TECHNICAL REPORT SERIES # 2

MENTAL HEALTH LEGISLATION

IN

THE CARIBBEAN

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This document was prepared by Miss Judith Herwood, BD, MA, during a summer residence with Health Legislation (HLE) under the Coordination of the Health Policies Development Program (HSP), at the Pan American Health Organization.
"It is now universally recognized that mental illness, like physical illness, is treatable by scientific methods of medicine incorporated in the discipline of psychiatry and that, moreover, it can be treated outside mental hospitals through community-based services. The open-door policy in running mental hospitals is an accomplished fact today and the concept of the therapeutic community has restored to the psychiatric patient his self-respect and dignity as an individual, and has restored our respect for his feelings and opinions and renewed our faith in his rehabilitability.

To give the necessary impetus to the "third psychiatric revolution", as community psychiatry has come to be called (Bellak, 1964), it is necessary to ensure that legislation concerning various aspects of the question of the mentally ill is humane and in tune with the progressive trends in current psychiatric thinking and practice. No amount of solemn declarations that mental illness is no different from physical illness will carry conviction as long as we choose to have unduly restrictive and dehumanizing laws governing admission of the mentally ill to mental hospitals and their discharge therefrom."

K. Bhasharan
Medical Superintendent
Hospital for Mental Diseases
Kanke, India
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INTRODUCTION

It is the intent of this document to analyze the mental health legislation of the English-speaking Caribbean, and to determine if it conforms to current international standards for such legislation.

The backdrop for this analysis, providing models and standards for comparison, was a series of documents on law and psychiatry published by the World Health Organization (WHO) and its office in the Americas—the Pan American Health Organization (PAHO/WHO). Also of utmost importance to this analysis were the proceedings of a Latin American Regional Conference on Restructuring Psychiatric Services held in Caracas, Venezuela in 1990 and an international seminar on Innovations in Mental Health Legislation and Government Policy: A European Perspective of the same year in the Netherlands. Finally, the official gazetted copies of mental health laws in the islands were the primary source of direct information on legislation in these countries. This information is contained in the LEYES database produced by the Health Policies Development Program (HSP) at PAHO, with the cooperation of the U.S. Library of Congress of the United States of America and the Faculty of Law Library at the University of the West Indies (UWI), Cave Hill, Barbados. The author’s knowledge of mental health care in developing countries, supplemented by the expertise of WHO and PAHO staff, permitted a more accurate appraisal of the situation in the Caribbean.

Unfortunately, epidemiologic data documenting the prevalence of mental illness in the Caribbean was not available. Also, an accurate picture of psychiatric services provided in the islands was impossible to obtain for purposes of this report. It was therefore difficult to determine whether services are operating de facto or under an established legal framework. It was also impossible to tell whether types of care mentioned in the laws, such as mental hospitals and licensed homes, are still in fact the only mental health services offered in the country. Nevertheless, the laws reflect the legal framework surrounding mental health care in the Caribbean.

Recognizing the severe limitations in mental health care around the world, the WHO and its regional offices have given priority to the advancement of mental health care in areas where services are inadequate. It has developed a policy suited to areas where resources, manpower and public acceptance are disastrously lacking.

Since the 1973 WHO Seminar on the Organization of Mental Health Services in Addis Abbaba, WHO has stressed the need for:

- decentralized, community-based services,
- integration of mental health services with primary health care,
- formulation of national mental health policies and establishment of mental health units in each country’s national administration,
- collaboration with nonmedical community agencies,
- training of nonspecialized health workers in psychiatric care;
- Adequate financing for a program of personnel recruitment and training, drugs, facilities and research.¹

It is believed that this is the most practical strategy to stretch resources and make services accessible and acceptable.

It requires cooperation between countries, collaboration among social sectors and a reorientation of thinking about mental health.

At PAHO’s Regional Conference for Restructuring Psychiatric Services in Caracas, countries declared that:

1. psychiatric care must be integrated with primary health care and local health systems, which permits promotion of alternative models centered in the community.

2. revision of the hegemonic role of the central psychiatric hospital in service delivery is critical.

3. resources and treatments must:
   a. safeguard personal dignity and human and civil rights.
   b. be rationally based and technically adequate.
   c. encourage maintenance of patients in their community.

