

# WHO-AIMS

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



**World Health  
Organization**



**MINISTRY OF HEALTH  
SURINAME**

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

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

*Suriname*

*2009*



**Ministry of Health  
Suriname**

*PAHO/WHO Representative Country office  
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WHO Department of Mental Health and Substance Abuse (MSD)*

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The project in Suriname was implemented by Herman Jintie (BSc) .

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This study was carried out by Herman Jintie, Nursing Director of the Mental Health Hospital of the Ministry of Health of Suriname. Technical support was provided by PAHO Mental Health Sub-Regional Advisor, Dévora Kestel, Mental Health focal point Primmath Ritoe, Lsc. (PAHO Suriname) and Mental Health Evidence and Research Team in Geneva.

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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 the Republic of Suriname. The goal of collecting this information was to improve the mental health system and to provide a baseline for monitoring the change. This is expected to enable Suriname to develop information-based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing health policy reforms, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

### **Policy, Plan and Legislative Framework**

Suriname has a mental health policy, developed by the mental hospital, which is incorporated with the general health policy document of the Ministry of Health. The last version of the mental health plan was revised in 2007. The mental health policy and plan are not comprehensive and strategic. Components such as downsizing of the mental health hospital, human rights protection and a monitoring system were not in the policy and plan. A disaster preparedness plan for mental health is present, and was last revised in 2006. The Mental Health Legislation Lunacy Act was enacted in 1912 and is outdated. Components like rights of mental health consumers, family members and other care givers, accreditation of professionals and facilities, mechanisms to oversee involuntary admission and treatment practices are not included. An update concerning voluntary admissions in 2002 was passed by Parliament but procedures and standardized documents were not put in place by the government and the hospital to accommodate voluntary admissions.

Mental health expenditure is 9% of total health care expenditures. This is high compared with other countries, but in Suriname, it is not only the Ministry of Health that is responsible for the mental health budget. The Ministry of Social affairs is spending a lot of money on mental health also. Compared to Social Affairs, Ministry of Health has a small budget for health. No national human rights protection policy, training or examining body exist and there is no review conducted.

### **Mental Health Services**

Mental health services are highly centralized and connected to the one and only national psychiatric hospital with its one day treatment facility. There are neither community residential facilities nor community-based inpatients units available in the whole country for persons with a mental health problem. There are five outpatient facilities headed by psychiatrists working fulltime for the mental hospital. All the mental health beds in the country are provided by the mental hospital. The annual length of stay in the mental health hospital is approximately 99 days. This is due to the great amount of chronic patients in the hospital. There are no psychiatric beds available in the 5 general hospitals in the country. The outdated mental health act doesn't allow admissions of patients outside the mental

hospital. There is no increase in mental health beds in the mental hospital. Data concerning mental health services and users is almost not available because of a lack of a proper data collecting system. The most frequent diagnosis of admission is mental and behavioral disorders due to psychoactive substance use. There is no specific forensic unit in Suriname. The social insurance scheme covers mental health. Psychotropic drugs from each therapeutic class are available throughout the country. Mental health data is collected by the Ministry of Health but there is no annual performance report disseminated.

### **Mental Health in Primary Health Care**

In terms of existing physician-based and non-physician-based primary health care clinics, none have assessment and treatment protocols for key mental health conditions available. There are some referrals between the non-physician-based PHC facilities with traditional practitioners, but no data of the amount, the impact and conditions of the referrals is available. In terms of refresher training on mental health neither primary health care doctors nor non-doctor/non-nurse primary health care workers have received at least two days of training in the past year. Nurses as well as non-doctor/ non-nurse primary health care workers are not allowed to prescribe psychotropic medications in any circumstance.

### **Human Resources**

The total number of human resources working in mental health facilities is 48.75 per 100,000 general population. There are 7 psychiatrists (1.45 per 100 000 population), 4 other medical doctors (0.83 per 100,000 population), 67 nurses (13.96 per 100,000 population), 3 psychologists (0.63 per 100,000 population), 8 social workers (1.67 per 100,000 population), 150 other health and mental health workers (31.25 per 100,000) and no occupational therapist (0.00 per 100,000). The distribution of human resources between urban and rural areas is disproportionate. All psychiatrists and all nurses work in or near the largest city. The majority of all mental health workers work in the city, where all the mental health facilities are located.

### **Public Education and Links with Other Sectors**

There is no coordinating body to oversee publication and awareness campaigns on mental health and mental disorders. Beside the mental hospital no NGOs are involved in developing and implementing policies. Public education and awareness campaigns are conducted by the mental hospital targeting the general public but not professional groups including teachers, health care providers (traditional medicinal medicine, conventional, and modern), or other groups. There are some formal links with other sectors like education, police, lawyers and judges.

### **Legislative and Financial Support**

There are no legislative and financial provisions to protect and provide support for persons with mental disorders. Neither are there any provisions concerning protection from discrimination solely on the account of a mental disorder. In addition, no legal provision exists – provisions concerning priority in state housing and in subsidized housing schemes for people with severe mental disorders. At the present time, there is no legislative or financial support for discrimination in housing.

### **Monitoring and Research**

The department of planning of the Ministry of Health monitors data collected from the whole country. Nevertheless the data on mental health is not analyzed or published yearly.

## Introduction

Suriname is an independent republic, situated in the northern coast of the continent of South America, between French and British Guyana. The geographical size is 63,038 sq miles (163,270 sq km). Suriname's estimated total population for 2007 is approximately 480,000 inhabitants, with approximately 74% living in the urban areas (2004<sup>1</sup>). The capital city is Paramaribo which is in the coastal area with a population of approximately 250,000. The hinterland which covers the largest part of the country's land area is very sparsely populated by Maroons and Indigenous populations (appr. 12% of the total population). The major ethnic groups are Hindustani (East-Indian descent) who account for approximately 37% of the population, and Creole (mixed white and black) 31%. The third largest ethnic group (15%) consists of Javanese, descendants from Indonesia. The unemployment rate in 1998 was 11%.

