WHO-AIMS

WHO-AIMS REPORT ON

MENTAL HEALTH SYSTEM

IN THE DOMINICAN REPUBLIC

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MENTAL HEALTH SYSTEMS

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Report of the Assessment of Mental Health Systems in Dominican Republic using the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS)

Dominican Republic

2008

State Secretariat of Public Health and Social Assistance (SESPAS)

Pan American Health Organization (PAHO/WHO)

WHO Department of Mental Health and Substance Abuse (MSD)

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Data collection and the initial report were developed by Ms. Ramona Torres, National Consultant, with the technical support of Dr. Ivonne Soto, who developed the final report.

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

For any further information please refer to WHO-AIMS (WHO, 2005) at the following Website: http: /www.who.int/mental_health/datos probatorios/WHO-AIMS/en/index.html

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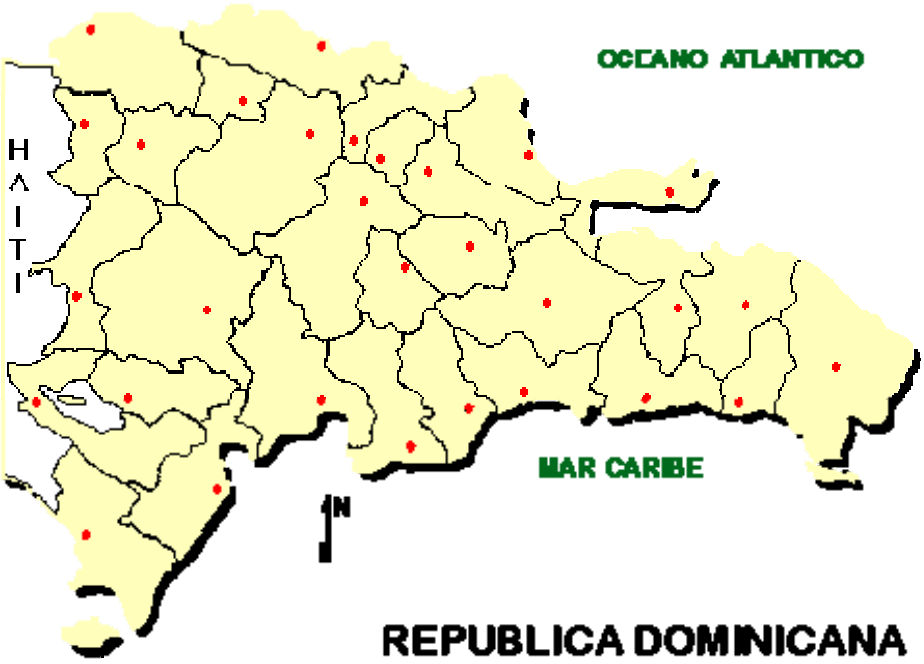
WHO-AIMS team in WHO headquarters includes: Benedetto Saraceno, Shekhar Saxena (coordinator), Tom Barrett, Antonio Lora, Mark van Ommeren, Jodi Morris, Grazia Motturi and Annamaria Berrino. Additional assistance has been provided by Patricia Esparza.



MENTAL HEALTH SYSTEM IN DOMINICAN REPUBLIC

WHO – AIMS

Assessment Results

Santo Domingo,
Dominican Republic

January 2008

Introduction

The Dominican Republic is a country that belongs to the Greater Antilles in the Hispanic Caribbean, in the eastern part of the Hispaniola Island, with an approximate geographic area of 48,442 square kilometers and a population of 8,562,541 million (last Census ONE 2002). Spanish is the official language and its population represents a heterogeneous ethnic composition, consisting mostly of mulattos and blacks. Catholicism is the official religion although there has always been religious freedom.

The Dominican Republic has a relatively young population where 34% of the population is under the age of 15 and 6% is over the age of 60. Forty percent of the population is rural and sixty percent of the population is concentrated in urban centers, which has exacerbated the remarkable contrasts resulting from the unequal distribution of income, migration and marginality. Life expectancy at birth is 65 for males and 72 years for females (2005), and healthy life expectancy at birth is 57 for males and 62 years for females (2002)[1]; with a literacy rate of 86.8% for males and 87.2% for females.[2]

The proportion of the health budget to GDP is 6.0 (2004). However, a study on the Efficiency of Public Expenditure in Central America and Dominican Republic published by the International Development Bank in December, 2006, shows that the actual ratio of the health budget to GDP is 1.4, which is one of the lowest ratios in the region; also showing one of the lowest levels of Social Expenditure in the continent, indicated both as a percentage of GDP (6.8, 2004) and Social Expenditure per capita (170).[3] The country is a lower middle income group country based on World Bank 2004 criteria.

In relation to the installed capacity of health services, there were 9,481 hospital beds in the public sector (11 per 10,000 population) in 2006, and 10,380 physicians (12 per 10,000 population) of which 61% (6,334.7 per 10,000 population) are general practitioners[4]. This

[1] Indicadores básicos OMS, 2005
[2] PNUD: El Desarrollo Humano en Republica Dominicana, 2006
[3] CERSS: Rojas, Gustavo; Gasto Social y Salud, Doce años de inversión y su impacto 1995-2006
[4] Republica Dominicana, SESPAS: Memorias 2006

proportion represents a significant regional difference, with a concentration of human resources in urban areas. In terms of primary care, there are 1,273 physician-based primary health care centers in the country (801 rural and urban clinics and 472 doctor offices and dispensaries).[5]

This study was carried out by Ms. Ramona Torres, National Consultant and Dr. Ivonne Soto, Technical Coordinator of the General Department of Mental Health – SESPAS. Technical support was provided by WHO's Mental Health Evidence and Research Team in Geneva: Benedetto Saraceno, Shekhar Saxena, Tom Barrett, Antonio Lora, Mark Van Ommeren, Jodi Morris, Grazia Motturi and Annamaria Berrino. Additional assistance was provided by Patricia Esparza.

The preparation of this study would not have been possible without the collaboration of the technical team of the General Department of Mental Health, State Secretariat of Public Health and Social Assistance and PAHO/WHO Representation in Dominican Republic. We are grateful for the support provided by the following doctors: Jorge Rodríguez, Víctor Aparicio and Dr. Gerardo Alfaro, PAHO/WHO Consultants, and was funded by the Center of Mental Health Services (under the guidance of the Mental Health and Substance Abuse Services Administration of the United States of America; the Health Authority of Regione Lombardia, Italy; the Ministry of Public Health of Belgium, the Institute of Neurosciences, Mental Health and Addiction, as well as the Canadian Institutes of Health Research).

Method and Procedures:

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was developed by the Evidence Research Team of the Department of Mental Health and Substance Abuse, World Health Organization, together with a team of consultants and is aimed to facilitate the collection of essential data on the mental health system of a country or region. The goal of collecting this information is to improve the mental health system and provide a baseline to monitor the impact of changes. This instrument was used to collect data on the mental health system in the Dominican Republic and this data will

[5] Ibdm

allow the country to develop mental health plans based on information with clear baseline information and targets. The country will also be able to monitor progress in implementing reform policies, providing community services, and involving consumers, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

WHO-AIMS consists of 6 domains covering 28 facets and 154 items. The 6 domains are interdependent, conceptually interlinked and somewhat overlapping. All the domains need to be assessed to form a relatively complete picture of a mental health system.

Data collection

WHO-AIMS was used to collect information in the Dominican Republic. The process started in July 2006 during a meeting held in Santo Domingo where the instrument was introduced and its application was discussed. The State Secretariat of Public Health and Social Assistance (SESPAS) gave the approval for carrying out the investigation and committed its support.

The next step was to explain the procedures in the application of WHO-AIMS to the country's technical team. The team was made up of a national consultancy firm contracted by PAHO/WHO, the National Director and the mental health Technical Coordinator, State Secretariat of Public Health and the consultant of PAHO/WHO Representation in charge of mental health.