4. legislation must assure respect for the civil and human rights of the mentally ill and provide for the organization of community-based services to see to that end.²

The Caracas conference also listed priorities for restructuring mental health care which have a direct bearing on the development of legislation in this area:

1. transformation of existing psychiatric hospitals.

2. data collection on chronic patients.

3. development of adequate sensitivity among technical and administrative personnel to induce attitudes of humanization and the beginning of deinstitutionalization of chronic patients.

4. therapeutic communities and rehabilitation centers.

5. use of beds in general hospitals for psychiatric patients.

6. creation of community services in defined areas.

7. health promotion and prevention activities.

8. program evaluation.³

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³ Ibid., p. 10.
The recommendations of PAHO and WHO have been incorporated into the analysis of Caribbean mental health legislation. By recognizing the elements that can positively impact the future of mental health care, we can project the quality of legislation required to accompany this transformation. By doing this we acknowledge the value of mental life, which, after all, distinguishes man from all other creatures.

The document contains the following sections:

II. Mental Health as a Public Health Problem. Describes the epidemiology of mental illness and mental health services.

III. Third World Mental Health Care. Conventional Institutional Model. Describes the prevailing policies and systems of treatment typical of less developed countries.

IV. The Law and Mental Health. Explores issues of law and psychiatry from historical and research perspectives, and presents experts’ opinions on preferred forms of mental health legislation.

V. Caribbean Mental Health Legislation. Describes and analyzes specific mental health laws of the English-speaking Caribbean, especially with respect to today’s recommended standards and international climate of reform.

VI. Conclusions

Appendix I. ICD-9-CM-Classification of Mental Disorders

Appendix II. Standards for Model Mental Health Legislation: one expert’s opinion.
I. MENTAL HEALTH AS A PUBLIC HEALTH PROBLEM

According to the WHO, over 300 million people around the world are afflicted with some type of mental disorder. At least 40 million suffer from the most severe forms of disease, such as schizophrenia and severe depression. At least twice as many are seriously disabled by mental retardation, dementia, drug dependence and alcohol-related problems. Epilepsy claims two to five of every thousand inhabitants of industrialized countries, and may be three to five times higher in developing countries. Another 200 million are devastated by less severe but nevertheless incapacitating forms of disorder, such as neuroses.

In many countries, mental illness is the main cause of disability for two of every five disabled persons. In both developed and developing countries, at least 20% of all contacts with healthcare providers stem from psychological factors. Between one-third and one-half of all mortality is due to diseases amenable to prevention or management through behavioral interventions, i.e. cardiovascular disease, accidents, some cancers, STDs. However, 50% of mental, neurological and psychosocial problems could be prevented if there existed the political will to do so.  

There is no known human group or community --whatever its level of development-- which is free from severe mental disease. It is apparent from the data above that in terms of individual suffering, the burden to families and the cost to communities, the health services are faced with a problem of great magnitude.

It is projected that psychiatric morbidity will grow as we approach the next century. Rising life expectancies and lowered mortality rates mean more survivors to become afflicted with these disorders. There will be increases in certain high risk groups, such as the elderly (dementia), young adults (schizophrenia), and the middle-aged (depression). Accidents will increase organic brain syndrome, infections and parasitic diseases can bring on psychoses, and stress, in its various forms, will contribute greatly to dysfunctional disorders.

Rapid social change resulting from economic development, industrialization and urbanization has profound effects on the structure of communities, the functioning of families, and the psychosocial support systems, thus reducing the ability of people to cope with distress, disease and disability. These effects are expected to multiply in the decades to come as societies modernize, degrade the environment, abandon rural areas, create economic uncertainty and change lifestyles for large segments of the population. The demand for mental health services will escalate in those countries experiencing psychosocial adjustments.

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A. Status of Mental Health Care

Despite a consistent prevalence of mental illness throughout the world, mental health care continues to occupy an abysmally low ranking in most countries' health priorities. This neglect for the concern of mental health of populations, especially in Third World countries, has arisen primarily from:

1. Limited or no epidemiological data about mental disorders.
2. Emphasis on setting up mental hospitals.
3. Shortage of trained mental health manpower.
4. Public misconceptions and superstitions.
5. Lack of simple models of mental health care.  

Lack of knowledge regarding mental illness is prevalent among Third World decision-makers, populations, and health professionals. Policy makers are unaware of the size of the problem and the benefits of services. The lack of infrastructure to provide care remains unrecognized. Many countries still do not have a clearly formulated national mental health policy, and much care remains the domain of isolated central institutions.

