

JAMAICA: COMMUNITY MENTAL HEALTH SERVICES

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Mental health services in Jamaica are in transition. Jamaica's Ministry of Health is trying to develop a better and more comprehensive community mental health system by building on the success of pioneer community services while scaling down Bellevue, the country's biggest and best known psychiatric hospital. Mental health officers (MHOs) are at the heart of the transformation; increasing the number of specialist nurses also is considered crucial for sustaining the delivery of quality services. These changes are occurring within the context of an ailing economy with tight fiscal controls.

This chapter describes the work of MHOs, as a way to showcase a model of mental health care delivery that can be replicated in other low- and middle-income countries. The material is based on a review of the literature on psychiatric services in Jamaica, as well as on 2003 field work during which Jamaica's MHOs and other mental health service providers were interviewed. The author would like to thank the Government of Jamaica's Ministry of Health, the Pan American Health Organization's country office, and last, but certainly not least, all the clinicians who were interviewed.

THE JAMAICAN CONTEXT

Jamaica, a former colony of the United Kingdom, lies in the Caribbean Sea just south of Cuba (1). Jamaica became independent from the United Kingdom in 1962, although it remains as a member of the British Commonwealth of Nations; Queen Elizabeth II is the country's Executive Chief of State, represented by the Governor General. The Prime Minister and members of the House of Representatives are democratically elected, but members of the Senate are appointed. The party that wins the general election automatically gets a senate majority. Administratively the country is divided into 14 parishes—Clarendon, Hanover, Kingston, Manchester, Portland, Saint Andrew, Saint Ann, Saint Catherine, Saint Elizabeth, Saint James, Saint Mary, Saint Thomas, Trelawny, Westmoreland (2).

Of the total territory, 25% is used for farming. The country suffers from extensive deforestation; its coastal waters are polluted by industrial waste, sewage, and oil spills; and coral reefs have been damaged. Kingston, the capital, has serious vehicle-emission air pollution (1).

Jamaica has a population of 2.5 million, most of which lives in coastland areas; Kingston and its surrounding areas being the most densely populated. Of the population, 91% is of African descent, originally brought to the island as slaves; the next largest group (7%) is of mixed race. The country's age structure is much like that of other low- or middle-income countries—30% under 14 years of age and 7% over 65 years of age. There is a net negative migration of seven persons per 1,000 per year. Official figures report a relatively long life expectancy, more than 73 years of age (3).

One in seven people over the age of 15 have never attended school. School non-attendance is more common among men than women.

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The economy depends heavily on tourism and bauxite mining. The annual per capita GDP in international dollars is \$3,776 (1). Deteriorating economic conditions during the 1970s led to recurrent violence and a drop in tourism. The democratic socialists were voted out of office in elections in 1980. Political violence marred elections in 1992, when the current Prime Minister, Percival James Patterson came to office. Through 1995–2000, the economy stagnated, but grew by 0.8% in 2000 and by 1.1% in 2001. Since autumn 2001, the global economic slowdown has stunted economic recovery. As of this writing, serious economic problems persist—high interest rates, increased foreign competition, changes in the exchange rates, a widening merchandise trade deficit, and a growing internal debt. Thirty four percent of Jamaicans live below the poverty line. Not surprisingly, the depressed economic conditions have led to increased crime (1).

Jamaica's economic situation also is marked by wide disparities. Inequality in the distribution of family income in a society can be measured using the Gini coefficient. A perfectly equal society would have a Gini coefficient of 0; a totally unequal country would have a Gini coefficient of 100. Gini coefficient values in Scandinavian countries tend to fall somewhere in the 20s, those in some sub-Saharan countries, in the 50s. Jamaica's Gini coefficient is 37.9, similar to the United Kingdom's (36.8), indicating that family income is more equally distributed than in the United States (45) (4).

The total health expenditure as a percentage of GDP as of the year 2000 was 5.5%, a figure in line with that of other Caribbean islands, but far behind that of the United States (13%) and somewhat less than that of its nearest neighbour, Cuba (6.8%) (3). The country's total per capita expenditure on health per year is approximately 200 international dollars—53% of this is private expenditure, either out-of-pocket payments by individuals, insurers, and third party payers other than social security or activities of non-governmental health care providers. This figure is high for the Region. It is in line with that of the United States (55.7%), but not that of similar Caribbean islands, which runs in the range of 30%-40% (3).