The consultancy firm responsible for collecting data and conducting WHO-AIMS was granted three months to perform the work, during which it maintained systematic contacts with the technical team that monitored and guided the process in the country.

At the completion of the data collection stage, a workshop was held with the officials of the General Department of Mental Health, State Secretary of Public Health and Social Assistance, where the results were discussed and validated. In November 2006, a workshop was held with the attendance of the country's representative as well as with PAHO's Mental Health Sub-Regional Consultant. Relevant reports were presented in this activity, which gave rise to a new discussion.

Data was collected in 2006 and is based on the year 2005.

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

The Dominican Republic does not have an explicit mental health policy. However, in 2006, the State Secretariat of Public Health and Social Assistance (SESPAS) announced the government's strategy for improving the country's mental health. This public statement was made during the official enactment of the new **Mental Health Law,** and became the foundation for the country's national **mental health policy**. In addition, the Dominican Republic has a national ten-year health plan (2006 – 2015), which includes a plan in the area of mental health. The mental health component of this national health plan involves upgrading the existing mental hospital and developing mental health services in primary health care.

In 2006, national standards for mental health care were updated and the Law No. 12-06 on mental health was enacted. This law stipulates that every individual has the right to receive the best mental health care available and provides guidelines for protecting the fundamental freedoms and rights of persons with mental disorders.

There is a national intervention program for survivors of natural disasters, and psychosocial interventions have been implemented at different times when the country has been affected by natural disasters.

With respect to **financing of mental health services**, this study shows that allocation of resources is very low. SESPAS allocates less than 1% (0.38%) of health care expenditures

to mental health services, and 50% of these resources are directed towards Padre Billini Mental Hospital.

Psychotropic medicines are available in all types of facilities, but in terms of affordability of mental health services, a small percentage of the population (7%) has free access to essential psychotropic medicines.

For those individuals that have to pay for their medications out of pocket, the cost of antipsychotic medication is 12% and the cost of antidepressant medications is 10% of the minimum national wage.

There is no national human rights review body in the Dominican Republic with the authority to oversee human rights inspections in mental health facilities, such as mental hospitals, or to impose sanctions on those facilities that violate patients' rights.

As for **mental health services**, there is a national authority that advises the government on mental health policies and legislation and is involved in service planning, monitoring and assessment of the services.

In terms of mental health facilities, 81% (56) are outpatient services, and 16% (9) are psychiatric inpatient units within general hospitals. There is only one mental hospital, one day treatment center, and one residential facility.

Only 4% of outpatient services are directed towards mental health care of children and adolescents and there are no children/adolescent inpatient units or forensic psychiatric units in the country. The users treated in outpatient facilities are primarily diagnosed with affective disorders and schizophrenia, and some (21-50%) received one or more psychosocial interventions in the last year.

Sixteen percent of the mental health services in the country are provided in psychiatric inpatient units within general hospitals. These services are similar to crisis intervention units or short stay admission.

The mental hospital is not organizationally integrated with mental health outpatient facilities and does not provide treatment for children or adolescents. The patients admitted in this hospital are diagnosed primarily with mood disorders and schizophrenia. Around 59% of patients spend less than one year in the mental hospital and the average length of stay is 19 days. The hospital has an occupancy rate of 79%.

Almost all psychiatric beds are concentrated in the mental hospital and psychiatric units within general hospitals, which are located in the country's capital and urban areas. This concentration of resources in urban areas prevents rural users from accessing mental health services.

Mental health services in the Dominican Republic have been poorly developed at the first level of care and no regular training programs on mental health are developed for primary care staff. Although all primary health care centers in the country have a medical doctor, they do not have assessment and treatment protocols for key mental health conditions available.

In terms of consumer and family associations, their development has been very limited. There are no consumer associations. Recently, committees of family members have been created and are beginning to interact with mental health facilities in the sectors of Gualey, Barrio Libertador de Herrera and Los Minas. These committees had not been formed during the WHO-AIMS application period.

With respect to financial support for users, mental health facilities do not have access to outside programs that provide employment, or subsidized housing for people with severe mental disorders.

There were significant challenges in the process of collecting data on the mental health system of the Dominican Republic, as facilities do not have an organized training and registration system for recording activities performed in each health care facility. Facilities report most of the data per conglomerate, which prevents accessing timely information on mental health morbidity per group, gender and diagnosis. Moreover, although the majority

of outpatient services do record and register their data, it is not included in the national information system because they record mental health information per conglomerate.

In terms of research, this is an area of major weakness in the country. Of all the publications in the country in the last five years, few have been on mental health, and there are no publications on PubMed about the Dominican Republic's mental health situation.

Evaluation Results:

DOMAIN 1: POLICY, PLANS, AND LEGISLATION

On the launch of the Mental Health Law in 2006, the State Secretariat of Public Health and Social Assistance (SESPAS) read a public statement that contained the principles and objectives for improving the mental health of the Dominican population. This statement became the basis for the country's national mental health policy. Throughout the year, and by enforcing part of these objectives, the Services Qualification Standards were developed and approved, and the National Mental Health Care Standards were updated (IBSN No. 9945-436-000-7). In addition, there is a list of essential medicines that includes antipsychotic, anxiolytic, antidepressant, mood stabilizers, and antiepileptic medicines.

With regard to a mental health plan, a five-year mental health plan has been developed and implemented in the country. This mental health plan was last revised in 2006 when mental health was considered in the revision and update of the Ten-Year National Health Plan (PLANDES) 2006 – 2015. The main mental health components in this plan include reforming and upgrading the mental hospital and developing mental health services in primary health care.

In addition, a National Intervention Program for victims of disasters was developed and last revised in the year 2006.

Legislation: In addition to the mental health elements that are integrated in various laws currently in effect in the country (e.g., Constitution of the Republic, General Health Law, Law 87-01 that implements the Dominican Social Security System, Law for the protection

of children, adolescents, Law against drugs, among others), a separate Mental Health Law (Law No. 12-06) was enacted on February 3, 2006. The objective of this law is to regulate the people's right to have access to the best mental health care available. It contains four Titles and nine Chapters. Chapters II and III address aspects in connection with basic rights and freedoms of people with mental disorders and living conditions in mental health institutions. It also considers aspects of the mental health system, hospitalization system, assistance and rehabilitation care, and Art. 79, Title IV, Chapter II establishes that public and private institutions and organizations that provide mental health services should have the necessary resources to provide mental health primary care.

Financing of mental health services

The allocation of resources for mental health in the Dominican Republic is considered to be inadequate, as it does not meet the needs and demands of the population. Less than 1% (0.38%) of health care expenditures by SESPAS are directed towards mental health. Of all mental health expenditures, 50% are directed towards the national mental hospital, which adversely affects outpatient and primary care services.

In terms of affordability of mental health services, a small percentage of the population (7%) has free access to essential psychotropic medicines. Free access to medication is provided primarily to inpatients from Padre Billini Mental Hospital and from some units within general hospitals. This means that the low-income population that seeks outpatient services has limited access to medication.

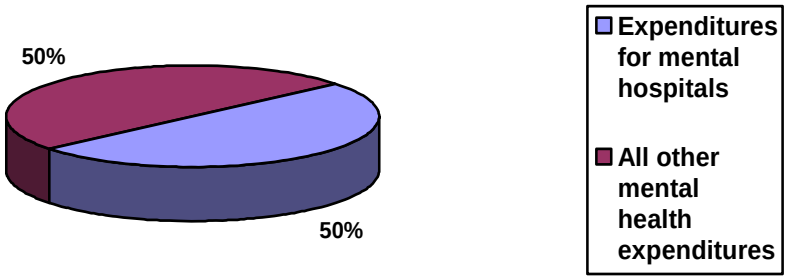
For those that have to pay out of pocket for their medicines, the cost of antipsychotic medication is 12% of the national minimum wage equivalent to RD $19.00 (US $0.58 dollars) per day and the cost for antidepressant medication is 10% of the minimum wage equivalent to RD $16.00 (US $0.49 dollars) per day. These calculations were based on the cheapest psychotropic medication in the local market.