The main political and social problems that affect the health situation or the performance of the health services are the lack of an inter-sectoral approach in addressing the problems in the area of water supply, sanitation, environmental protection, food production, basic education, social housing and employment (2004<sup>2</sup>).

In addition, other problems are the issues related to cost recovery as an instrument for social participation and cost containment, without excluding the poor and near poor. The socioeconomic decline that has taken place over the past 10 to 15 years has adversely affected all segments of society, including the health sector.

Bauxite mining and processing is the main contributor to the economy accounting for more than 15% of GDP and 70% of export earnings. The public sector is the most important sector in terms of formal employment and contribution to GDP. The Dutch development aid is the main external financial contributor to the total budget income of the public sector.

It is estimated that the life expectancy at birth is 70.9 years, with females (73.5 years) expected to live longer than males (68.3 years) (2002<sup>3</sup>). For the year 2000 preliminary survey results estimated the overall literacy of the population aged 15 years and older to be 94.2%. However, in the interior, only 51% of the population is literate. Female literacy is lower than male and the literacy percentage declines with age.

The table below gives an impression of the health situation of Suriname

Table 1: Demographic and health data of Suriname

Rate of growth/year	1,3%
GNP/per capita	2.78 €
Overall mortality rate per 1000	18

<sup>1</sup> Source: National Bureau of Statistics: 2004 population and housing census

<sup>2</sup> White Paper Health Sector Reform in Suriname: 2004

<sup>3</sup> Health System Profile: 2002 Pan American Health Organization



There are no legal or constitutional rules for the allocation of the government budget between the different sectors. Currently there is no total overview of expenditures or contribution of the government (as a total) to the health sector. Each ministry makes its own calculation and budgets the costs of the individual tasks on their own budget. So it is not clear how much of government expenditure is on health in general and mental health in particular.

The Ministry of Health (MOH) is responsible for the availability, accessibility and affordability of health care. The main responsibilities of the MOH are the following: policy making, evaluation, coordination, and setting of standards and values. The core institutions of the health care system are the Central Office of the Ministry of Health, the Bureau of Public Health and the Inspectorate. The central office and the inspectorate function at the level of global health planning and standard-setting, inspection and monitoring while the Bureau of Public Health is responsible for program development.

Providers of health care include government subsidized primary health care organizations for the poor and near poor, namely the *Regional Health Service (RGD)*, which covers the coastal area, while the *Medical Mission* covers the population living in the interior. Also, the majority of *Private General Practitioners (GP)* are in private practice and serve people that are covered by the State Health Insurance (SZF), private firms or persons who are self-paying. There are specialists who provide outpatient and inpatient care and primary care clinics that are managed by large firms. *Government Run Vertical Programs*, such as special health services for the entire population e.g. STD's, leprosy, youth dental care, malaria, and immunization. Many NGOs are recognized by the government to provide specific health care services, e.g. the Foundation for Family Planning (Stichting Lobi), specialized in the field of reproductive health.

The contribution of the private sector is at the level of service-provider and its activities are mostly in the curative field, while the government subsidized Regional Health Services and Medical Mission provide curative as well as preventive health care services. The only mental health institution in Suriname is the mental health hospital, situated in Paramaribo. Admission is limited. Currently, there is a transformation of the social psychiatric care system. Keys for the future are prevention, decentralization of care and ambulatory treatment. More attention has been given to the care of persons living with an addiction, care for children and youth and the homeless. The hospital has 482 employees and approximately 300 beds.

The number of primary health care clinics in the country is not known, however the total number of private general practitioners in Suriname is 120. The majority provides limited preventive tasks, e.g. prenatal care, and is not involved in public health activities (2008<sup>4</sup>).

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<sup>4</sup> Feasibility study Good Medical Practice NV: 2008

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

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

Suriname's mental health policy was last revised in 2007 and includes the following components: (1) developing community mental health services, (2) developing a mental health component in primary health care, (3) human resources, (4) involvement of users and family, (5) advocacy and promotion, (6) equity of access to different groups, (7) financing and (8) quality improvement. Components that are not included in the policy are: (1) downsizing of the mental health hospital, (2) human rights protection and (3) a monitoring system. In addition, there is a national list of essential drugs. In the list of essential medicines the following medicines are included: (1) antipsychotics, (2) anxiolytics, (3) antidepressants, (4) mood stabilizers and (5) antiepileptic drugs.

The last revision of the mental health plan was in 2007. This plan contains the same components as the policy document. In addition, a timeframe with specific goals exists in this plan, but without a specified budget. In 2007 efforts were made to involve the primary healthcare in the mental health system.

A disaster/emergency preparedness plan for mental health is present and it was last revised in 2006.

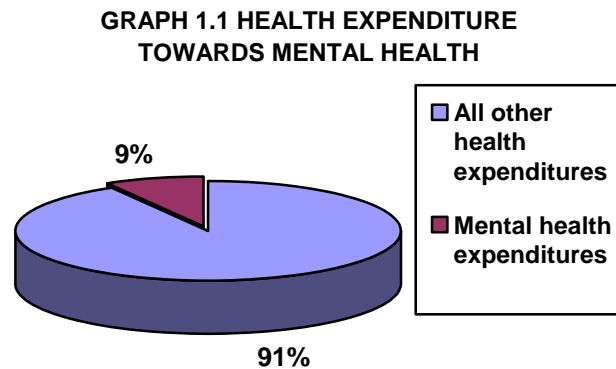
The last piece of mental health legislation was enacted in 1912 with an amendment in 2002, dealing with involuntary admissions in the mental health hospital, which focused on: (1) access to mental health care including access to the least restrictive care, (2) voluntary and involuntary treatment, (3) competency, capacity and guardianship issues for people with mental illness, (4) law enforcement and other juridical system issues for people with mental illness as well as (5) mechanisms to implement the provision of mental health legislation. Components like (1) rights of mental health consumers, family members and other care givers, (2) accreditation of professionals and facilities, (3) mechanisms to oversee involuntary admission and treatment practices are not included. Before 2002 the mental health legislation allowed patients to be admitted only if it was voluntarily. Some procedures and standardized documents were put in place by the government and the hospital to accommodate involuntary admissions. For example, all dossiers must be sent to the Justice Authority to be approved; however, this is not needed when a patient is admitted voluntarily, but still all documents are sent to this authority.