Income inequality, economic downturn, crime, and violence are all associated with higher rates of mental illness (5). Coupled with the fact that only a relatively low percentage of health expenditures come from government sources, these factors pose serious challenges for restructuring the country's mental health services.

MENTAL HEALTH SERVICES IN JAMAICA

The overall delivery of mental health services is under the control of Jamaica's Ministry of Health. A mental health unit in the Ministry's Programme, Planning, and Integration Division sets policy, regulates, monitors, conducts research, and undertakes program development. There is significant decentralisation, however. Both mental and physical health services are organized by regions, as follows: South East (including Kingston and St. Andrew), North East, Southern, and Western. Mental health teams for each region are led by a psychiatrist, and the configuration of each team and its working practices differ from region to region.

Inpatient Units

Bellevue Hospital in Kingston is Jamaica's largest hospital, with more than 1,000 beds. Of the hospital's patients, 40% are older than 65 years, 60% of them are regarded as chronically ill, and 300 of them have lived in the hospital for most of their adult lives. Most admissions come from Kingston and St. Andrew, but any patient requiring psychiatric intensive care may be transferred there. University Hospital West Indies (UHWI), also located in Kingston, has a 20-bed psychiatric unit. It is an acute unit with an average length of stay of 15 days. Jamaica's rural and western

regions are served partly by Cornwall Regional Hospital. This 60-bed unit offers a full range of services, but only 30 beds are used because of staff shortages.

Beds in general hospital wards also are used to treat people with acute mental illness. The level of care given to those treated in these non-specialist beds depends on the availability of mental health officers or of a psychiatrist in the area to take over care or support physicians and surgeons in managing patients. It also may depend on the proximity of a mental health unit: the nearer a general hospital is to a mental health unit, the less pressure it may feel to admit patients with psychiatric illnesses. In general hospitals, patients with mental health problems are nursed on open wards. In the North East and Southern regions, where there are no specialist psychiatric hospitals, patients with mental health problems are mainly treated on general wards.

Emergency Psychiatric Hospital Services

General hospitals offer island-wide emergency services 24 hours a day seven days a week. In addition, psychiatric units at Bellevue, Cornwall and UHWI also offer 24-hour services.

Emergency calls are directed to mental health officers (MHOs), specialist psychiatric community-based nurses, who may make home visits with a team including psychiatric aides. There are two mobile crisis teams in operation and others are under development.

Outpatient Care

Adult outpatients are seen at Bellevue Hospital, UHWI, and the regional and general hospitals. Clinics also are conducted in primary care. Outpatient clinics are conducted by psychiatrists and MHOs. Most clinics in primary care are conducted by MHOs.

Medication

Medications for treating mental health problems are limited and their availability varies district by district. Older antipsychotic drugs are usually available, but there is only limited availability of the newer, more expensive anti-psychotics. In the North East, some patients are treated with clozapine by special arrangement by the district psychiatrist. Moreover, because it sees so many patients and has control over its own budget, Bellevue Hospital can take advantage of economies of scale and, thus, keep a more varied medicine armamentarium than is typical in the public sector. A wider selection of drugs is available in the private sector where cost is less of a concern.

There is about a US\$ 2 charge for prescribed medications. Depot injections are free, but anti-cholinergic medication to counter side effects is not. There is government assistance for low-income patients. However, the frontline staff interviewed for this chapter said that, in practice, few people ask for it. This impression was supported by this author's findings in one clinic, where none of those who were prescribed medication (at least 35) had asked for assistance, despite the fact that none of them were working. It is customary for families to pay for their relatives' medication. Caregivers considered a lack of money and the need to pay for prescriptions as a deterrent for coming to the clinic. Government assistance did not seem to counter this, because of the stigma attached to being considered eligible for assistance. In fact, some of this stigma seemed to have shaped the way in which the system was enacted. For instance, in one district the decision about whether the patient should be asked to pay for medication or not was made by the pharmacist. The pharmacists had to decide whether or not to ask for proof that a patient requesting assistance was in genuine need, but pharmacists do not like asking such questions. With no guidelines in force, the pharmacist often relies on cues such as how the patient is dressed to make a decision. Because being considered scruffy is considered insulting, patients with mental health problems dress up when they come to the clinic, hence they are not asked whether they

need assistance and are sent directly to the clerk to pay. They could, of course tell the clerk that they need assistance, but this is considered embarrassing because the setting lacks privacy. As a result, some patients do not come to the clinic unless they have enough money to pay for their medication.