User's out of the pocket cost for two psychotropic medicines (proportion of minimum wage needed to pay for one day of psychotropic and antidepressant medication)

Country	Antipsychotic	Antidepressant
Dominican Republic	12% (US $0.58)	10% (US $0.49)

In October 2006, mental health authorities started a plan to provide essential psychotropic medicines through Long Stay Patients Clinics (CLIPLE), which are located in the National District and in other provinces of the country. In addition, the authorities established a program for selling low cost psychotropic medication through the Essential Medication Program (PROMESE).

GRAPH 1.1
MENTAL HEALTH EXPENDITURES TOWARDS MENTAL HOSPITALS



Human rights policies

There is no national human rights review body in the Dominican Republic with the authority to oversee inspections in mental health facilities nor to impose sanctions on those facilities that violate patients' rights.

It is important to emphasize that Chapter III, Articles 15-20 of the Mental Health Law (Number 12-06) outlines basic rights, fundamental freedoms and living conditions in mental health facilities. The implementation of this Law is currently being standardized through a regulation process.

In terms of training, 100% of mental hospital staff, and 20% of inpatient psychiatric units and community residential facilities staff have had at least one day training, meeting or other type of working session on the protection of patient's human rights in the year of assessment**. However, no strategy for formal and systematic training on the subject has been developed for mental health staff.**

DOMAIN 2: ORGANIZATION OF MENTAL HEALTH SERVICES

2.1 Organization of mental health services

Within the State Secretariat of Public Health and Social Assistance (SESPAS), a national authority exists that provides advice to the government on mental health policies and legislation. The mental health authority is also involved in service planning and monitoring and quality assessment of mental health services. Mental health services are integrated in the general health network.

2.2 Mental Health Outpatient Facilities

There are 56 mental health outpatient facilities available in the country, of which 4% are for children and adolescents only. These facilities are made up of external medical visits to general and specialized hospitals, polyclinics, doctor's surgery, and community mental health facilities. Most of them are located in urban areas and have psychiatrists and psychologists that provide care. Some of these services are provided by general practitioners trained in mental health.

The outpatient mental health services that are exclusively for children and adolescents meet only a small fraction of the actual need of the population. There is one outpatient facility for children and adolescents in Roberto Read Cabral Children Hospital in Santo Domingo, the capital city, and one in Arturo Grullon Children Hospital in the city of Santiago de los Caballeros. While Jaime Mota Hospital, located in the province of Barahona, does not have exclusive care available for children and adolescents, it treats a high proportion of children and adolescents within its user population. The information in the following chart

shows the need to create care units for children and adolescents and to train human resources specialized in this area.

Country	Outpatient services	Outpatient services for children and adolescents only	Percentage
Dominican Republic	56	2	4%

These mental health outpatient facilities treat 266 users per 100,000 population. Of all users treated in mental health outpatient facilities, 40% are children or adolescents. Unfortunately, there are no data available on the proportion of female users. The users treated in outpatient facilities are primarily diagnosed with mood disorders (affective) (32%) and schizophrenia (31%). The average number of contacts per user is two (2). Only eighteen percent (18%) of outpatient facilities provide follow-up care in the community, while just 2% have mobile mental health teams.

In terms of available treatments, only 21 to 50% of patients in outpatient facilities last year received one or more psychosocial intervention and all the outpatient facilities had at least one psychotropic medication of each therapeutic class (antipsychotic, antidepressant, mood stabilizers, anxiolytic and antiepileptic) available in the facility or in a near-by pharmacy all year long.

Day treatment facilities

There is one day treatment facility available in the country. This facility treats 18 users per 100,000 population. Sixty percent of users in this day treatment facility are female and it does not include treatment for children/adolescents. It is important to mention that the low average length of stay in this facility could be explained by the fact that some users did not remain in the program as they lived in rural areas and had transportation problems; also because at the time that the information was collected, this service was being restructured.

Psychiatric inpatient units within general hospitals

There are 9 psychiatric inpatient units within general hospitals in the country for a total of 76 beds or 0.9 beds per 100,000 population. These psychiatric units within general hospitals do not have beds reserved for children and adolescents and do not have records based on the users' gender or age or on diagnoses and rate of admissions. However, based on the data available, it was estimated that 55% of the users are females. Most of these units are crisis intervention units or units that provide care to users with acute problems and the period of stay is usually short.

Few patients (1-20%) in psychiatric inpatient units within general hospitals received one or more psychosocial intervention in the past year, while 100% of these units had at least one psychotropic medication of each therapeutic class (antipsychotic, antidepressant, mood stabilizers, anxiolytic and antiepileptic) available in the facility for inpatient users. A strategy is currently being developed to open new mental health units within general hospitals in order to reduce the number of hospitalizations in the mental hospital.

Community residential facilities

There is one community residential facility available in the country located in a neighborhood of the city of Santo Domingo as an alternative for managing patients with long evolution pathologies who do not have family members. This facility treats 0.05 users per 100,000 population and despite having four beds available, only two females lived there, and one of them had died prior to this study. This type of facility treats patients with long-term mental disorders. It does not treat children or adolescents. On average, the two patients spent 365 days in this community residential facility.

There are other kinds of residential facilities, not mental health specific, that are in the public and the private sector, and where aging patients with different disorders are treated. There are 9 residential facilities for persons with dementia, with a total of 90 beds/places, and 4 facilities for persons with substance abuse problems, with a total of 1522 beds/places.

Mental Hospitals

There is one mental hospital in the country, located in the rural area of the National District. This mental hospital has a total of 150 beds, which represents an availability of 1.75 beds per 100,000 population. The number of beds has decreased by 25% in the last five years. The mental hospital is not organizationally integrated with mental health outpatient facilities and there are no beds reserved for children or adolescents or for people over 65 years of age.

Fifty-four percent (54%) of patients are females and it does not treat children or adolescents. The patients admitted in the mental hospital belong primarily to the following diagnostic groups: mood disorders (69%), schizophrenia (21%) and other disorders such as mental and behavioral disorders related to the use of psychoactive substances (5%). Affective disorders are the most common diagnosis in the mental hospital, which would explain the results from the analysis of the mental health situation, carried out in 2005. The results of the situation analysis indicated that 50% of the schizophrenic patients remain in their communities and a significant number of them wander about the streets.

On average, patients spend 19 days in the mental hospital. Fifty-nine percent of patients spend less than one year in the mental hospital, 30% spend more than 10 years, 7% spend 5-10 years and 3% spend 1-4 years in this hospital. Few patients (1-20%) received one or more psychosocial interventions in the last year. This mental hospital had at least one psychotropic medication of each therapeutic class (antipsychotic, antidepressant, mood stabilizers, anxiolytic and antiepileptic) available in the facility the past year.

Forensic and other residential facilities:

There are no forensic psychiatric units in the country.

Mental Health Facilities available

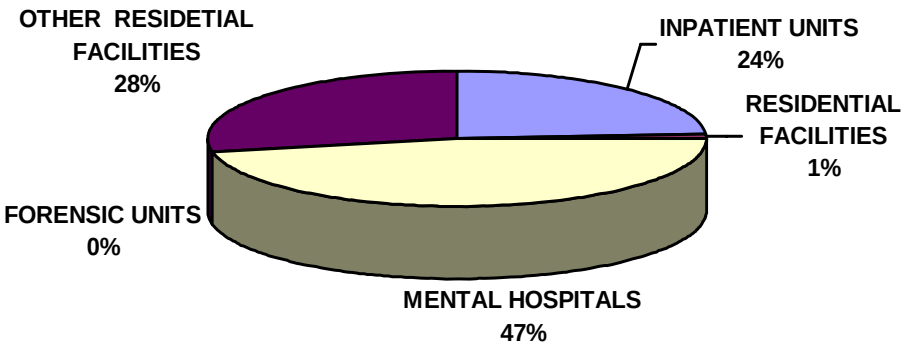
Outpatient Services	Day Center	MH Units within General Hospitals	Mental Hospitals	Residential Facilities	Forensic Units
56	1	9	1	1	0

Human rights and equity

Involuntary admissions of patients and physical restrain or seclusion in inpatient psychiatric facilities are not monitored in the country. Although there are no systematic records, it is estimated that almost 70% of admissions were involuntary and 11-20% of patients were restrained or secluded in the mental hospital the past year. This information could not be collected in the inpatient psychiatric units in general hospitals. 73% (166) of psychiatric beds in the country are located in or near the largest city. Such a distribution prevents access for rural users.