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

Currently there is no total overview of expenditures or contributions of the Government (as a total) to the health sector. The majority of costs for the health system is made up by the Ministry of Social Affairs and Housing and the Ministry of Health (Central Office and State Health Insurance). Nine percent of health care expenditures by the Ministry of Health are directed towards mental health. The health budget in Suriname is made up of more than one Ministry, namely the Ministry of Health, the Ministry of Social Affairs,

the Ministry of Justice and Police, the Ministry of Defense. If we look at these budgets, more is being spent on health in general and in mental health particularly by these different ministries. The amount that the Ministry of Social Affairs and the other ministries are spending on mental health per year is not clear. Of all the expenditures spent on mental health, 83 % is directed towards mental hospitals.

Graph 1.1: Health expenditures towards mental health



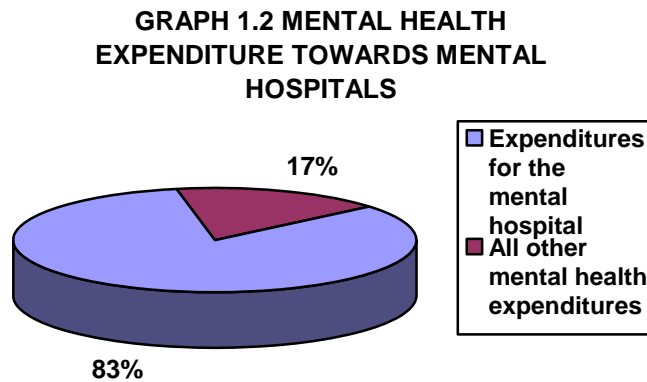
(Finance Department of the Ministry of Health, 2007)

All other health expenditures: 104,280,000

Mental health expenditures: 9,000,000

In terms of affordability of mental health services, 100 % of the population has free access to essential psychotropic medicines. For those that pay out of pocket, the cost of antipsychotic medication is 0.20 Surinamese dollars and antidepressant medication is 0.30 Surinamese dollars. All mental health disorders and mental health problems of clinical concern are covered in social insurance schemes.

Graph 1.2: Expenditures on mental hospitals as a proportion of total mental health care spending



(Finance Department of the Ministry of Health, 2007)

Expenditures for mental hospitals: 7.500.000

All other mental health expenditures: 9.000.000 – 7.500.000

### **Human rights policies**

A national or regional human rights review body doesn't exist. None of the mental hospitals have at least one review/inspection of human rights protection of patients per year. The staff of the one and only mental hospital has not had at least one day training, meeting, or other type of working session on human rights protection of patients in the year of assessment. There are no inpatient psychiatric units or community residential facilities. The latest training on human rights protection of patients was in 2006, when a training of patient's advocacy was conducted. The title was: "Patients thrust person"

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

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

There is no mental health authority in the country/region. The Ministry of Health is working diligently to employ a focal point for mental health, which will be responsible for service planning and monitoring and quality assessment of mental health services. Mental health services are not organized in terms of catchment/service areas.

### **Mental health outpatient facilities**

There are five outpatient mental health facilities available in the country, of which one is specifically for children and adolescents only. There are approximately 5458 outpatient contacts (visits) per 100,000 general population. Only figures on contacts were available. It was also not recorded whether the users were female, adolescents or children. In the

records the users treated in outpatient facilities were not diagnosed. The average number of contacts per user is unknown. As stated before there is no data collecting system available in the mental health outpatient facilities. Approximately 20% of outpatient facilities provide follow-up care in the community. There are no mobile mental health teams available. The mental health hospital has a unit that does a lot of outreach in communities nationally. This unit is run by qualified community mental health nurses that are trained to do follow up care and psychosocial interventions. In terms of available treatments, the majority (51-80%) of the outpatient facilities offer psychosocial treatments. Eighty percent (80%) of mental health outpatient facilities had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility or a near-by pharmacy all year round.

### **Day treatment facilities**

There is one (1) day treatment facility available in the country. This day treatment facility is connected to the mental health hospital as it serves the patients admitted to the hospital as well as those who are discharged. It is unknown what percentage of the general population it served, because there was no data collected in the year of this research. Because of this it is not known whether the users treated in this facility were male or female, adolescents or children. It is also not clear how long on average a user stayed in this facility for treatment.

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

There are no community-based psychiatric units available in the country. In none of the general hospitals in the country are there beds for psychiatric patients. There are no beds for psychiatric patients in any of the general hospitals nationwide. Mental health legislation does not allow admissions of psychiatric patients to facilities other than the mental health hospital.

### **Community residential facilities**

There are no community residential facilities available in the country. There was a foundation years ago that had 4 residential facilities, but due to socio-economic factors, these facilities were closed.