Community Mental Health Services

Community mental health services are fragmented in Jamaica. The range of services and access to them is limited. The mental health officers are the backbone of the service; their responsibilities will be detailed below. This section will outline currently available services.

By crude estimates, there are 500,000 persons in Jamaica who have mental health problems (2). The number of patients on the books of the community services has increased from 7,779 in 1995 to 10,907 in 2000 (6). Community services treat patients with serious mental illness. There is little or no service for people with more common mental disorders such as anxiety disorders and mild depression .

To date, Jamaica has not had a strategic development of rehabilitation services. This is partly due to a lack of funds. In addition, there are only a handful of occupational therapists on the island and there are no specific training programs in rehabilitation nursing. Rehabilitation services are primarily located in Bellevue and UHWI.

There are three halfway houses for mentally ill persons that are operated by private, nonprofit organizations in the community. All three facilities are in St. Andrew, and they offer assisted living and independent living; one facility is for clients with dual diagnosis. Each house has places for between 10 and 20 persons. Referrals can be from relatives, carers, or mental health practitioners. However, families have to pay for these services. Data on length of stay is not available.

Four Church organizations offer counselling, with two of them providing a mixture of counselling, rehabilitation, and night shelter.

Old Age, Child, and Forensic Services

Old age, child and adolescent and forensic adolescent services are important for the proper management of the mentally ill in the community. On the one hand, child and adolescent services have expanded in the country. However, although they are staffed by a dedicated group of professionals working in difficult circumstances, they do not meet the population's needs. On the other hand, there is presently no funded national strategy for developing old age or forensic services. There have been discussions about the need for and possible models of forensic services, and there are psychiatrists who offer their services to prisons and diversion schemes, but these efforts are not centrally coordinated and coverage is patchy.

Among the mentally ill population of Jamaica, 2% is homeless, and this group accounts for 60% of the homeless in the country. Homeless shelters are not provided by the government. Six hundred and twenty people are housed in charity, NGO or church hostels. The models of care and rehabilitation are variable.

Training

The University of the West Indies offers training in general nursing, psychiatric nursing, psychology, social work, and medicine; it also offers a residency program in psychiatry. At the time of this writing, two doctors were going through this program, but there was no assurance that there would be enough work to absorb them once they were qualified. The strategic mental

health plan suggests that all doctors doing their post graduate residency should undertake some time in psychiatry, but this has not as yet been enacted.

The Ministry of Health offers courses in general nursing and training to become a mental health officer or psychiatric aid (a nursing assistant who undergoes a four month course in psychiatry).

Mental Health Law

Jamaica's mental health law has recently undergone changes. The Mental Health Act of 1873 was amended in 1974, a change that authorized Mental Health Officers to enter the home of any mentally ill person and take that person to a clinic or hospital for evaluation and treatment by medical practitioners. This authorization fell under the common law system which governs the treatment of physically ill persons who are incapacitated. Those living with the person deemed mentally ill were required by law to assist the MHO. This law used the same powers of detention for those with mental health problems as for those with physical health problems.

A new Mental Health Act was passed in 1997. The new legislation detailed many of the powers covered by the 1974 amendment, but added clauses covering compulsory detention and appeals. It made detention different from that for physical illness and limited detention to 14 days (7).

The overall impact of the new legislation on psychiatric practice is still to be assessed. In a recent test case in the courts, an MHO was charged with battery and false imprisonment and the plaintiff (patient) was awarded damages. The decision led to a discussion over whether there is a need for a code of conduct to be drawn up, for protocols and regulations for MHOs field work, a formal program of education on the Mental Health Act for practitioners, and another review of the law.

THE DEVELOPMENT OF COMMUNITY CARE IN JAMAICA

Psychiatry in Jamaica has been dominated by Bellevue Hospital. This huge Victorian institution was built by the British Colonial Government in 1862, and was originally called the Lunatic Asylum. It was designed to meet the needs of an extended-stay population when there was no effective treatment or management of severe, enduring mental health problems. By the time Jamaica gained its independence a century later, the hospital had 3,000 inpatients and little psychiatric care was provided anywhere else on the island. However, plans were already afoot to diversify psychiatric treatment. Reports published by PAHO in 1958 and 1963 paved the way for change (2).