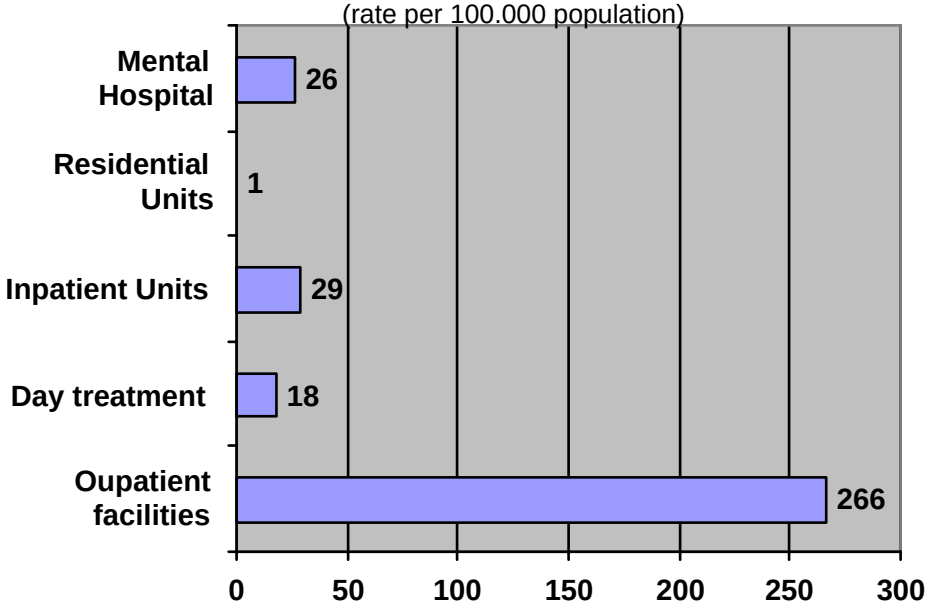
Summary Charts

GRAPH 1.2
- BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES



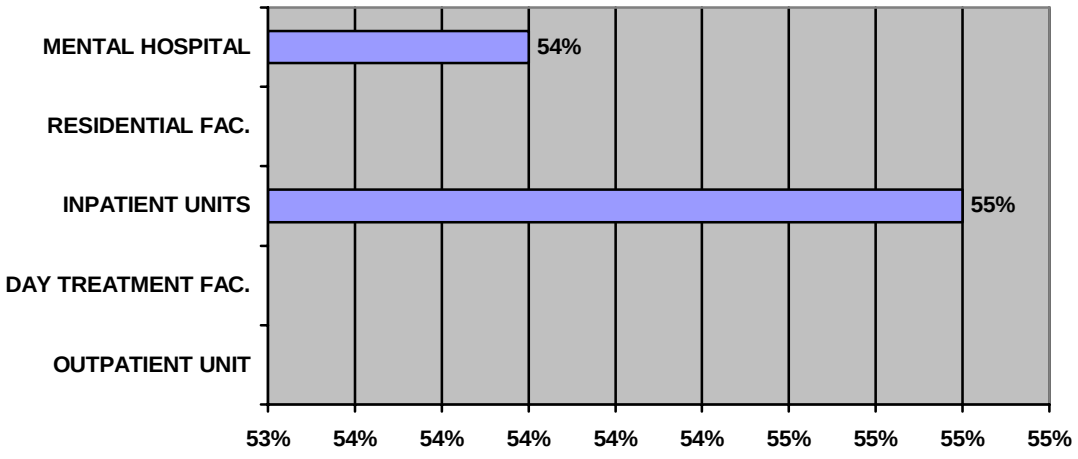
The majority of beds in the country are located in the mental hospital, followed by residential units inside and outside the mental health system, including those beds for patients with substance abuse problems and homes for the aging.

GRAPH 2.2
Patients treated in Mental Health Facilities
(rate per 100.000 population)



The majority of the users are treated in outpatient facilities and psychiatric inpatient units within general hospitals, as well as in the mental hospital, while the rate of users treated in day treatment facilities and residential facilities is very low.

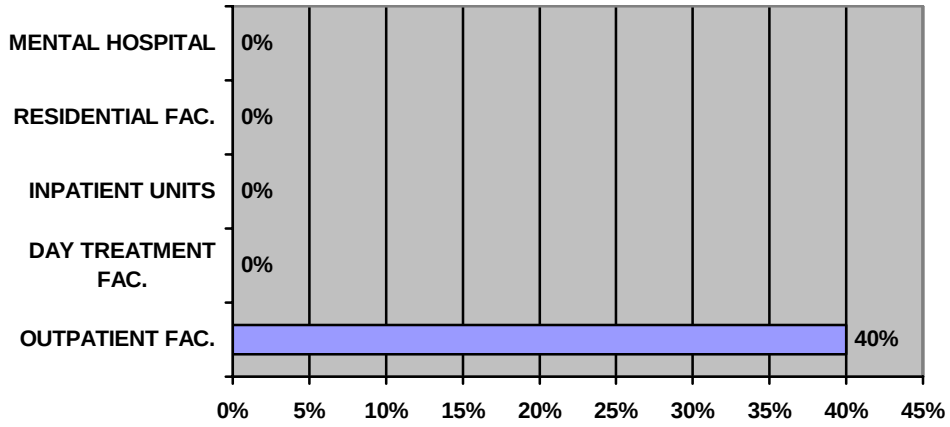
GRAPH 1.4
PERCENTAGES OF FEMAL USERS TREATED
IN MENTAL HEALTH FACILITIES



Female users make up an average of 54% of the population in mental health facilities in the country. The proportion of female users is only slightly higher in psychiatric inpatient units within

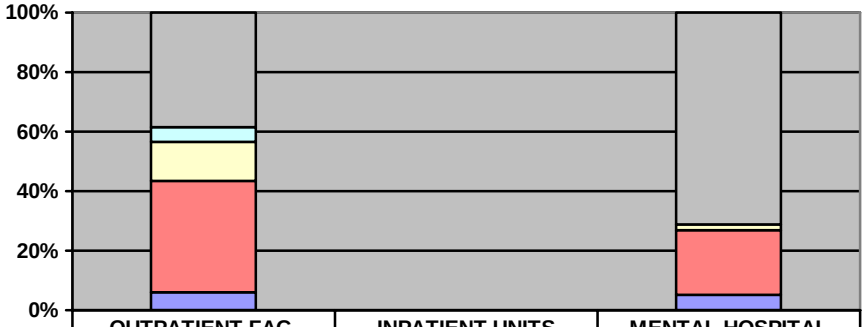
general hospitals than in the mental hospital. There is no information available on the distribution by gender in residential facilities, outpatient facilities, or in day treatment facilities.

GRAPH 1.5
PERCENTAGES OF CHILDREN AND ADOLESCENTS
TREATED IN MENTAL HEALTH FACILITIES



Children and/or adolescents are treated in outpatient facilities only, which equals 40% of the population treated in this type of facilities. There are no psychiatric beds reserved for children and/or adolescents, except for treatment centers for drug users, which are managed by the private sector and by nongovernmental organizations.

