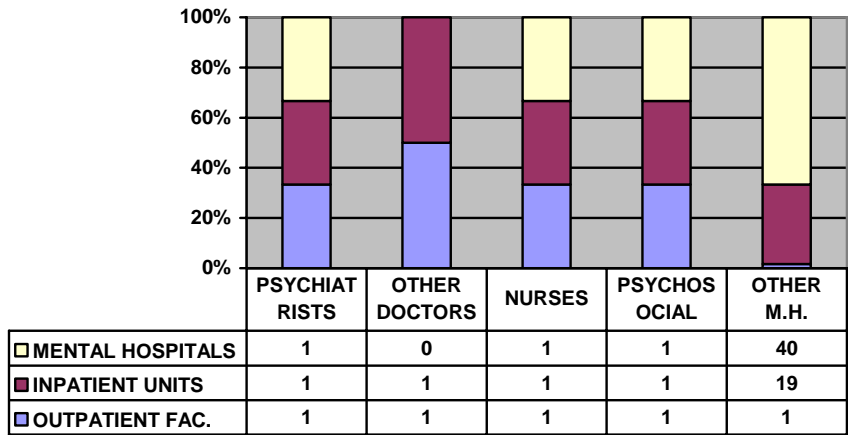
In terms of staffing in mental health facilities, there are 0.03 psychiatrists per bed in community-based psychiatric inpatient units, in comparison to 0.004 psychiatrists per bed in the national mental hospital. As for nurses, there are 0.03 nurses per bed in community-based psychiatric inpatient units, in comparison to 0.004 per bed in mental hospitals. As for social worker, there are 0.03 per bed in community-based psychiatric inpatient units and 0.004 per bed in the national mental hospital. Finally, for other mental health care staff, there are 0.63 per bed for community-based psychiatric inpatient units, and 0.17 per bed in the national mental hospital.

There is an inequitable distribution of human resources between urban and rural areas with all available specialized mental health staff working at the mental hospital or in the capital city of Georgetown: one psychiatrist in 1.61 and one nurse in 1.81 works in or near the largest city.

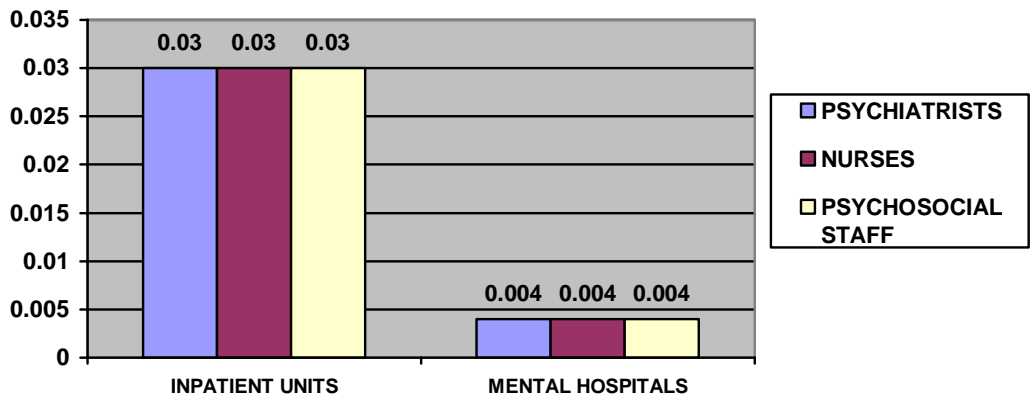
**GRAPH 4.1 - HUMAN RESOURCES IN MENTAL HEALTH**  
(rate per 100.000 population)