By the 1960s, modern approaches to treatment, the recognition that large psychiatric institutions could lead to patients becoming "institutionalized," and the advent of pharmaceutical treatment and contemporary rehabilitative methods were accepted worldwide. Jamaica's move away from custodial care followed this trend. A new mental health inpatient unit was built on the island's west; given that there were only a handful of psychiatrists employed by the Government at the time, physicians and other medical ward staff were trained and supported in treating acute psychosis on their wards. These wards aimed to discharge clients in 10–14 days (2). In addition, the role of primary care was expanded. By 1992, there were 335 local clinics and 1,200 general practitioners. Primary care physicians treat moderately severe mental illness and work with

MHOs to assess and treat persons suffering from severe mental illness that are stable. More complex cases and the more severely ill are referred to mental health clinics (8).

PAHO was instrumental in developing countrywide community care in Jamaica (9). In 1962, PAHO consultants recommended that Jamaica redraft its mental health legislation and develop a community mental health service, an intensive training program for mental health providers and rehabilitation, and a systematic deinstitutionalization program for Bellevue (2).

An analysis of Jamaica's mental health statistics demonstrates that the admission rate and resident population off the main psychiatric hospital, Bellevue, decreased between 1960 and 1990. Although the country's population increased by 50% in these three decades, the resident population of Bellevue Hospital decreased by 58% (from 3,094 to 1,296) and the admission numbers decreased by 67% (from 1,097 to 557 patients a year). In 1975, the community psychiatric services referred 139 patients to Bellevue and 606 to parish hospitals. By 1990, they were referring only 29 patients to Bellevue and 551 to parish hospitals. Total referrals dropped by 22%, but this does not take into account the length of stay or the fact that the number of patients seen by the services had increased by 10% over this period. At the same time, home visits to patients increased by more than 300%.

Taking into account increases in the population, the admission rate per 100,000 decreased by 50% between 1971 and 1988 (2).

When asked why admissions to Bellevue Hospital had decreased, Dr Earl Wright, the current head of psychiatry in the Department of Health of Jamaica, cited three reasons:

- 1) The way that health services were regionally restructured, with local acute hospitals being expected to take psychiatric admissions, made it more difficult to admit patients.
- 2) The opening of Cornwall Hospital.
- 3) MHOs were developed which increased the capacity in the community. He also said that all services were encouraged to use outpatient treatments, which was facilitated by the existence of the MHOs.

Professor Fredrick Hickling, Head of the Department of Psychiatry at the University of the West Indies, added that Bellevue was not working and a decision had been made to shut it down. Therefore, MHOs were developed and trained to take over the care of people who either came out of or were not admitted to Bellevue.

There is broad agreement that mental health care has shifted from hospital to community-based care. Some of the Bellevue figures reflect the use of general hospital beds for the treatment of acute psychosis, but it is generally agreed that there has been a decrease in all hospitalizations, and that this has been due to an increase in community care. Because there is little in the way of rehabilitation services or true community-based psychiatrists, community care has had to rely on MHOs.

Several other factors have encouraged the use of MHOs. First, as primary care expanded, it allowed for some medical support for community care. Second, the decrease in the number of psychiatric beds made admission to hospital more difficult. Third, because of a lack of psychiatrists, there was a need for a group that could offer support to medical wards, which now were expected to offer care to acutely ill patients with mental health illness. Thus, MHOs have become the backbone of community services, and their deployment is considered vital for the success of Jamaica's community care.

Deinstitutionalization may well be the end point of several initiatives, but the unique role of the Mental Health Officer is what is remarkable. Despite a far from comprehensive strategy to

promote community care, the multifaceted nature of the work of MHOs has been the glue that has held together the country's mental health system. It is unclear how regionalization of mental health services, decreasing beds and expanding primary care could have worked without MHOs. Moreover, given the fact that so few were originally employed, it could be argued that it is a testimony to the hard work of these professionals that community care in Jamaica has even survived.

MENTAL HEALTH OFFICERS

A Brief History

A pilot project in three of the country's eastern parishes employed the first two mental health officers in the early 1960s. By 1969, there were five MHOs employed; by 1972, there were 19 and every parish had at least one (2). As discussed previously, a 1974 amendment to the 1873 Mental Health Act authorized MHOs to enter the home of any mentally ill person and take that person to a clinic or hospital for evaluation and treatment by a medical practitioner.

As of this writing, there are 41 MHOs in the country (6), which includes five regional supervisors and one national coordinator. Nationwide, the total active caseload is more than 14,000 patients. The average caseload of an MHO is 500 patients, but some of these may not be active. They see more than 200 patients a month. Care is, however, shared with regional psychiatrists, district medical officers and, more often than not, the patient's family. Indeed, it is hard to envisage community care in Jamaica working without robust family support networks. The family acts to support, to offer home treatment, to ensure compliance and to monitor patient's mental state and risk. With minimal financial aid and rehabilitation, the family is vital for sustained recovery.