GRAPH 1.6
- PATIENTS TREATED IN MENTAL HEALTH
FACILITIES BY DIAGNOSIS

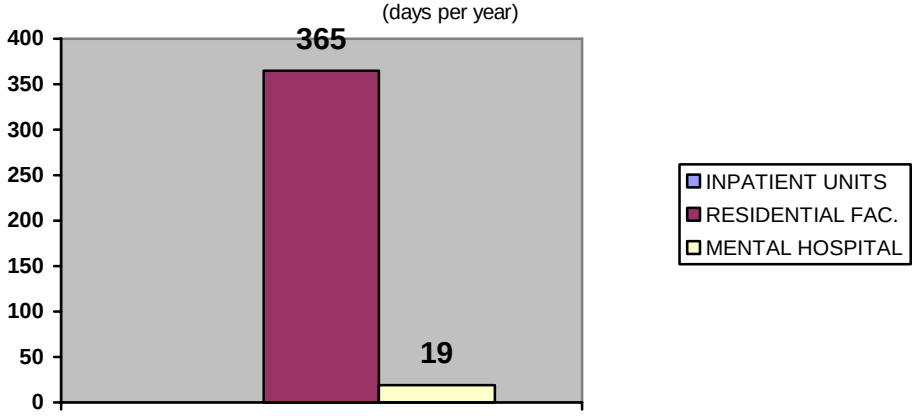


	OUTPATIENT FAC.	INPATIENT UNITS	MENTAL HOSPITAL
AFFECTIVE DIS.	32%	UN	69%
PERSONALITY DIS	4%	UN	0%
NEUROTIC DIS.	11%	UN	2%
SCHIZOPHRENIA	31%	UN	21%
Substance Abuce	5%	UN	5%

UN= unknown

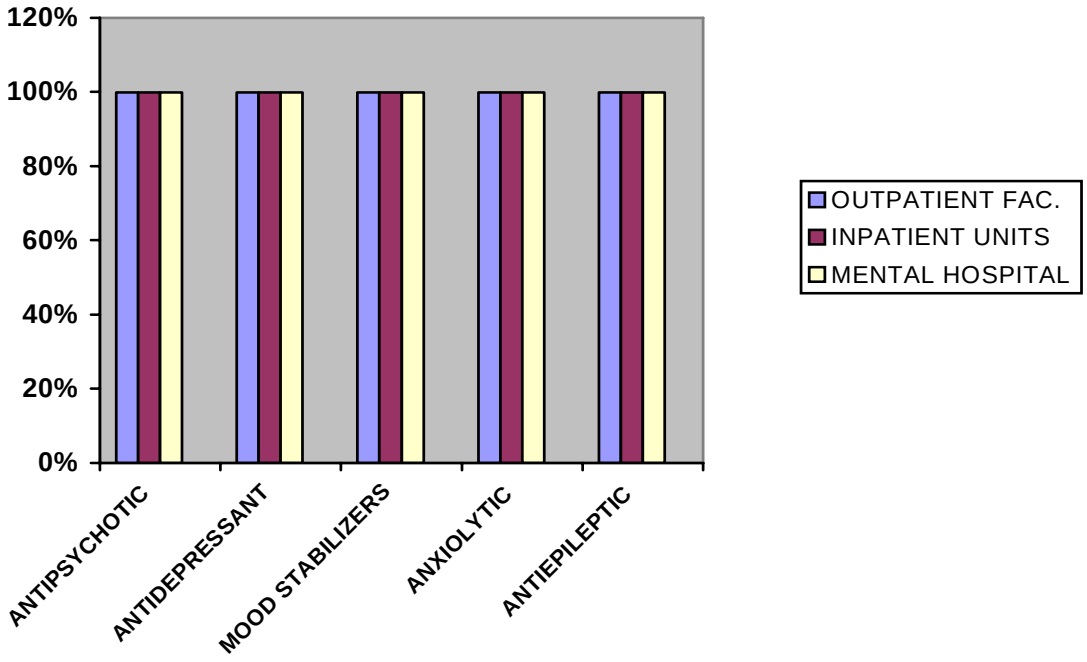
Affective disorders and schizophrenia are the most common mental disorders in outpatient facilities and in the mental hospital. This type of information was not recorded in psychiatric inpatient units within general hospitals.

GRAPH 1.7
- LENGTH OF STAY IN INPATIENT FACILITIES
(days per year)



The longest length of stay for users is in community residential facilities, followed by the mental hospital. This type of data was not available for psychiatric inpatient units within general hospitals.

GRAPH 1.8
- AVAILABILITY OF PSYCHOTROPIC DRUGS IN MENTAL HEALTH FACILITIES



Psychotropic medication is widely available in the three types of facilities. However, in terms of accessibility, only a small percentage of the population (7%) has free access to essential psychotropic medicines. Inpatients in Padre Billini Mental Hospital and the population with the right to hospital services at the Dominican Social Security Institute have free access to medication.

DOMAIN 3: MENTAL HEALTH IN HEALTH PRIMARY CARE

Training in mental health care for primary care staff

Educational programs for physicians and nurses were evaluated to determine the time devoted to mental health subjects in their undergraduate education (university). This study included all of the universities in the country that teach medicine and nursing. We found that three percent (3%) of the training for medical doctors is devoted to mental health,

compared to four (4%) for nurses, while there are no data available for non-doctor/non-nurse primary health care workers.

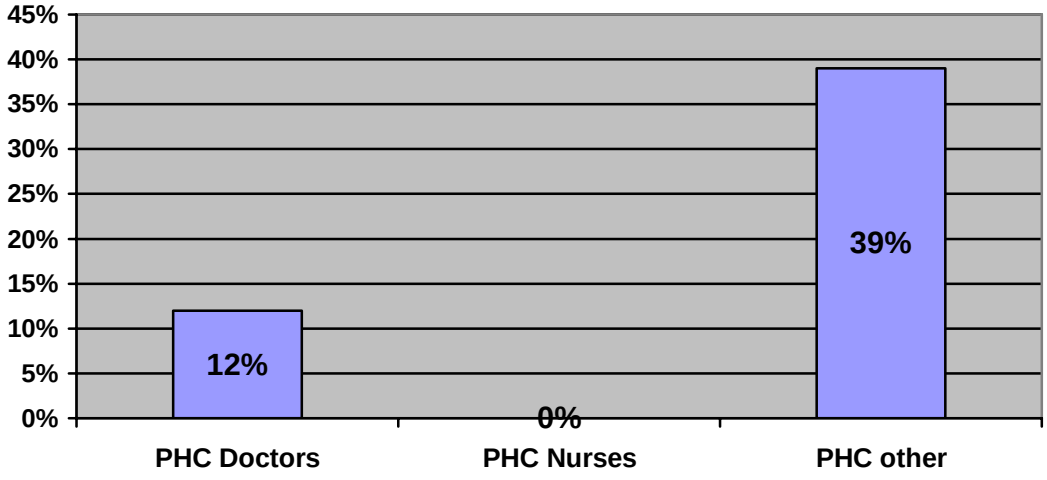
In terms of refresher training, 12% of primary health care doctors have received at least two days of refresher training in mental health, while 0% of nurses and 39% of non-doctor/non-nurse primary health care workers have received such training.

In general, there is a lack of regular training programs on mental health for Primary Care workers. The results described in this report are from isolated courses and from the one-year training requirement for doctors who are in the process of being incorporated in the health system. This training component requires doctors to provide services for one year in order to obtain the certification that will enable them to exercise their medical profession.

However, it is important to mention that, in 1999, a strategy to provide training for general doctors in community mental health care was implemented in which seven general doctors were trained and are now providing mental health services through outpatient care at some municipalities in the interior of the country.

It is important to note that these data were not available in the regular information systems. Hence, it was necessary to collect this information from various sources.

GRAPH 3.1 - PERCENTAGE OF PRIMARY HEALTH PROFESSIONALS WITH AT LEAST 2 DAYS OF REFRESHER TRAINING IN MENTAL HEALTH IN THE LAST YEAR



Mental health in primary health care

All the primary health care centers (PHC) in the country have a doctor. These centers, however, do not have assessment and treatment protocols for key mental health conditions available. Few primary health care centers (1-20%) make an average of at least one referral per month to a mental health professional. The same percentage is reported in connection with the professional interaction between primary health care staff and other health care providers. Specifically, less than 20% of primary health care doctors have interacted with a mental health professional at least once in the last year.