**GRAPH 4.2 - STAFF WORKING IN MENTAL HEALTH FACILITIES**  
(percentage in the graph, number in the table)



**GRAPH 4.3 - RATIO HUMAN RESOURCES/BEDS**

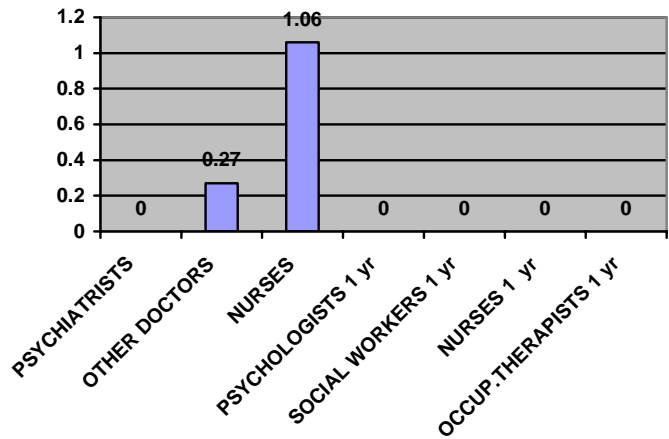


**Training professionals in mental health**

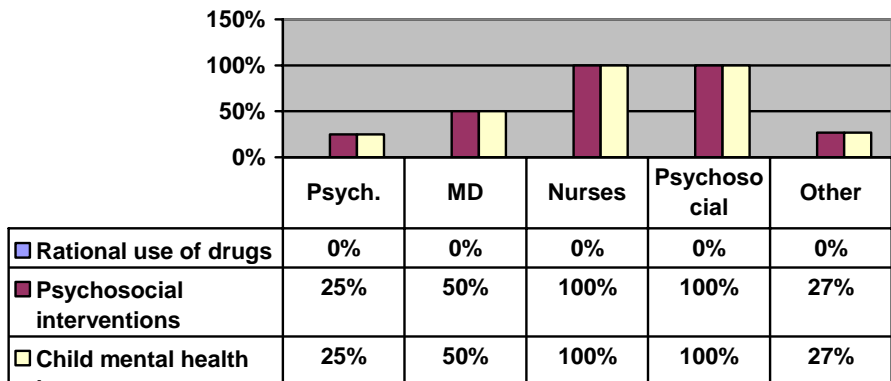
The number of professionals graduated last year in academic and educational institutions in Guyana per 100,000 is as follows: 0 psychiatrists; 0.26 per 100,000 population general medical doctors (not specialized in psychiatry); 1.06 per 100,000 population nurses. There is no psychiatry residency training program currently available in Guyana and no training programs available that provide at least one year training in mental health care for nursing, psychology, social work, or occupational

therapy. The following graph shows the percentage of mental health care staff with at least two days of refresher training in the rational use of drugs, psychosocial interventions, and child/adolescent mental health problems.

**GRAPH 4.4 - PROFESSIONALS GRADUATED IN MENTAL HEALTH (rate per 100.000 population)**



**GRAPH 4.5 - PERCENTAGE OF MENTAL HEALTH STAFF WITH TWO DAYS OF REFRESHER TRAINING IN THE PAST YEAR**



**Consumer and family associations**

There are no mental health consumer or family associations in Guyana. There are 2 NGOs in the country involved in individual assistance activities such as counselling, housing, and support groups for persons affected by substance use disorders - the Salvation Army and Phoenix Recovery. Both NGOs participated in the drafting of the draft mental health policy and plan.

## **Domain 5: Public Education and Links to other Sectors**

### **Public education and awareness campaigns on mental health**

The Ministry of Health's Social Mobilization Unit is responsible for coordinating and overseeing health and mental health publication and awareness campaigns. Over the past year there have been public education material published in the local newspaper on depression, substance abuse and eating disorders. The Ministry of Health has a weekly public education program that has actively promoted mental health awareness and has dedicated one show every 2-3 months to a mental health issue. In the past one year depression, anxiety, trauma-related disorders and substance use disorders have been featured. In addition, the Substance Abuse Unit within the Ministry of Health hosts a weekly television program called 'Changing Course' that provides public education and information regarding substance use related problems and issues.

In addition, the Ministry of Health and PAHO/WHO hold annual mental health public education and awareness campaigns for World Mental Health Day. Annual World Mental Health Day activities include a parade involving both community and consumers and a community breakfast featuring mental health awareness talks at the National Psychiatric Hospital for the public, consumers and staff.

### **Legislative and financial provisions for persons with mental disorders**

At the present time, there are no specific legislative provisions against discrimination at work, or against discrimination in housing for persons with mental illness. Legislative provisions concerning access and availability of employment opportunities, appropriate health care, education and affordable housing for people with disability and protection from discrimination in at work and allocation of housing are specifically addressed in the *Persons with Disabilities Bill 2007*; however, this bill has not yet been enacted.

Financial assistance is available for all persons suffering from a mental disorder through the National Insurance Scheme and is accessed by consumers and families through the treating physician who provides supportive documentation. By best estimate, 75% of persons accessing outpatient mental health care services and 40% of persons who are currently inpatients of the National Psychiatric Hospital or the Georgetown Public Hospital Corporation Psychiatric Unit receive benefits through the National Insurance Scheme. Family members, not consumers, most often make requests for assistance. Those who do not receive benefits are believed to not be aware that they are eligible for financial assistance or their families do not require it.