Who They Are

A Mental Health Officer is a specially trained nurse practitioner, a cross between a community psychiatric nurse such as seen in many other services around the world, and junior doctors working in community psychiatry. The MHO training, which is undertaken by Jamaica's Ministry of Health, includes courses in general medicine, psychiatry, psychology, social work, psychopharmacology, and patient management. Training is geared to allow MHOs to deal with most psychiatric referrals, offer initial assessments, advise primary-care and hospital physicians on how to treat people with mental health problems, and offer crisis, home treatment, assertive outreach and case management.

MHOs are not expected to initiate treatment themselves nor to change the type of treatment a patient is already receiving. (For that, patients are expected to see a doctor—a primary care physician, a physician in hospital, or a psychiatrist.) MHOs can reinstitute treatment in the event of a patient's noncompliance or when a patient has previously been treated.

There are significant differences between a MHO and a community psychiatric nurse. The breadth and depth of the job are much greater for MHOs. Not only can they reinstate drug therapy, they also are designated by law as the group which can initiate detention under the mental health act. Rather than being part of a multidisciplinary team, MHOs are professionals who are largely autonomous but are supported by others when they request it.

The major differences between MHOs and a junior psychiatrist in training are that the former do not have a medical qualification and the scope of their training is limited. In theory, this should make MHOs quicker and less expensive to train. In practice, however, there is stiff

competition to become an MHO, and most of them have many years of nursing experience before they are accepted to the MHO course.

It is important for those who are considering adopting this model to know that it is not clear whether it is the job's specifications, the training, or the high standard of applicants that are mainly responsible for the reputedly first rate care that MHOs are said to provide. Indeed, Dr. Earl Wright, Director of Mental Health and Substance Abuse in Jamaica's Ministry of Health, stated that the main barrier to increasing the number of MHOs to the desired figure of 101 was finding the right applicants. This may, in part, reflect the high calibre of nurses required to fill the role, but may also have to do with the attractive financial packages currently offered to applicants if they leave Jamaica and take jobs in high-income countries, where salaries are much higher and the quality of life is thought to be much better. Dr. Wright did not offer figures, but stated that the flight of nurses from Jamaica to the United States of America was a major problem.

Continuing Professional Development and MHOs

Local MHOs meet regularly (at least once a week) to discuss patients and support each other. There also are weekly national educational meetings for MHOs where they can discuss clinical issues and other service-related issues. Some of the meetings may include presentations from outside speakers. Attendance at these formal, chaired meetings tops 90%. MHOs also can take courses to maintain skills or develop new ones. These are often off island and so can be costly; there is a limited budget available to facilitate this.

Another qualification, that of psychiatric nurse practitioner, is available on other Caribbean islands, although not on Jamaica. MHOs attendance to this course depends on Ministry of Health funding. It happens rarely (only 4 of the 41 MHOs have taken that course) and there are no set criteria for a successful application for funding. Only 4 of 41 of the MHOs have taken this course.

Mental Health Officers In Action

It is perhaps easier to understand how MHOs work by considering the pathway to assessment and care of a person with an acute mental health problem.

Referral can be from any source—social worker, probation officer, or family member. Routine referrals also come from prenatal clinics, well-baby clinics, primary care practitioners at all levels, nurses in various hospital clinics, the police, the courts, and self referrals. These referral systems are informal and have been established mostly by contact between different services. They vary from area to area, depending on the closeness of the relationship between different MHO teams and other parts of the service.

Referrals are made directly to the MHO or to a psychiatrist. There are differences in balance between areas but, in general, the majority of people are initially seen by a MHO, a crisis response team, or at an accident and emergency department. The MHO is the point of access for the crisis response team. They are telephoned by a hospital unit.

Crisis calls are usually made directly to a hospital unit. After 5 p.m., the hospital forwards the call to the MHO on duty, who then discusses the case with the carer or with the relatives. At this stage, there are two possible outcomes: advice alone or a visit by the on-call team, which consists of an MHO and two to four psychiatric aids, depending on the district. (Doctors are not part of on-call teams.) Mobile response units with the same composition have also been developed. Initially, two teams were set up, one in the South East and one in the West. Jamaica's Strategic Plan calls for a psychiatric emergency team in each parish by 2006. mobile teams will eventually act as proactive outreach and home treatment teams.