### **Mental hospitals**

There is one mental hospital available in the country for a total of 62.5 beds per 100,000 population. This facility is organizationally integrated with mental health outpatient facilities, because of the fact that all psychiatrists available in the country are employed by the mental health hospital. These psychiatrists also serve all the outpatient facilities. In fact, the biggest outpatient facility is owned by and connected with the mental health hospital. None of the beds in the mental hospital are reserved for children and adolescents only. In the last five years the number of beds hasn't increased. The patients admitted to

the mental hospital belong primarily to the following two diagnostic groups: mental and behavioural disorders due to psychoactive substance use (50%) and mood/affective disorders (20%). The number of admissions in mental hospitals is approximately 204 per 100.000. No children were treated and 31% of the treated patients are female. One hundred percent of all admissions were involuntary. However, this needs to be explained. Before 2002 the mental health legislation did not allow patients to be admitted voluntarily. Even though the legislation was passed in 2002, nothing was put in place by the government or the hospital to accommodate involuntary admissions, e.g. administratively all dossiers must be sent to the Justice Authority to be approved. This is not needed when a patient is admitted voluntarily, but still all documents are sent to this authority.

The average number of days spent in mental hospitals is 99.03 days. This is due to the fact that the majority of patients in the mental health hospital are admitted as chronic patients, staying in the long stay units of this hospital. 27% of patients spend less than one year, 39% of patients spend 1-4 years, 11% of patients spend 5-10 years, and 23% of patients spend more than 10 years in the mental hospital.

The occupancy rate of the mental hospital is 89%. Some patients (21-50 %) in mental hospitals received one or more psychosocial interventions in the last year. The one and only mental hospital had 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 specific forensic inpatient unit in the mental hospital. Patients that can be classified as forensic patients are treated in one of the long stay units of the mental hospital, together with other types of patients. There is no specific data concerning this group of patients available. Concerning beds in other residential facilities, there are 55 beds specifically for persons (of any age) with mental retardation, 0 beds specifically for persons of 17 years and younger with mental retardation, 93 beds for persons with substance abuse (including alcohol) problems, 0 beds for persons with dementia, 30 beds in a facility that is not formally a mental health facility, but where nevertheless, the majority of the people residing in the facility, have diagnosable mental disorders.

### **Human rights and equity**

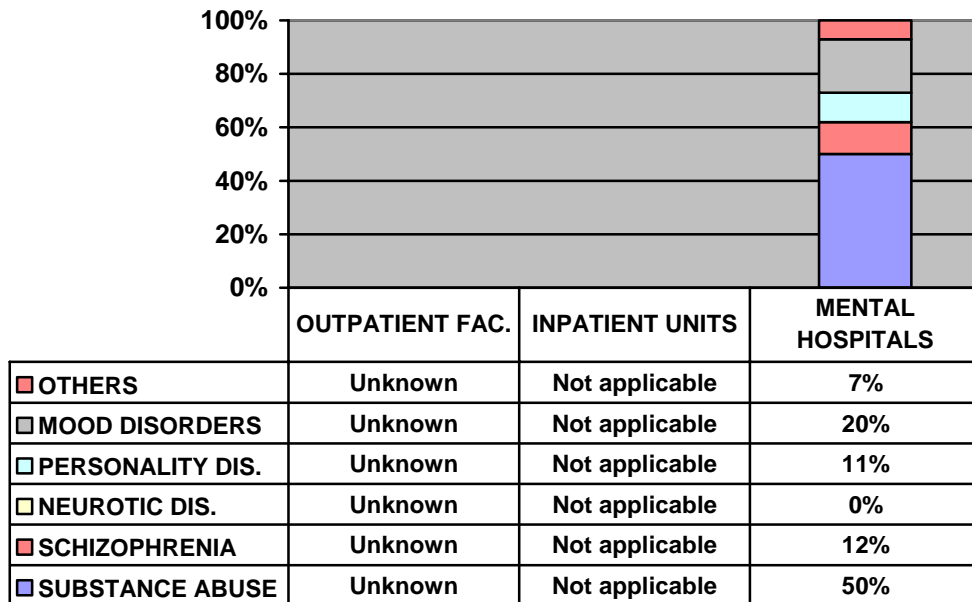
There are no community-based inpatient psychiatric units in Suriname and 100 % of all admissions to the mental hospital are involuntary. Between 0-1 % of the patients in the mental hospital were secluded/retrained in the last year. In terms of equity, the distribution of psychiatric beds between the largest city and the rest of the country remains unfair. The ratio of number of psychiatry beds in or near the largest city to the total number of psychiatry beds in the country is 1.92. Such a distribution of beds prevents access for rural users. Because of the distance between the mental hospital and the rural area cost-wise, people that need mental care are not able to make use of the facility. The same issue of distance

makes for a long admission period in the mental hospital. Patients cannot always be discharged as planned.

Inequity of access to mental health services for other minority users (e.g. linguistic, ethnic, religious minorities) is not an issue in the country. Although no official data is available, it is estimated that persons of all linguistic, ethnic or religious minority groups have similar access to all mental health facilities.

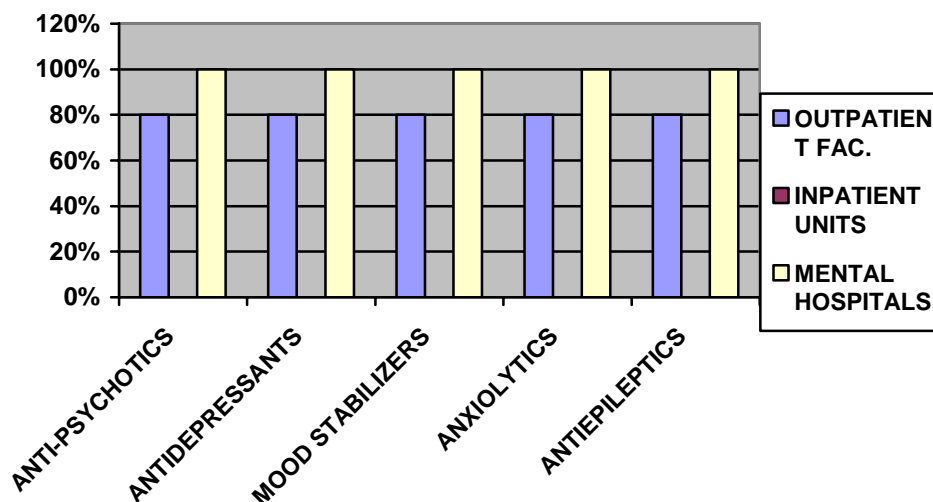
### Summary Graphs

**GRAPH 2.1 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS**



The distribution of diagnoses varies in the mental health facility. Substance abuse and mood disorders are most frequent. Data concerning diagnosis was also not available in the outpatient facilities, while the country has no inpatient units for mental health.