Little progress has been made with regard to formulating or updating mental health legislation. A 1979 WHO study found national mental health laws in Europe to be from ten to forty years old.  

Most countries still prescribe to laws held over from colonial eras. In India, it is still called the Lunacy Act.  

In many developing countries there is one psychiatrist per 100,000 population. In some there is one per million. With only 2% of U.S. medical students choosing psychiatry as their field of specialization in the 80’s, it is not difficult to understand that in the next 10-20 years there is no prospect of meeting the world’s mental health manpower needs.

Finally, stigma --the unfavorable and prejudiced attitude toward the mentally ill and against psychiatry-- still remains the dominant constraint to development and utilization of mental health services. Prevalent among the general public, but shared by medical and other professions, this attitude inhibits those who are ill from seeking care and those who could give care from providing it.

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10 Ibid.

II. THIRD WORLD MENTAL HEALTH CARE THE CONVENTIONAL INSTITUTION MODEL

A. History

While colonial powers transformed the political and economic life of indigenous populations, their influence in other areas was more uneven.\textsuperscript{12} Members of local elites, who mediated colonial rule to the masses, often had access to Western-style education, bureaucratic jobs, and medical assistance. The vast majority of the colonized populations remained peripheral to these advantages.

Health care for the most part remained confined to elite urban populations. Very few clinics or hospitals were found in rural areas, leaving peasants to seek medical assistance from traditional, village-based practitioners. This imbalance has remained for centuries and to this day, has only been remedied in small ways in Third World countries.

Mental health care was no exception to this scenario, and was plagued by practices even worse than in general medicine. The British, Portuguese and Dutch incarcerated disturbed individuals along with common criminals. The conception of a disease-oriented approach to the phenomenon of "madness" had not yet taken hold.

Institutional and custodial care began in the colonies about the same time as in the United States-- early 19th century. In 1829 Penang had a "lunatic asylum" populated by Chinese, Portuguese and Indians.\textsuperscript{13} By the end of the nineteenth century, colonial architects and health administrators had created rambling custodial enclaves-- all remarkably alike-- from Brazil to Southeast Asia.

B. Policy

The overriding policy for dealing with the mentally ill in colonial, and later developing countries was, and sometimes remains, institutionalization. Aimed only at custodial care, not treatment, this method reflected the policy and attitude of governments toward the mentally ill: that they should be locked away to protect the community at large.

Often built in rural zones remote from areas of dense population, mental institutions were generally the end of the road for people referred there. Largely untrained staffs functioned more as jailers than as caretakers or therapists. Ominous images associated with such institutions shaped the perceptions of surrounding populations. Names of towns became associated with "madness."

Such psychiatric facilities, oblivious to the more global, spiritual and humanistic notions of health and illness occurring around them, did not disappear after national independence following World War II. In many locations, antiquated institutions and policies, cut off from Western medical and psychological theory, survive to this day.


\textsuperscript{13} Ibid., p. 3.
In other cultures, development and modernization have begun to transform notions about mental illness and mental health. Leaders have sometimes advocated for mental health priorities, citing mental illness as detrimental to socioeconomic development. Psychiatry, they have argued, is a valuable tool for development, when its techniques can be used to motivate and empower people for productive ends. They now recognize that industrialization, urbanization, and modernization bring with them the stresses and alienation that produce higher psychiatric morbidity to be handled.

C. Conclusions

Custodial care is expensive, necessitating maintenance of huge institutions and staffs. It ties up resources that could otherwise be used for patient treatment. Institutionalization perpetuates chronicity through lack of outpatient care. It can isolate the mentally ill from modern psychiatry and result in multiple readmissions and a "revolving door" trend. Chronic cases are still a considerable burden in some countries. Rehabilitation programs are scarce. But long term confinement is now considered anachronistic and inapplicable to modern medicine and public health.

Many developing countries have one central facility. Centralization precludes treatment for rural or distant populations. It has been documented in Africa that some patients who seek treatment must travel 300 miles to see a psychiatrist for 5-10 minutes.\textsuperscript{14}

Central institutional policies do not encourage development of mental health manpower. Future doctors must rely on foreign institutions for postgraduate work, and these other countries are becoming increasingly restrictive in their admissions policies.