The Dominican Republic has continued to set and develop mental health care standards and protocols for Primary Care workers. These protocols were developed with the support of the Pan American Health Organization (PAHO) and were, at first, focused on depression management, but have not yet been disseminated or implemented.

Prescription in primary health care

Non-doctor/non-nurse primary health care workers are not allowed to prescribe any type of medications. In contrast, primary health care doctors are allowed to prescribe without restriction, except for those controlled medications for which a special license is required. Availability of psychotropic medicines is limited and only few PHC centers (1-20%) have at least one psychotropic medication of each therapeutic class (antipsychotic, antidepressant, mood stabilizers, anxiolytic and antiepileptic) available in the facility or at a near-by pharmacy.

DOMAIN 4: HUMAN RESOURCES

Number of mental resources in mental health care

The total number of human resources working in mental health facilities or private practice per 100,000 population is 11.68. The breakdown according to profession is as follows: 2.07

psychiatrists; 0.37 other medical doctors (not specialized in psychiatry); 1.61 nurses, 3.17 psychologists; 0.14 social workers; and 0.21 occupational therapists; other health care workers (auxiliary staff, non-doctor PHC workers, health assistant, etc.) exclusive.

Human resources in mental health facilities

Human resources	**Dominican Republic**
Psychiatrists	178
Nurses	138
Psychologists	272
Social Workers	12
Occupational Therapists	18
Other mental health workers	327

This information corresponds to the public sector only (Secretaria de Salud y Seguro Social)

The majority of psychiatrists (68%) work in private practice and for profit mental health facilities, while 59% of the psychosocial staff (psychologists, social workers and occupational therapists) works for government-administered mental health facilities.

As shown in Graph 4.1, the country has two psychiatrists per 100,000 population, which shows the need to increase this human resource. Compared to other professionals, there are fewer nurses providing services in the area of mental health. The scarcity of nurses is a significant limitation considering the country's intention to strengthen mental health services at the first level of care.

Another situation to consider is the concentration of human resources in urban areas, as well as the pluri-employment of psychiatrists, psychologists and nurses who work in both public and private practice. This situation negatively affects the performance of human resources in the mental health sector.

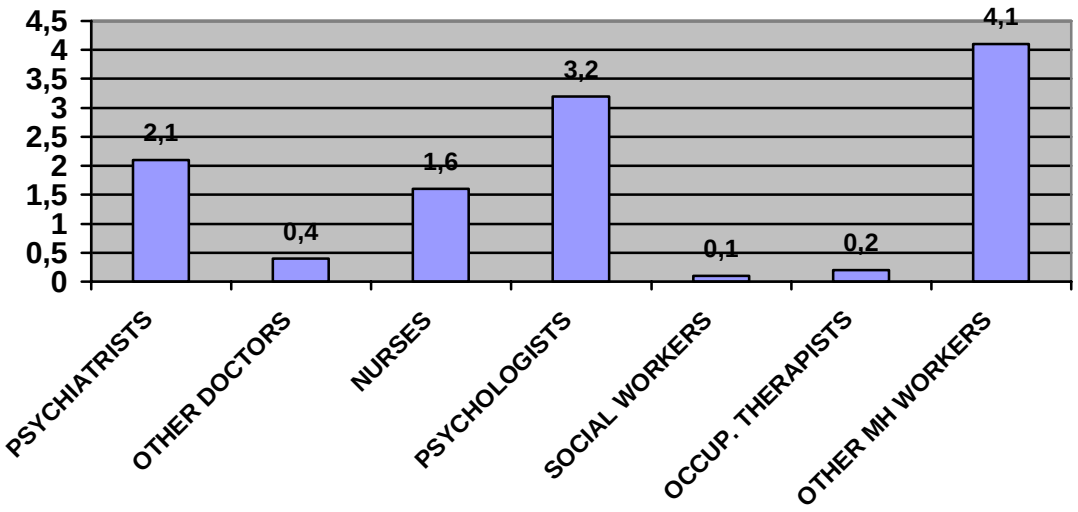
Country	**Proportion between rates of psychiatrists throughout the country and those in the capital city**
Dominican Republic	0.19

Regarding the workplace, 122 psychiatrists work in outpatient facilities, 17 work in psychiatric inpatient units in general hospitals and 13 work in the mental hospital. Thirteen medical doctors not specialized in mental health work in outpatient facilities, 7 work in psychiatric inpatient units in general hospitals, and 12 work in the mental hospital.

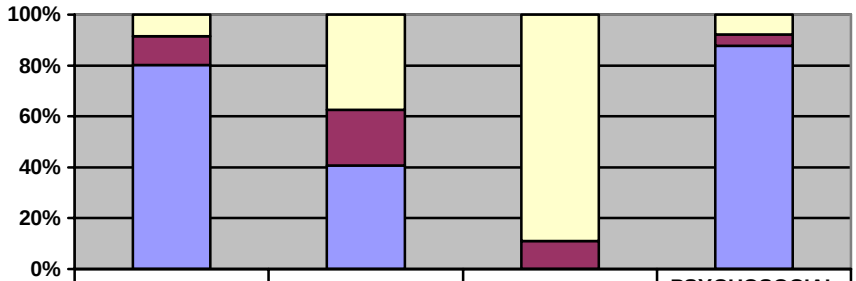
As far as nurses, 14 work in psychiatric inpatient units in general hospitals and 112 in the mental hospital. We were not able to obtain the number of nurses that work in outpatient facilities. As for psychologists, social workers and occupational therapists, 261 work in outpatient facilities, 14 in psychiatric inpatient units in general hospitals, and 23 in the mental hospital.

In terms of staffing in mental health facilities, there are 0.22 psychiatrists per bed in psychiatric inpatient units within general hospitals, compared to 0.09 psychiatrists per bed in the mental hospital. As for nurses, there are 0.18 nurses per bed in psychiatric inpatient units within general hospitals, in comparison to 0.75 nurses per bed in the mental hospital. Finally, for psychosocial staff (e.g. psychologists, social workers, and occupational therapists), there are 0.2 for psychiatric inpatient units in general hospitals and 0.15 per bed in the mental hospital.

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

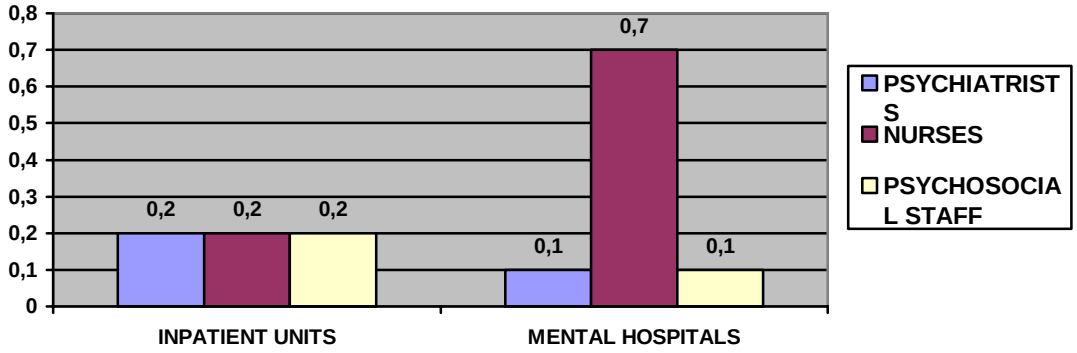


GRAPH 4.2 - STAFF WORKING IN MENTAL HEALTH FACILITIES
(percentage in the graph, number in the table)



	PSYCHIATRISTS	OTHER DOCTORS	NURSES	PSYCHOSOCIAL STAFF
MENTAL HOSPITAL	13	12	112	23
INPATIENT FAC.	17	7	14	14
OUTPATIENT FAC.	122	13	UN	261