**GRAPH 2.2 - AVAILABILITY OF PSYCHOTROPIC DRUGS IN MENTAL HEALTH FACILITIES**



Psychotropic drugs are mostly widely available in mental hospitals, followed by outpatient units. There are no inpatient mental health facilities in the country.

### **Domain 3: Mental Health in Primary Health Care**

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

Six percent of the training for medical doctors is devoted to mental health, in comparison to 4% nurses and 0% for non-doctor/non-nurse primary health care workers. In terms of refresher training, none of the primary health care doctors, nurses or non-doctors/non-nurses has received at least two days of refresher training in mental health in the past year.

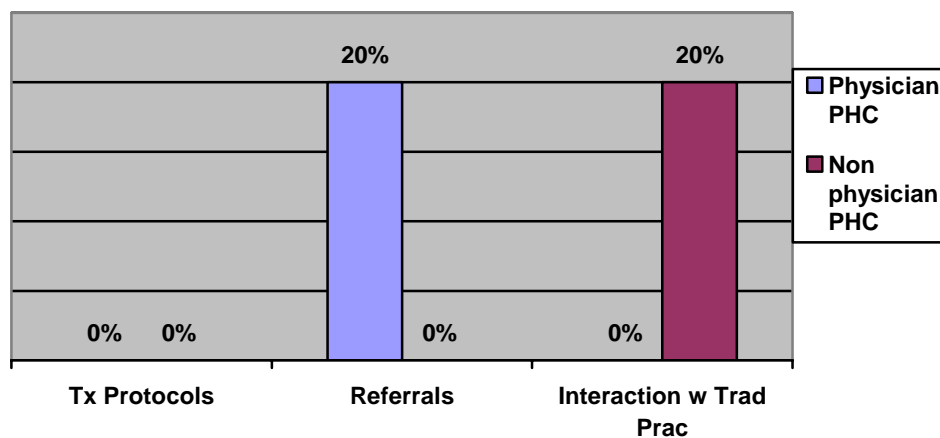
#### **Mental health in primary health care**

Both physician based primary health care (PHC) and non-physician based PHC clinics are present in the country. Neither physician-based nor non-physician-based primary health care clinics have assessment or treatment protocols available for key mental health conditions. A few (1-20%) of physician-based primary health care clinics make on average at least one referral per month to a mental health professional. There is an under-registration of persons who have a mental health problem. None of the non-physician based primary health care clinics make a referral to a higher level of care. As for professional interaction between primary health care staff and other care providers, a few (1-20%) of primary care doctors have interacted with a mental health professional at least



monthly in the last year. None of physician-based PHC facilities have had interaction with a complimentary/alternative/traditional practitioner, in comparison to a few (1-20%) of non-physician-based PHC clinics, and none of mental health facilities. The primary health care organization in the hinterland of the country (i.e. Medical Mission) interacts informally with traditional birth attendance and three Conservation International clinics. There are some referrals between these three non-physician-based PHC facilities with traditional practitioners, but no data of the amount, the impact and conditions of the referrals is available.

**GRAPH 3.1 - COMPARISON OF PHYSICIAN BASED PRIMARY HEALTH CARE WITH NON-PHYSICIAN BASED PRIMARY HEALTH CARE**



There are no treatment protocols available for key mental health conditions. Some of the PHC professionals make at least one mental health referral per month and some non-physician PHC professionals interact with complimentary/alternative/traditional practitioners per month.

### **Prescription in primary health care**

Primary health care non-doctor/non –nurse primary health care workers are not allowed to prescribe psychotropic medications in any circumstance. Primary health care nurses working with the Medical Mission are not allowed to initiate, but can prescribe as a follow-up treatment under supervision of a physician. Regional Health Services (RGD) nurses are allowed to hand-out medicines, but are formally not allowed to prescribe, even in emergencies. In contrast, primary health care physicians are allowed to prescribe psychotropic medications without restrictions. As for availability of psychotropic medicines, all or almost all clinics (81-100%) of physician-based PHC clinics as well as non-physician-based PHC clinics have at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) as well as all or almost all non-physician-based clinics.