The teams also visit and assess patients. Three possible outcomes can come out of these visits: the patient is taken to the nearest treatment point, the patient is given treatment at home, or no treatment is given but support and counselling is offered to the responsible carer.

For those treated at home, medication is initiated in liaison with a primary care physician. However, since MHOs' training in psychopharmacology varies and there is no mandatory psychiatric rotation as part of their training, complex cases are referred to a psychiatrist for assessment. Treatment in hospital is usually recommended either because patients are experiencing high levels of arousal or because a lack of family support makes home treatment impossible. But, because ambulances are not always available out of hours, in some regions the move to a hospital is facilitated by the police. The police are sometimes reluctant to do this, however. If the police decline to convey people to hospital, family members may be called on to help. Training the police and setting up specific police response teams has proved feasible, and it has increased the capability of the police force to respond to the needs of crisis assessment teams. Patients who arrive at accident and emergency departments are assessed there by an attending doctor who may or may not be a psychiatrist. The assessment is done in association with an MHO. That said, most people are treated in the community and admission to hospital is rare. Those who are considered suitable for community treatment are discharged to the care of an MHO. If people are admitted to hospital, the MHO sees them regularly and liaises with the inpatient team and local psychiatrist. The average stay is two weeks.

Acutely psychotic patients are treated with intramuscular injections or oral antipsychotics until they become less aroused. Once they are more settled (not necessarily less psychotic) they are discharged to the care of an MHO in the community. The patient's family is counselled on how to continue treatment and a clinic appointment is made for two or three days after when they will see an MHO. Family support is vital for success in community-based treatment because without it patient non-attendance at follow-up appointments and non-compliance with the medication is much more likely.

Follow-up by home visit rather than out-patient clinics is more likely if the patient lives far from the hospital or if there is no family support.

As previously stated, treatment for psychiatric problems is started by either a primary care physician or a psychiatrist. Continuing care for those who have seen a psychiatrist is provided by the MHO. Referral back to a psychiatrist by an MHO is only made if further assessment or a change in medication is required. MHOs defer to doctors and refer back to doctors if a case is complex or treatment needs change. In practice, this may not be as much of a safeguard as it might first seem, because some doctors have much less experience than MHOs and are unsupervised.

Some MHOs said they often gave relatives their mobile telephone number and sometimes gave depressed or suicidal patients their telephone number as well. They said that they were known in the community anyway, so people could always find them if they really wanted to. All MHOs live in the regions that they service. They thought this open access worked well.

In addition to direct patient care, MHOs in some regions also take part in health promotion. They offer health promotion for community groups and seminars on conflict resolution, stress management, anxiety management, child disorders, and substance abuse. MHOs said that, at one time, they did more work in schools, but that much of this work is now being done through the new child guidance clinics.

Problems Cited by MHOs and Other Service Providers

MHOs noted several problems concerning funding for education and other activities. In addition, they cited that not everyone acknowledged their expertise, including some doctors in hospital who preferred to deal with other doctors and did not like referring their patients to nurses. The problem also held true in court—an MHO stated that the judges preferred a doctor's opinion.

There were other practical problems that had to do with the context in which MHOs work. For instance, working in Kingston is challenging, as the high level of violence hinders the care that can be offered. In fact, some clinics, such as the one in Olympic Gardens, have closed because of violence. Population density and traffic congestion also cause problems for responding to emergency calls; in some instances, police units have been asked to clear the way. Kingston MHOs said that policemen were becoming increasingly necessary, because patients sometimes carried dangerous weapons. These health workers stated that police presence calmed down 95% of patients who were armed and aggressive, allowing an assessment to be made or admission to occur. Although MHOs only go on such assessments with supervision and support from police, the potential for violence prevents assessments in about 5% of the cases.

MHOs also said that there were practical issues concerning the need to have more social workers in the community. They felt that there was insufficient expertise and assistance for patients with regards to housing, financial, and childcare issues, a fact that impeded recovery and rehabilitation. Additionally, given the need for appropriate accommodation and community-based rehabilitation for patients, coupled with the central government's tight fiscal control, led MHOs to conclude that there was an urgent need to engage nongovernmental organization to cover these needs.

Future Plans for MHOs

Dr. Earl Wright stated that there was a plan to increase the number of MHOs to 101 in the next five years. He said the Government would try to train 12 MHOs each year, but that the real limiting factor would be finding the right persons. As already stated, there is a flight of highly qualified nurses leaving Jamaica to work in the United States, where salaries and quality of life are considered to be better.