Minor mental disorders are often inappropriately treated by the general health services which lack psychiatric training.

Most countries lack clearly formulated national policies, and psychiatric services are still isolated systems of hospitalization with no supportive community-based services. No infrastructure exists from which to develop effective mental health care. Facilities for special populations, such as mentally ill offenders, the mentally retarded, and drug dependent persons are generally defective. Legislation is out-dated, patient rights ignored, and stigma thrives. In countries where mental health policies have been developed, they are usually not fully explicit and made public.\textsuperscript{15}


III. THE LAW AND MENTAL HEALTH

Issues of law and psychiatry are hotly debated throughout the world. Philosophical differences in this arena are not the primary concern of this report. However, various points of view are documented below to validate the importance of harmony between the two if the needs of the mentally ill are to be adequately and humanely addressed.

The wide gulf between psychiatric thinking and the state of legislation concerning the mentally ill in many countries is one of the major factors responsible for the stigma associated with mental illness and mental hospitals, the delay in securing treatment, unwarranted fear of the mentally ill, and lack of enthusiasm on the part of the community for more active commitment and participation in community-based mental health services.16 As stated by a WHO Expert Committee: "most existing legislation is misdirected in its aim. It is concerned too much with placing checks on the mental patient and his physician and too little with the public's responsibility for providing services for the mentally ill. It does little to foster a positive approach to mental health."17

A. Contemporary Historical Perspectives

Larry Gostin describes the process of mental health legislation reform as a pendulum swinging between two opposing schools of thought legalism and professional discretion, using English law as an example.18 Traditional "legalism", he explains, embodies a set of principles whereby use of compulsory powers in mental health are limited by clear criteria and legal procedures, such as the judicial determination of the need for compulsory admission.19

The English Lunacy Laws of 1890-1930, which became the models for its colonies, contained intricate legal regulation of admission to and conditions in mental hospitals. Described by social historian Kathleen Jones as being "virtually obsolete at the time it was enacted,"20 the Lunacy Law was seen as an obstacle to early and effective treatment of mentally disordered people.

The Mental Health Act of 1959 in Britain was thought of as a negation of and reaction to, legal formalism. Its intent was to make access to treatment and care a matter for professional discretion. Review of medical decision-making was limited to a small minority of cases.

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16 Bahaskaran, K. "Essential Requirements of Mental Health Legislation." In Mental health services in developing countries. WHO offset publication No. 22, 1975, p. 81.


19 Ibid.

The Mental Health (Amendment) Act of 1982 swings again toward legal formalism, and is considered to be the "new legalism". Its provisions are concerned, principally, with furthering the legal safeguards available to patients, though the initial decision regarding admission and treatment remains in the hands of medical professionals.

The tension between "legalism" and "professional discretion" is probably the central cause of controversy at the interface of psychiatry and the law.\(^{21}\) Psychiatry perceives that the legal profession is seeking to substitute its discretion for that of the medical and social work professions. Kathleen Jones suggests that legal intervention can only be remedial, not creative or inspiring. "Legal enactments have been tried repeatedly and contributed little to psychiatric progress."\(^{22}\)

Traditional legalism is founded upon the application of a body of law to individual cases so that relatively consistent and fixed results accrue from reasonably equivalent factual circumstances. However, those who oppose legal intervention argue that a formalistic approach is not suited to a field of human endeavor which is, by nature, individualistic and unpredictable. Also, traditional law is essentially negative and reactive; the law reacts to events and attempts to control them once they have occurred, but it cannot shape or influence them in a positive way.

Gostin explains how the Amendment Act of 1982 reduced but did not eliminate professional discretion. The law requires a behavioral basis, such as aggression or serious irresponsibility, for long-term compulsory admission. There is a "treatability" test requiring that treatment is likely to alleviate or prevent a deterioration in the condition of those mentally impaired. Guardianship encompasses specific and limited powers, but does not address the issue of "incompetency" being transient and varied in the mentally ill. The Act significantly increases opportunities for Tribunal Review, after the decision of European Court of Human Rights in X v. the United Kingdom, in which patients under the 1959 Act were unable to have a binding periodic judicial determination of the justification for their detention. Intricate regulations outline consent and treatment issues. Basically, consent of patients is not required for treatment, except in the specific cases described in the law.