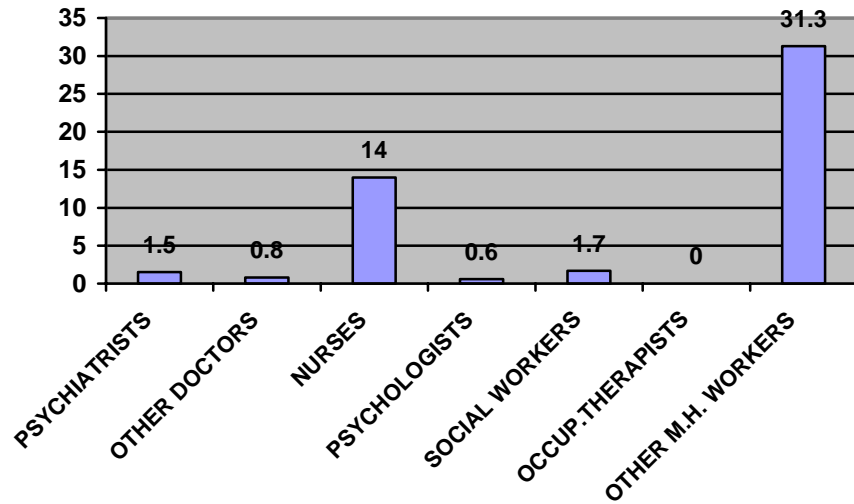
## **Domain 4: Human Resources**

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

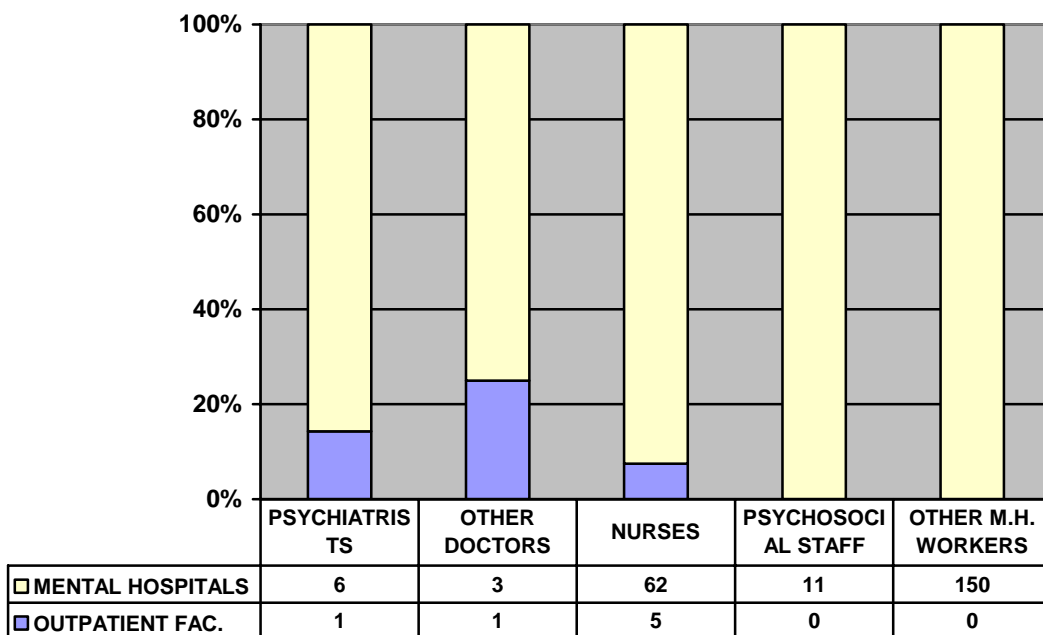
The total number of human resources working in mental health facilities or private practice per 100,000 population is 48.75. The breakdown according to profession (raw numbers) is as follows: 7 psychiatrists, 4 other medical doctors (not specialized in psychiatry), 62 nurses, 3 psychologists, 8 social workers, 0 occupational therapists, 150 other health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counselors). None of psychiatrists work only for government administered mental health facilities, only for NGOs, only for profit mental health facilities or only in private practice; all work for both the sectors. All of the psychologists, social workers, nurses and occupational therapists work only for government administered mental health facilities. Regarding the workplace, one psychiatrist works in the outpatient facility and 6 psychiatrists work in the mental hospital. One other medical doctor, not specialized in mental health, works in outpatient facilities and 3 in mental hospitals.

As far as nurses, 5 work in outpatient facilities and 62 in the mental hospital. No psychologists, social workers or occupational therapists work in outpatient facilities and 11 work in mental hospitals. No other health or mental health workers work in outpatient facilities and 150 work in mental hospitals. In terms of staffing in mental health facilities, there are 0.02 psychiatrists per bed in the mental hospital. As for nurses, there are 0.21 per bed in the mental hospital. Finally, as for other mental health care staff (e.g. psychologists, social workers, occupational therapists, other health or mental health workers), there are 0.54 per bed in the mental hospital. The distribution of human resources between urban and rural areas is unfair: controlling for population density the number of psychiatrist and nurse works in or near the largest city is almost double (1.92 times) the number available in the rest of the country. As stated, the majority of all mental health workers work in or nearby the city, where all the mental health facilities are located.

**GRAPH 4.1 - HUMAN RESOURCES IN MENTAL HEALTH**  
(rate per 100,000 population)

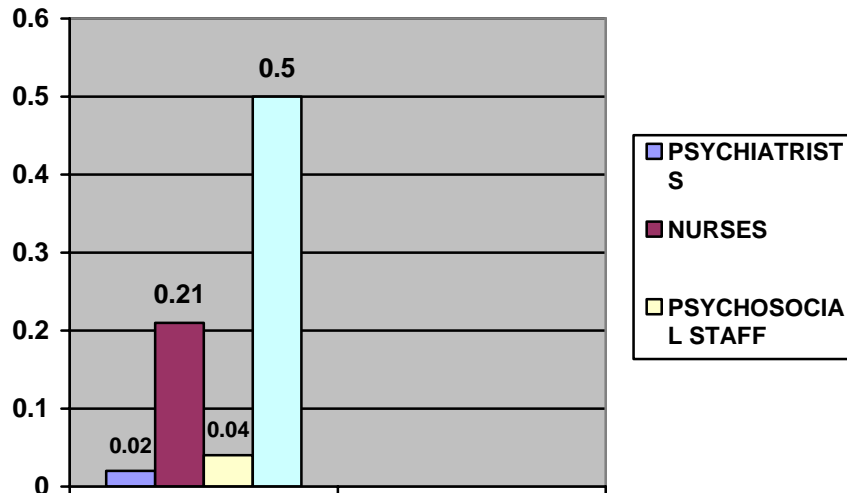


**GRAPH 4.2 - STAFF WORKING IN MENTAL HEALTH FACILITIES**  
(percentage in the graph, number in the table)



The majority of mental health care workers are employed in the mental hospital. There is no community inpatient unit available in the country.