### **Links with other sectors**

Over the past 2 years, the Ministry of Health has actively encouraged the development of inter-ministerial and multi-sectoral collaborative initiatives to assist with the development of the mental health program. Examples include the 2007 partnership of the Ministry of Human Services with the Ministry of Health to begin the development of a strategy to address the needs of the homeless population in Guyana 2007; the 2007 partnership with faith-based organisations, private sector, NGOs, Ministry of Human Services, Ministry of Education, Ministry of Youth Sports and Culture, and Ministry of Home Affairs with the Ministry of Health to develop a national suicide prevention strategy; the 2008 partnership between the Ministry of Human Services, Ministry of Education, and UNICEF with the Ministry of Health to support programs to enhance the capacity of communities to address the mental health consequences of trauma exposure on children and youth; the 2008 partnership of 2 NGOs (Phoenix Recovery and Salvation Army) providing substance abuse counselling and residential care services in Georgetown with the Ministry of Health to develop a national substance abuse and addictions program.

In terms of support for child and adolescent health, none of the 440 primary or 106 secondary schools have either a part-time or full-time mental health professional, and there are no formal school-based activities to promote mental health and prevent mental disorders. The GPHC provides a twice-monthly multidisciplinary child and adolescent mental health ambulatory clinic. This service is collaboratively provided by paediatrics and mental health.

Regarding mental health activities in the criminal justice and penitentiary system, the percentage of prisoners with psychosis, according to the best estimate by attending psychiatrists, is 2 - 5%, while the corresponding percentage for mental retardation is unknown since there has been no formal psychological testing or diagnostic evaluation for mental retardation of inmates at the prisons in Guyana and prisoners with mental retardation are not referred to mental health services. Out of the five adult correctional facilities, 1-20% of prisons have at least one prisoner per month in treatment contact with a mental health professional and mental health services are provided at 2 of the 5 correctional facilities: the Georgetown and the New Amsterdam Prisons.

As for training, few police officers (1 – 20%) and no judges or lawyers have participated in educational activities on mental health in the last five years.

## **Domain 6: Monitoring and Research**

An annual report on all health services is published by the Ministry of Health, which includes data from mental health facilities. A formally defined list of individual data items to be collected by all mental health facilities exists for both outpatient and inpatient information. Inpatient data includes total number of patient contacts, number of beds, acute patients, acute patients with nowhere to go, chronic long term patients, chronic patients with nowhere to go, number of discharges, number of deaths, drug and alcohol related patients, mental retardation cases and patients that are convicted by the judiciary system (prisoners). Outpatient data includes the total number of patient contacts, number of new outpatients as well as their attendances. Data regarding number of users of inpatient and outpatient facilities, number of

involuntary admissions to inpatient facilities and the use of restraints in inpatient facilities is not collected. As shown in the table 6.1, the type of data collection is consistent among mental health facilities; however, the submission of data to the Ministry of Health is not timely. As a consequence, data sets from mental health facilities for the 2005 -2006 annual health report were incomplete. At present, the data for 2007 is being collected.

**GRAPH 6.1 - PERCENTAGES OF MENTAL HEALTH FACILITIES TRANSMITTING DATA TO HEALTH DEPARTMENT**

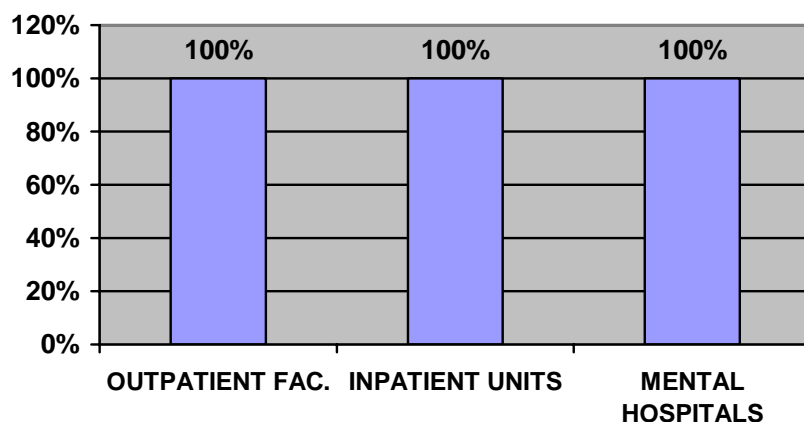


Table 6.1 - Percentage of mental health facilities collecting and compiling data by type of information

	<b>MENTAL HOSPITALS</b>	<b>INPATIENT UNITS</b>	<b>OUTPATIENT FAC.</b>
<b>N° of beds</b>	100%	100%	-----
<b>N° inpatient admissions/users treated in outpatient fac.</b>	100%	100%	0%
<b>N° of days spent/user contacts in outpatient fac.</b>	100%	100%	100%
<b>N° of involuntary admissions</b>	0%	0%	-----
<b>N° of users restrained</b>	0%	0%	-----
<b>Diagnoses</b>	100%	100%	100%

In terms of research, 11% of all health publications in the country were related to mental health. The last publication was a non-epidemiological assessment focused on completed suicides and suicide attempts based on the data collected by the GPHC.