GRAPH 4.3 - RATIO HUMAN RESOURCES/BEDS

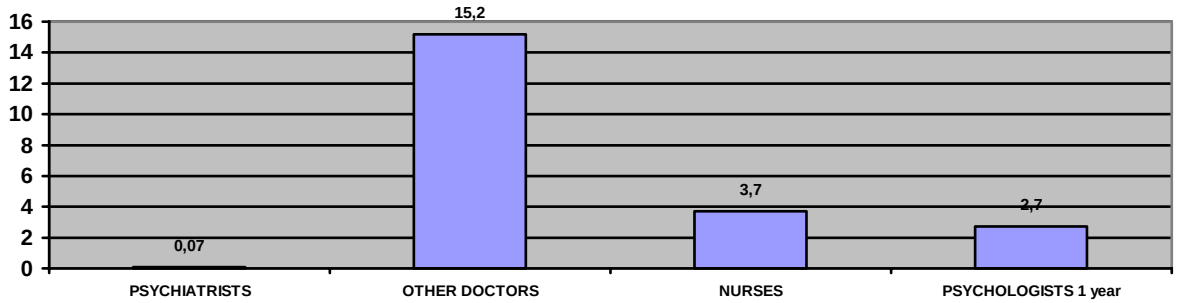


Training professionals in mental health

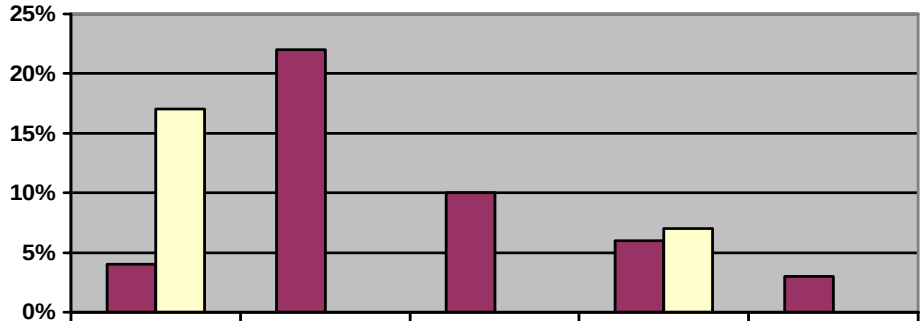
The number of professionals that graduated last year in academic and educational institutions is as follows: 6 psychiatrists, 1,306 medical doctors (not specialized in psychiatry), 321 nurses, and 229 psychologists. The number of social workers and occupational therapists trained in this period could not be determined. Few psychiatrists (1-20%) emigrate to other countries within five years of completion of their training.

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

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



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



	PSYCH.	MD	Nurses	Psychosocial	Other
Psychosocial interventions	4%	22%	10%	6%	3%
Child mental health	17%	UN	UN	7%	UN

Psic = psychiatrists, MD = other medical doctors not specialized in psychiatry; psychosocial staff = psychologists, social workers and occupational therapists. Others = other health and mental health workers.

Consumer and family associations

While there are no consumer associations in the country, 45 family members have formed committees to defend the rights of persons with mental disorders.

Initial efforts are under way to develop family associations. An association in Barrio Libertador de Herrera has been started but has been poorly developed, and its interaction with mental health services has been very limited. Committees or family groups in the sectors of Gualey, Herrera and Los Minas, are also in the process of being strengthened with the aim of becoming fully-established associations.

In addition, there are 16 nongovernmental organizations in the country involved in individual assistance activities such as counseling, housing or support groups.

DOMAIN 5: PUBLIC EDUCATION AND LINKS WITH OTHER SECTORS

Public education and awareness campaigns on mental health

The General Department of Health Promotion and Education (DIGPRES) of SESPAS, is the coordinating body that oversees the public education and awareness campaigns on different aspects of health including those related to mental health and mental disorders. Government agencies, nongovernmental organizations, and professional organizations have all promoted public education and awareness campaigns in the last five years. These campaigns have targeted the following groups: children and adolescents, women, trauma survivors and other vulnerable minority groups. In addition, there have been public education and awareness campaigns targeting professional groups including teachers and healthcare providers

Legislative and financial provisions for persons with mental disorders

In the Dominican Republic, there are legislative provisions concerning a legal obligation for employers to hire a certain percentage of employees who are disabled, and provisions concerning protection from discrimination (dismissal, lower wages) solely on the account of a mental disorder. However, these provisions have not been implemented. There is no legal provision concerning priority in state housing and in subsidized housing schemes for people with severe mental disorders.

Links with other sectors

There are formal collaborations in the country with the agencies or departments responsible for: child and adolescent health, welfare, and criminal justice. In terms of support for child and adolescent health, few primary and secondary schools (16%) have either a part-time or full-time mental health professional, and few schools (1-20%) have school-based activities to promote mental health and prevent mental disorders.

Regarding mental health activities in the criminal justice system, the percentage of persons with mental retardation and for psychosis is less than 2%. Few prisons (between 1-20%) have at least one prisoner per month in treatment contact with a mental health professional. As for training, some police officers (between 21-50%) and few judges (1-20%) have participated in educational activities on mental health in the last five years. In terms of financial support for users, no mental health facilities have access to programs outside the mental health facility that provide outside employment for users with severe mental disorders.

DOMAIN 6: MONITORING AND RESEARCH

A formally defined list of individual data that should be collected in mental health services exists only in Padre Billini Mental Hospital, SESPAS and in mental health services provided in the reference hospital of the Dominican Social Security Institution. This list includes the number of beds, admissions, length of stay and patient diagnoses. The government health department received data from 100% of mental hospitals, 22% of psychiatric inpatient units within general hospitals, and 100% of mental health outpatient facilities. It is important to note that these data is not registered in the national information system and therefore were collected by the mental health staff that provide the services. The only data available were the number of users treated without the distribution by gender, age or diagnosis.

In terms of research, there is a significant weakness in this area as there are very few mental health publications in the country. Some investigations have been conducted in the area of violence and drugs.

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

Indicator	Mental Hospital	Psychiatric Inpatient Units in general hospitals	Outpatient facilities
Nº of beds	100%	100%	
Nº inpatient admissions/users treated in outpatient facilities	100%	22%	100%
Nº of days spent/user contacts in outpatient facilities	100%	0%	100%
Nº of involuntary admissions	0%	0%	
Nº of users restrained	0%	0%	
Diagnoses	100%	33%	5%

Limitations in data collection

The data collection process on the mental health system of the Dominican Republic had several limitations. First, facilities do not have an organized training and registration system for activities in health care facilities, reporting most of the data per conglomerate, which prevents from having timely information on mental health morbidity per group and gender.

Another aspect to be considered is the fear of the informants, who erroneously think that if they provide information it will be evaluated on an individual basis.

A Mental Health Situation Analysis was performed in 2005 with the support of the Pan American Health Office. Based on these data, a report with comments was published. As in this evaluation, the following was evidenced:

- The majority of outpatient services register their data, but it is not included in the national information system as the facilities register the information per conglomerate.
- Collected data is insufficient for a proper situation analysis.
- There are sub-records or poor quality records in the primary register.
- There is no data available from the private sector.

- There are publications or reports in SESPAS's annual report but mental health data is not segregated.
- Staff providing care use the DSM-IV and does not use the classification officially accepted by the country (CIE-10).

Strengths and weaknesses of the mental health system

Mental health care in the Dominican Republic was first developed with the perspective that treatment of mental patients consisted primarily with "insane" hospitalization. Mental health care later improved with the gradual development of external health care consultations and short stay admissions. Now the perspective is to prioritize health promotion and prevention of mental disorders and psychosocial problems by including the participation of the community and public and private service agencies through a National Care Network.