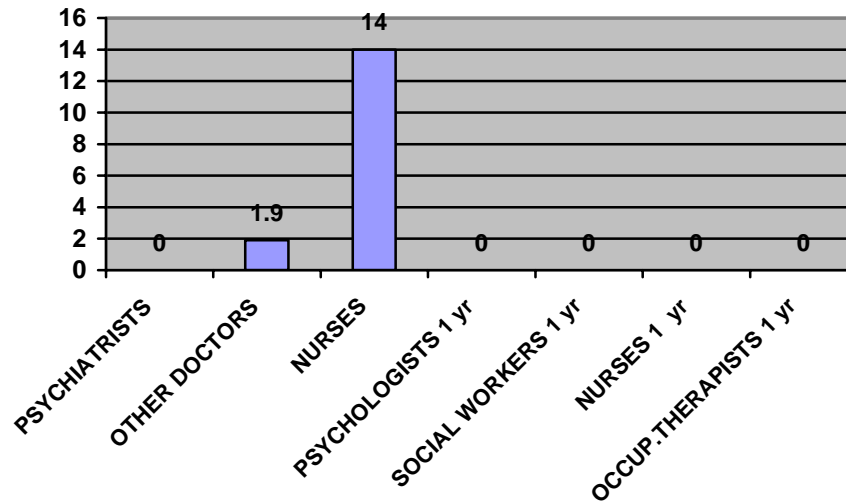
**GRAPH 4.3 - RATIO HUMAN RESOURCES/BEDS  
IN MENTAL HOSPITALS**



### **Training professionals in mental health**

The number of professionals graduated last year in academic and educational institutions per 100,000 is as follows: no psychiatrists, 1.9 other medical doctors (not specialized in psychiatry), 14 nurses, no psychologists, no social workers, no occupational therapists, no other health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counselors). No psychiatrists emigrated to other countries within five years of the completion of their training. Data was collected on the percentage of mental health care staff with at least two days of refresher training concerning mental health. 15% of nurses were the only staff to receive refresher training in psychosocial interventions, and no health staff had refresher training in the rational use of drugs or child/adolescent mental health issues.

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



(University of Suriname & Ministry of Health)

### **Consumer and family associations**

There are no users/consumers that are members of consumer associations and approximately 35 family members are members of the family association Ypsilon. The government doesn't provide economic support for the family associations. The family association has never been involved in the formulation or implementation of mental health policies, plans, or legislation in the past two years. But the mental health facilities do interact with the family association regularly. The mental health hospital accommodates the family association's monthly meetings. Also the family organization has free access to the hospital when needed. In addition to the family association, there are two other NGOs in the country involved in individual assistance activities in the field of counselling and support for HIV/AIDS. There are some other NGOs in the country such as NGOs looking at suicide, domestic violence, child abuse, etc. but no data was available.

## **Domain 5: Public Education and Links with Other Sectors**

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

There is no coordinating body to oversee publication and awareness campaigns on mental health and mental disorders. The mental health hospital, as a government organization, and the family association have promoted public education and awareness campaigns in the last five years. These campaigns have targeted the following groups: the general public, children, women, adolescents, trauma survivors, ethnic groups and other vulnerable or minority groups. However the public education and awareness campaigns didn't target professional groups such as health care providers, complementary/traditional/alternative sector, teachers, social services staff, leaders and politicians or other professional groups linked to the health sector.

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

No legislative and financial provisions exist to protect and provide support for persons with mental disorders. Neither is there any provisions concerning protection from discrimination solely on the account of a mental disorder. In addition, no legal provision exists – provisions concerning priority in state housing and in subsidized housing schemes for people with severe mental disorders. At the time, there is no legislative or financial support for discrimination in housing.

### **Links with other sectors**

In addition to legislative and financial support, there are formal collaborations with the departments/agencies responsible for primary health care/community health, HIV/AIDS, substance abuse, welfare and other agencies on suicide, dementia and domestic violence. There are no formal collaborations with reproductive health, child and adolescent health, child protection, education, employment, housing and the elderly. In terms of support for child and adolescent health, none of the primary or secondary schools has either a part-time or full-time mental health professional; a few (1-20%) of primary and secondary schools have school-based activities to promote mental health and prevent mental disorders. The percentage of prisoners with psychosis is less than 2%, while the corresponding percentage for mental retardation is 2-5%. Regarding mental health activities in the criminal justice system, all or almost all prisons (81-100%) have at least one prisoner per month in treatment contact with a mental health professional. As for training, a few (1-20%) of police officers and no judges or lawyers have participated in educational activities on mental health in the last five years. In terms of financial support for users, only the mental health hospital has access to programs outside the mental health facility that provide outside employment for users with severe mental disorders. Finally, it is not clear how many people who receive social welfare benefits do so for a mental disability. People with a mental disorder are not being seen as a special group by the Ministry of Social affairs.

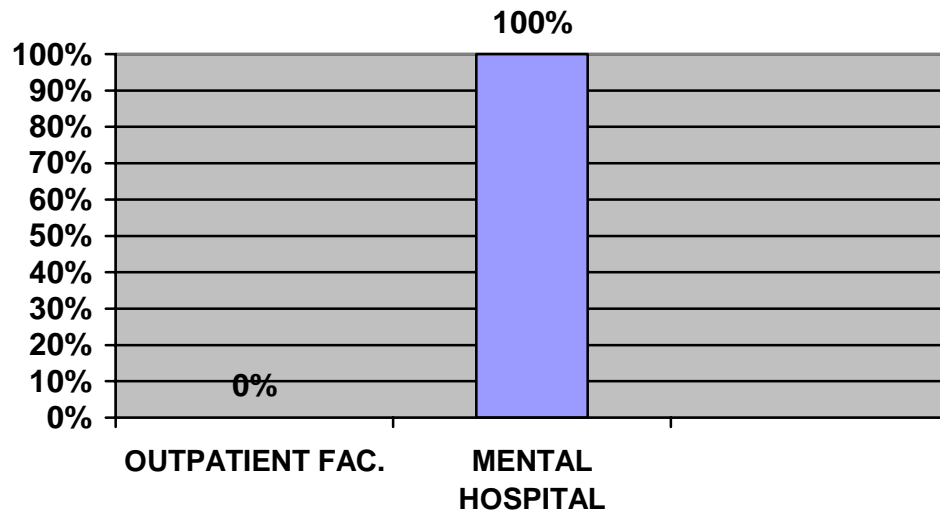
## **Domain 6: Monitoring and Research**