MHOs have indicated that it is important to incorporate psychologists into teams. They believed that psychologists would increase the therapeutic options available, and that this would improve patient care.

Discussion

Mental health services in Jamaica have been shifting toward to a community-based system since the early 1960s. A balanced assessment of the research would conclude that MHOs have played a major role in keeping admission rates down and treating people in the community. Given the lack of other community resources, it would seem that the services offered by MHOs are among the most important factors for the decrease in admission rates. Without question, the direct care given by MHOs is important, but the liaison work with primary care physicians and other clinicians and hospital clinical teams also must be considered.

Though many referrals go through MHOs, it is unclear whether it is their role as gatekeepers, educators, or facilitators of appropriate treatment by other professionals that is the most important. It is likely to be a bit of all three, but I would hazard a guess that the general reluctance of physicians to admit or prolong inpatient treatment for people with mental health problems, coupled with the MHOs focus on community-based care, are the reasons for low admission rates. Clearly, the work of the MHOs, or indeed any complex job, is more than the sum

of its parts, and so there may be limited merit in trying to disentangle and assess separately the different aspects of their work. They work in a context, and the different parts of their job are interrelated. Moreover, the multifaceted nature of the job may, in part, be what attracts high calibre applicants.

The independence to practice much as they wish once medication has been initiated is likely to be important in keeping patients in the community, but also in keeping MHOs in their jobs. Most professionals would prefer to treat people in their own domain if it is safe to do so. Moreover, the fact that they have power to change the level of treatment and re-initiate treatment offers immediate care that supplements the close relationships they build with their clients.

MHOs are the backbone of the service. They are a well-motivated and dedicated group. They are experienced and well-educated. They are cohesive; their group activities and meetings are well attended. In addition, they are enthusiastic and willing to accept continuing professional development, although this seems to have been limited by economic imperatives. Perhaps most importantly, MHOs have a good reputation and standing in the community.

Mental health officers are potentially quicker to train and significantly less expensive to employ than doctors. Moreover, they may be more flexible. They offer a truly community-based service, which is unlikely to be offered by psychiatrists. Moreover, psychiatrists are in short supply in Jamaica, as they are in most low-income countries. It is difficult to envisage the Government being able to afford a huge expansion of medical staffing. Even if it did, it is not clear that psychiatrists would be willing to offer community-based or home-based treatment. It also is unclear that such a system would attract doctors to psychiatry.

Given that relatively autonomous, community-based work is considered attractive to highly skilled nurses, and that the goal is to move psychiatry into the community, it would seem logical to expand services with less well-paid, tried-and-trusted MHOs, rather than opt for approaches such as have been developed in the United Kingdom where psychiatrists have moved into the community along with community nurses.

It should be noted, however, that there has been no systematic evaluation of the quality of MHOs' work. There has also been no evaluation at all from a patient's perspective. Of course, given the dearth of other community care initiatives it will be difficult to properly evaluate the potential impact of MHOs, per se, as any addition to community-based mental health resources is likely to be welcomed and to improve service delivery.

MHOs currently have no specific governing body or union, so their work terms and conditions seem to be fluid. Moreover, there is no body that inspects or evaluates the quality of individual MHO's work.

Currently there are plans to more than double the number of MHOs. The aim is to offer a more comprehensive community service and more rehabilitation, and to decrease the prominence of Bellevue as a provider. Part of the plans includes some offering some sub-specialization of MHOs' roles. While it seems reasonable to assume that MHOs represent a cost-effective strategy to meet community care needs, and one could argue that more MHOs would lead to more need being met, this may not, in fact, be the case. Context is very important in this regard. MHOs are a relatively small group of dedicated people. They were set up at a time when there was little or no community care. It is very likely that the initial returns of such a situation will be great. But times have changed. The first MHOs have set the bar high and do a huge amount of work. They have improved the level of community care. There is much less improvement available for newer mental health officers to make. The individual returns start to could diminish.

One of the appealing facets of the job, and possibly a reason why MHOs seem to offer much more than they are paid for, is that many still view themselves as pioneers. As several of

them stated, there is an obvious need for the work they do, and they can see the positive results. It is unclear whether the need will continue to be as clear when there are more MHOs. It also is unclear whether specialization in rehabilitation, or crisis, or continuing care will diminish the "all-things-to-everybody" role of the MHO, a role that makes their job exciting and confers status on them. Finally, newer recruits who are overly specialized may be less happy to work as a doctor while being paid as a nurse.