B. WHO Study Findings and Other Trends

Gostin concludes by stating the contemporary legal principle: "legislation should not place extra jurisprudential, social or political burdens on those designated as mentally disordered unless these are justified by substantial and reasonable societal objectives."\(^{23}\)

As far back as 1955, the WHO's Expert Committee on Mental Health had a similar message: "The true functions of legislation affecting the mentally ill...are to enable treatment and care...and to protect the patient and society. Most existing mental health legislation is unsatisfactory...Good mental health legislation should be a help rather than an obstacle to psychiatric care...The greatest single weakness is that purely legal considerations are given too much weight, and medical considerations too little. In many countries, before admission to a


\(^{22}\) Ibid., p. 48.

\(^{23}\) Ibid., p. 61.
mental hospital can be secured numerous legal formalities have to be satisfied. Sometimes the patient must be arrested by the police...an appearance before a judge or magistrate who will certify him as insane...or administrative authorities are empowered to authorize the admission...Few countries make it possible for a mental patient to enter hospital on a truly voluntary basis...Limitations may be placed on the patient’s liberty, terminology which is offensive may be employed, and civil rights may be forfeited." 24

The Expert Committee further found that "too few countries have minimum standards laid down by law, to which the psychiatric services must conform...the law is instead used to relieve administrative authorities of their obligation to provide services." 26

If there were better psychiatric services, the committee contends, there would be less need for laws. "A law authorizing and regulating the compulsory treatment of patients is no substitute for a satisfactory psychiatric service, since it does nothing to reduce the number of such patients. It is important, therefore, that legislation should devote considerable attention to the development of satisfactory psychiatric services." 28 Also regarding compulsory admission: "as long as civil mental hospitals contain patients committed to them by judicial order, so long will they be stigmatized in the public eye." 27

Finally, this Committee had the foresight in 1955 to recognize that new legislation would be needed for the new types of psychiatric services on the horizon, since existing laws were drafted when the mental hospital was the only means of treatment available. They also favored establishment of central and local mental health authorities under the country’s health service, and not attached to judicial or police authorities.

Between 1955 and the next WHO international survey of mental health legislation in 1976-77, enormous changes had taken place in mental health care: medications, changing patterns of care from central mental hospitals to community/outpatient services (U.S.), use of inpatient units in general hospitals and sectorization (Europe). New policies were being pursued: decentralization, integration with primary health care, service delivery by mental health workers.

The far-reaching legal implications of these changes are still only minimally reflected in legislative texts. Existing law and the aims of mental health care have become worlds apart. Of the 43 countries surveyed by WHO, only 18 have introduced major legislative changes since 1950. While the French law of 1838 has aged well, providing for both development of psychiatric services and access to treatment, and permitting adequate advances through new legislation, the countries basing their laws on the British Lunacy Act are dealing with quite a different matter.

The reasons for this legislative inertia are that in many countries legislative programs are overloaded, skilled legal draftsmen are in short supply, and the process of consultation, discussion,

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25 Ibid., p. 6.

28 Ibid., p. 11.

27 Ibid., pp. 13-14.
and redrafting of a new law is extremely time consuming. Also mental health is not a priority in most countries. Sometimes initial enthusiasm cannot be sustained after 2-3 years. In Trinidad and Tobago, where imaginative provisions were put into law, the process took 10 years.\footnote{28} Therefore, 12 countries out of 43 were operating without any specific legislation covering treatment or hospitalization for mental disorders.\footnote{29} Sometimes these "informal" systems are preferable because, lacking laws, questions of admission, discharge, extramural support etc. becomes a joint responsibility of the family and psychiatric team.

But the majority of countries leave things such as involuntary admissions under judicial orders. In fact, this method of hospitalization is the most frequently used throughout the world. It is the only method of hospitalization in the law of Germany.\footnote{30} Most legislation is concerned exclusively with hospitalization procedures and related matters, such as empowerment of police and social workers to apply for admission of patients, protecting their rights and welfare, guardianship, foster home care, and payment for care. Very few countries provide for the organization of services, especially community mental health services. France, Norway (nursing homes and day care centers), Senegal (psychiatric villages, outpatient care, family care), Canada (regional and community services) and the U.S. (community mental health centers) are the exceptions. In many countries the law neither authorizes nor prohibits community-based services.