A formally defined list of individual data items that ought to be collected by all mental health facilities exists. This list includes the number of beds, admissions, involuntary admissions, length of stay and patient diagnoses. There is no information about the frequency or reasons why people are secluded. The government health department received data from only the one mental hospital. Based on this data, a report was produced by the mental hospital, but was not commented upon nor published by the Ministry of Health. In terms of research, few mental health professionals (1-20% of psychiatrists and 21-50% of nurses) are involved in mental health research as investigators or co-investigators (including dissertations and theses). The proportion of publications that are on mental health in the last five years is unknown. There has been some non-epidemiological clinical/questionnaires assessment of mental disorders, but no publications in indexed journals were on mental health.

**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%	Not applicable	-----
<b>N° inpatient admissions/users treated in outpatient fac.</b>	100%	Not applicable	0%
<b>N° of days spent/user contacts in outpatient fac.</b>	100%	Not applicable	0%
<b>N° of involuntary admissions</b>	100%	Not applicable	-----
<b>N° of users restrained</b>	unknown	Not applicable	-----
<b>Diagnoses</b>	100%	Not applicable	0%

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





# **Strengths and Weaknesses of the Mental Health System in Suriname**

## **Strengths:**

The mental health system has the following strengths:

- There are basic academic as well as follow up training opportunities for some mental health specialists available in and outside the country, specifically for psychiatrists and nurses
- There is a mental health policy and a plan available
- Public education and awareness are being carried out
- Exposure of primary care staff (doctors, nurses) to mental health issues during their pre-service (basic) training
- Essential psychotropic medicines are available in almost all facilities throughout the country
- A family association exists and is cooperating with the mental health hospital
- There are links with sectors like suicide, HIV/AIDS and drugs/alcohol abuse

## **Weaknesses:**

- Non existence of a mental health coordination unit at the Ministry of Health
- No policy and plans for integrating mental health in primary health care
- Outdated mental health legislation
- Mental health policy and plan need to be updated
- No investment in mental health infrastructure at community level, human resources or research
- Equity and access of mental health services is an issue
- Mental health services are centralized
- No community-based mental health services available in the country
- No integration of mental health care in general health care
- No mechanisms to protect the human rights of patients
- No post basic training of mental health and primary health care workers in general
- No consumer association exists
- No formal links with some of the other sectors, e.g. education, criminal justice
- No mental health information, data analysis or reporting system
- Mental health focus is on cure of mental health problems and not on prevention

It is clear that there is a need to update the mental health legislation and to finalize the mental health policy, to develop a strategic plan for mental health and to direct more efforts towards strengthening the integration of mental health into primary health care in Suriname.

## **Next Steps in Strengthening the Mental Health System**

WHO-AIMS data will serve as a baseline for the future development and capacity building for the mental health care system including community based mental health care in Suriname.

A workshop for the formulation and development for the five year strategic plan for strengthening mental health is proposed to be conducted. Funds to conduct this workshop may be explored either from the Office or PAHO Headquarters. Participation will be by senior officials from the Ministry of Health or the mental hospital as well as from potential donors. The objective of the workshop will be to advocate and formulate strategies for the way forward to further strengthen and build capacity for the mental health care system in Suriname. The output of this workshop will be the document “Five year strategic plan for strengthening mental health in Suriname” which will address issues such as:

- Current mental health situation
- Goal, objectives and strategic directions
- Program and implementation approaches
- Logical framework
- Detail work-plan
- Monitoring and evaluation matrix

This document will also serve as an advocacy document and for resource mobilization.

### **Dissemination**

The following institutions/people should receive a copy of this report owing to their involvement in mental health services, programs, budgeting and finance:

- In the Ministry of health, key policy makers such as:
- Minister of health
- Director of health
- Chair of Steering Committee on mental health
- Head of department of planning
- Director of Regional Health Services (RGD)
- Director of Medical Mission Primary Healthcare Suriname (MZ)
- Director of PCS (Mental Health Hospital)
- Head of the Nursing Inspectorate (IVV)
- The Ministry of Social Affairs (SOZAVO)
- The Ministry of Planning and Development (PLOS)
- The Pan American Health Organization Regional Office
- The ADEK University of Suriname (Medical Faculty)
- The EFS/COVAB (Central College of Nursing)
- Chair of the Suriname Nursing Body (SNB)
- Chair of National Hospital Board (NZR)
- Ypsilon (Family association)

The World Health Organization has recently developed the *WHO Assessment Instrument for Mental Health Systems* (WHO-AIMS), a comprehensive mental health systems assessment, designed with the needs of middle and low-income countries in mind. This instrument has been used to collect information on the mental health system in Suriname to improve the system and to provide a baseline for monitoring the change.

Suriname has no general mental health policy or plan. The mental health hospital, the only mental health institution of the Ministry of Health, is up till now responsible for the national policy concerning mental health. The mental health legislation is outdated.

The density of psychiatric beds, psychiatrists and psychiatric nurses in and around the largest city is greater than the density in the entire country. Services are unequally distributed across the country.

Mental health expenditure from the Ministry of Health is 9% of total health care expenditures. This is high compared to other countries in the region, but it's not only the Ministry of Health that is responsible for the mental health budget. The Ministries of Social Affairs, Defense and Justice & Police are spending a lot of money on mental health also.

The next steps for improving mental health in Suriname include the development of community mental health facilities and the provision of mental health in primary health care. In addition, data on mental health need to be analyzed and published yearly.