And there would be added complications as MHO numbers increase. For example, it is not surprising that an MHO interviewed for this review spoke of the need to have a building that they could call their own. MHOs felt that they were an important group of professionals who understood how community mental health services worked in Jamaica, and that this should be reflected in their status. The building would confer some status: it would form the basis for a professional organization, for the development of a greater hierarchy, and for the establishment of protocols, professional standards, and career pathways. As MHO numbers increase, there also would be differences in the level of experience between MHOs. There also would be generational differences, and even differences in the specifications of the job that they are asked to do. Some MHOs may be involved in assertive outreach while others continue a more general role; some may take a teaching role. It would be difficult to continue running the professional group as a cohort of like-minded individuals with little or no internal structure, however. Given that it is unclear who would decide on such a structure, there could be disagreement. The current set up of regional supervisors is a hierarchy that functions for clinical purposes, but it may not work for policy making. As can be seen, this could prove to be fertile ground for divisive politics and could diffuse energy away from direct patient care. As groups try to define not only what they currently do, but how their jobs should be structured in the future, there may be different views on the way forward. This would need to be carefully negotiated, as would the balance of power among the MHOs, the Ministry of Health, and psychiatrists.

In short, increasing the number of MHOs may change the context in which they work and the efficiency of services. It is unclear whether these changes will be gradual or whether a threshold will be reached after which it will be difficult to keep the model working. Even if there are no problems associated with increasing the numbers of mental health officers, it seems that in addition to the pioneer aspect of the job, the working of mental health officers is dependent on close bonds between individuals and groups of individuals and a strong group identity. Group loyalty and identity may be important for promoting quality of work in the absence of proper external scrutiny. Such bonding and increased social capital can produce effective teams, but it may be size dependent. Sub-specialization, an increase in team size, and external scrutiny are all possible threats to the cohesion which may be important for the efficacy of the model. Adding numbers of MHOs may bring new challenges to the model which will need to be dealt with.

Expanding community care reflects the need for better quality services, as well as a desire to shut down Bellevue Hospital. Most of the remaining patients in Bellevue are extended stay or elderly patients, however, so they would not be the sort of patients with whom MHOs would traditionally work. Moreover, there would be a need to acquire significant extra community resources in support of MHOs in order to make community-based work with patients remaining in Bellevue possible and rewarding. The historical link between MHOs and the decreased admission rates should not lead to the mistaken belief that the number of remaining patients could be further decreased by training and employing more MHOs. Moreover a significant change in the work that MHOs perform or a perceived change in the efficacy of the work because they are taking on patients for whom the model is unproved, could undermine the status of MHOs in the community and their job satisfaction.

Could Others Learn and Adopt the MHO Model?

The MHO model seems to offer a cost-effective model for community care and home treatment in areas where there are few doctors. It also could be argued that in developed countries where there are doctor shortages, such as the United Kingdom, MHOs could offer an alternative care strategy. The fact that many MHOs live and work in the same area, and so were considered to be part of the community, would be attractive to developed countries where the remoteness of mental health professionals is considered a problem.

Clearly, local circumstances will dictate how the MHOs role should be modified, but it does seem that the core principles of experienced nurses working autonomously in the community and when patients are admitted to hospital, who are able to prescribe, and who are a link between primary and secondary care would need to remain in place—as would the status, support networks, and continued reflection and training.

It also would be useful to recognize the possibility that team size should not increase too much and that the regional structure might be necessary to maintain group and ensure the model's success.

It should be stressed that any country that wishes to adopt this model must have a strong department of health willing to persuade primary care physicians to treat psychosis and to listen to the advice of nurses. MHOs also rely significantly on the support of families so this would have to be taken into account when designing services.

In areas where capital funding is difficult, it would make sense to invest in people-led services rather than in infrastructure. The caveat for MHOs is that there needs to be sufficient infrastructure to facilitate the work and sufficient peer support and cohesion to retain highly trained and motivated staff in the services.

CONCLUSION

Delivering community care with tight resources is difficult. With a dearth of doctors and no real likelihood that there will be a significant expansion in numbers to meet the population needs, MHOs have been an answer for Jamaica. They offer a service that is different from traditional community psychiatric nurses or junior doctors working in community teams. They are well regarded and considered effective. Whether they are the answer to the need to increase available community care and to improve its quality remains to be seen.

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