The key problem to improving mental health services in the country has been the poor development of mental health services in Primary Care. In addition, the mental hospital continues to be hegemonic; however, some progress has been made in outpatient care and in the opening of mental health units within general hospitals. In addition, the national mental health plan emphasizes the importance of mental health in primary care. The new emphasis has given rise to local user/family groups, such as the one carried out in Gualey, which was supported by the Rey Ardid Foundation from Zaragoza, Spain.

The General Department of Mental Health is a body within SESPAS whose mission is to set the standards for mental health care and ensure the delivery of effective services, as required by the population's right to health care. The mental health services are defined by:

- The threats of a growing incidence of mental disorders and undesirable psychosocial behaviors affecting personal, family and social stability.
- The weakness of concentrating services in hospital treatment of mental disorders.
- The opportunity provided by the ten-year plan and the political will to reform the health sector, driven by laws that impose the right for health.

- The strength of having experienced and proper human resources guided towards the plan to reform the mental health sector, and the support of social sectors willing to get involved in health services.

The Project for the Development of the National Mental Health Network in the Dominican Republic consists of reorganizing mental health care pursuant to the new legal regulation of the National Health System, the National Social Security System and the Plan to Reform and Upgrade the State (Health Sector).

The purpose of reorganizing the health care network is to help to improve mental health. This means adapting service provision and its standards to the actual needs and demands of the population, as well as extending the health care vision to include promotion, prevention and treatment. This also means developing a strategy, agreed by the key stakeholders of the national mental health services, to respond to the following basic needs:

a) Prioritize prevention and rehabilitation services within the health care system.
b) Extend the coverage so that the population with higher risk and vulnerability can have easy access to health care.
c) Transfer technologies and provide resources to enable the participation of more people and entities in services organization, administration, and service provision.

As stipulated in the Ten-Year Health Plan, the aim is to achieve universal access for all the people at the primary care level of the National Health System. At the same time, the objective is to reformulate the System and its Services Networks in order to strengthen care at the primary level until it reaches the ability to meet 80% of the demand and address the health care needs of the different sectors of the population.

The mental health network is envisioned to:

A) Respond with the quality and efficiency required to meet the actual demand of the population.

B) Respond to mental health priorities on a phased basis, according to the degree of complexity of care (promotion, prevention, diagnosis, treatment and

rehabilitation) and the health system structures (community groups, primary care units – UNAP -, crisis intervention units, general hospitals and specialized hospitals).

C) Ensure that each level in the health care network has sustainable potential to meet its specific offer and quality and efficiency standards.

D) Encourage public, independent and community service sectors to participate on a formal and contractual basis as a support network for the mental health sub-system.

It is of key importance that the government systematizes data collection in order to quantify, in an actual and tangible manner, the real problems and needs of its population, and in this manner, be able to prioritize the solutions.

We will have to increase efforts to monitor and supervise the protection of human rights of people with mental disorders, and develop an awareness campaign that is based on the recently-enacted Mental Health Law, which contains several articles on the protection of these rights.

It is also necessary to systematize the training and refresher training processes of mental health professionals and primary health care workers. Within the implementation of the Family Health Insurance, we recommend that the country execute an action plan, at short and medium term, that will strengthen and further develop the mental health services in the country.

New Steps in Planning Mental Health Actions

Planning workshop

This document will be sent to different bodies, agencies and sectors with certain links to the subject (Dominical Psychiatry Society, Psychologists Association, Human Rights

Commission, Directors, Heads of service and coordinators of mental health services of the public and private sector, health regional and provincial authorities, representatives of family associations, among others) for them to review it and participate in a workshop to be held in the first quarter of 2008, where, based on the results of this report, proposals for actions or interventions will be discussed to strengthen mental health services.

A guide for answers and recommendations should be sent together with the document that will be submitted and discussed in the workshop.

Recommendations for action

The following are a set of recommendations that we consider appropriate for improving the country's health system:

1. To prioritize the existence of free or subsidized psychotropic medications in PHC facilities and mental health outpatient services.
2. To extend and strengthen mental health community services, allocating proper human and financial resources.
3. To increase the number of economic and human resources towards community-based services.
4. To reinforce mental health care of childhood and adolescence. To recommend the implementation of a specific program suited to the country's conditions and resources that includes training of human resources on these matters.
5. To design and implement a regular training program for PHC workers to ensure that at least 80% of this staff can be trained in two years.
6. To create children-adolescents units and psychiatric inpatient forensic units.
7. To increase the budget directed towards mental health and to change the expenditure structure within the mental health system, ensuring community and outpatient services are prioritized over the mental hospital.
8. To establish agreements between SESPAS and Human Rights agencies to regularize the inspection and surveillance of the human rights of persons with mental disorders, ensuring their protection.

Mental Health Systems

1. To promote the opening of new psychiatric services within general hospitals that do not yet have them, in order to facilitate users' community services.
2. To develop day treatment facilities and hospitals linked to mental health outpatient services or psychiatric services within general hospitals.
3. To design and implement strategies and specific actions to allow an equal access to services for rural users.
4. To implement an epidemiologic surveillance program of prioritized mental and behavioral disorders.
5. To design intervention strategies in mental health for the aging population.

Mental health in primary health care

6. To approve standards and protocols in mental health for PHC. The goal should be its implementation in at least 80% of the facilities.
7. Training primary care staff in early detection and management of mental disorders prioritized at that level of care.
8. To develop an early detection and brief intervention program for problems in connection with alcohol consumption.

Human resources

9. To increase the number of mental health subjects in the university's' medicine and nursing programs.
10. To establish strategies for allocating human resources, and for ensuring coverage of mental health services in rural areas and the interior of the country.
11. To strengthen the training program of Psychiatry Residence.
12. To develop a training program for nurses on mental health.
13. To Train human resources on the mental health care of children-adolescents.

Health education and links with other sectors

14. To reinforce the agreements between the Education Secretariat and Health Secretariat to ensure the gradual assignment of mental health professionals in public primary and secondary schools. At the same time, to train teachers and PHC workers, so that they can jointly develop activities that include health promotion and the prevention of mental and behavioral disorders in schools.
15. To encourage the training of users and family organizations, including their active participation in mental health plans and programs and favoring their systematic interaction with the services.

Assessment and investigation

16. To form workgroups with joint participation of universities and public agencies to promote mental health research. PAHO/WHO can support this initiative.

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The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect data on the mental health system of the Dominican Republic. The goal of collecting this information is to improve the mental health system and provide a baseline to monitor the impact of changes. This data will allow the country to develop mental health plans based on information with clear baseline information and targets. The country will also be able to monitor progress in implementing reform policies, providing community services, and involving consumers, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

This document outlines the main limitations and problems facing the country in the area of mental health services. Although the Dominican Republic does not have an explicit mental health policy, a new Mental Health Law was enacted in 2006, which stipulates that every individual has the right to receive the best mental health care available and provides guidelines for protecting the fundamental freedoms and rights of persons with mental disorders.

The allocation of resources for mental health is very low. Less than 1% of health care expenditures are directed towards mental health. Of all mental health expenditures, 50% are directed towards the national mental hospital, which adversely affects outpatient and primary care services.

In terms of mental health facilities, 81% (56) are outpatient services, and 16% (9) are psychiatric inpatient units within general hospitals. There is one mental hospital, one day treatment center, and one residential facility.

Mental health services in the Dominican Republic have been poorly developed at the first level of care and no regular training programs on mental health are developed for primary care staff.

The country has two psychiatrists per 100,000 population, which shows the need to increase this human resource. Compared to other professionals, there are few nurses providing services in the area of mental health. Almost all psychiatric beds are concentrated in the mental hospital and psychiatric units within general hospitals, which are located in the country's capital and urban areas. This concentration of resources in urban areas prevents rural users from accessing mental health services.

Government agencies, nongovernmental organizations, and professional organizations have all promoted public education and awareness campaigns in the last five years. While there are no consumer associations, some family members have established committees.

Of all the publications in the country in the last five years, few have been on the mental health situation of the country.