### Strengths and Weaknesses of the Mental Health System of Guyana:

WEAKNESSES	STRENGTHS
Mental Health lags behind other areas of health in terms of development.	Mental Health has been clearly positioned as a priority area for development in the Ministry of Health's Health Sector Strategy 2008-2012.
Financing for Mental Health is insufficient	The Ministry of Health has a dedicated budget for mental health that has increased annually for the past 5 years and has been successful in enhancing available resources for mental health through task alignment and resource harmonisation, grant funding, and international partnerships.
No formally endorsed Mental Health Policy or Plan	A 'draft mental health policy and plan' are available and are informing the development of the mental health program.
There are currently no guidelines for clinical practice in mental health or for the rational use of psychotropic medications, neither are there national or institutional standards of mental health care.	The Ministry of Health has completed the first two (national guidelines for the management of anxiety and depression in primary care) of a series of national mental health clinical guidelines. Guidelines for the use of antidepressant medications, antipsychotic medications, and the management of psychotic and trauma related disorders will be completed in 2009.
Current Mental Health legislation is antiquated.	The Ministry of Health initiated the process of drafting new updated mental health legislation. In addition, disability legislation which addresses the equity needs of both the physically and mentally disabled will be introduced in 2009.
There has been little mental health governance and leadership at both national and regional levels in Guyana.	The Ministry of Health has introduced a governance structure for mental health (the Mental Health Unit) within the organisational framework of the Ministry of Health.
Mental Health Services have been fragmented and are largely institution based.	The establishment of the Mental Health Unit has facilitated the integration of existing mental health services. The Ministry of Health has actively promoted the development of primary care capacity to provide first line mental health care along with the development of specialist mental health consultation, mentoring and supervision – a shared care model of mental health care delivery for communities.
There is a dearth of specialized mental health care professionals	The Ministry of Health has been actively engaged in mental health care capacity building at each level of the health sector within existing health human resources in order to reduce the reliance on specialist care.
There is little community based mental health care.	The Ministry of Health has actively engaged with FBOs, NGOs, and other government sectors (particularly education and human services), and the private sector to develop community support services for persons affected by mental illness.
Multi-sectoral collaboration in Mental Health has been poor.	The Ministry of Health has successfully engaged inter-ministerial and multi-sectoral partners in the development of the mental health program.
There is inadequate mental health service data available.	Mental Health is an identified priority area included within the health information system development process underway.
There is little research in mental health.	All mental health activities are now completed within a monitoring and evaluation framework and expectant data will be utilized for research.

### **Next Steps for Planning Mental Health Action:**

Considering the WHO-AIMS data and the context provided above, possible areas of action are:

1. Development of community-based mental health care services.
2. Development of a suicide prevention strategy for Guyana
3. Revision of the current mental health legislation of Guyana to meet international and PAHO/WHO standards.
4. Development of a functional plan for the National Psychiatric Hospital that promotes the deinstitutionalization of mental health care and the recovery of persons with mental illness.

The following could be possible actions in these areas:

1. Training of community and primary care health workers to provide therapeutic, community-based mental health care and management.
2. Development of 'shared care' services between primary health and mental health services.
3. Implementing a workshop on evidence based global suicide prevention strategies.
4. Implementing a workshop on Mental Health Legislation and Human Rights.
5. Training of National Psychiatric Hospital staff in mental health therapeutic rehabilitation.



The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Guyana. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change.

Although Guyana's mental health legislation of 1930 is outdated, the country currently drafted a mental health policy and plan. However, few of the country's financial and human resources are devoted towards mental health. Only 1% of its health budget is directed towards mental health services, and only a limited number of specialized health professionals provide mental health care, including 3 psychiatrists, 3 social workers, 2 other medical doctors, and 2 nurses. There are currently no psychologists in the country.

Guyana's mental health network consists of 1 mental hospital (with 240 beds), 2 outpatient facilities, and 1 community-based psychiatric inpatient unit (with 4 beds). Four times more outpatient care is provided in the country (with 274.9 outpatient users per 100,000 population) than inpatient care (59.2 and 33.7 users per 100,000 in the community-based inpatient unit and mental hospital, respectively).

To improve mental health services, in recent years, the Ministry of Health established a Mental Health Unit within the ministry, has held public education and awareness campaigns, and has actively encouraged links with other health agencies, such as the Ministry of Human Resources and Ministry of Education. Finally, an annual report is published by the government that includes information collected by mental health facilities.