The WHO survey showed other trends. There was a greater move toward voluntary care, with voluntary admission rates the only quantitative measure available. The highest rates were in developing countries due to the informality of procedures. With involuntary commitment, there is a trend away from judicial approval toward medical certification alone, and some countries are dropping "observational" commitment. At the time of the survey, only the United States law contained provisions for patient rights, but indications were that England, Poland, Scandinavia, India, Pakistan, Egypt and Australia were considering such legislation.

C. Standards for Model Legislation

In their book, Madness in the Streets, Isaac and Armat claim that national mental health legislation in the U.S. since the 60's is responsible for the homeless mentally ill on our streets today. They maintain that deinstitutionalization, the right to treatment, the right to refuse treatment, and other legislated policies have granted mental patients the "freedom to be insane".\footnote{31} They accuse the "mental health bar" and politicians of insisting upon patient liberties over treatment. They call for a "need-for-treatment" standard with legal safeguards, making commitment the preferred method for securing treatment.

This book of course takes an extreme view and invalidates one of the most important innovations in mental health care of this century: release of mental patients from custodial hospitals to be treated in their own communities by people who know them.

\footnote{29}{Ibid.}
Italy, in its Reform Law 180 of 1978, implemented the opposite scheme. It prohibited further admissions to psychiatric hospitals, and required that patients be seen by teams in their communities. Each community was required to develop mental health services for a proscribed target area. For necessary hospitalization, 15 beds in each general hospital were to be utilized.

These regulated policies of deinstitutionalization also required humanizing of the environment in mental health services, abandonment of physical restraints, elimination of ECT, and development of a system of "open doors" according to the principles of the therapeutic community of Maxwell Jones.\textsuperscript{32}

Larry Gostin advocates a contribution of the law to the provision of adequate health and social services. Calling this the "ideology of entitlement," its premise is that access to health and social services should not be based upon charitable or professional discretion, but upon enforceable rights.\textsuperscript{33} The objective of this legal approach is to provide safeguards for the patient in either of two situations. First, the patient who refuses to consent to a treatment should be entitled to protection under the law. This places the psychiatric patient in a similar position to physically ill patients. Second, a treatment should not be administered unless the doctor can demonstrate that it is reasonable efficacious and that it acts without disproportionate risks or adverse effects.

Gostin reiterates that traditionally, mental health legislation has been devoted not to the provision of services, but to the "systematic withdrawal of liberties and civil rights or status which are afforded to other members of society."\textsuperscript{34} In 1987 Gostin proposed five international human rights principles in Kyoto, Japan:

1. The right to humane, dignified and professional treatment.
2. Voluntary admission should be encouraged whenever treatment is necessary.
3. The right to a full and impartial judicial hearing before involuntary loss of liberty.
4. The right to a free and open environment and free communication.
5. The right not to be discriminated against on grounds of mental illness.\textsuperscript{35}

WHO researchers such as Harding and Curran remind us that the law in mental health not only serves to regulate admission and discharge from hospitals and provides access to courts and tribunals to protect rights. The law can specify what services are to be provided for different groups, can reflect a national commitment to mental health policy, and can stimulate new roles


\textsuperscript{34} Ibid., p. 46.

for professional and auxiliary personnel. It can lead to improved standards of care by requiring periodic review of all patients in hospital, can be a tool for public education, and change attitudes toward the mentally ill through public awareness.\textsuperscript{36}

Harding and Curran suggest a basic statutory structure which includes the following elements: Policy, Authority, Budget, Operations, Research and Training, Access to Services, Protection of Individuals, Minimum Standards, Regulation of drugs and other Treatment Methods, and Delegation.\textsuperscript{37}

Bhaskaran formulated an extensive blueprint for satisfactory mental health legislation.\textsuperscript{38} The author agrees that his list of components represent a comprehensive state-of-the-art account of pertinent mental health law. Bhaskaran's recommendations can be found in Appendix II of this document.

Bhaskaran's model calls for modern concepts such as patient rights, treatment with current psychiatric technology, deletion of stigmatizing terminology, provision for community-based services, less cumbersome "formal" admissions to hospitals, "therapeutic community" ideals, and Review Boards.

\textsuperscript{36} Harding and Curran, \textit{Op. Cit.}, p. 112.

\textsuperscript{37} Ibid., p. 112-113.

IV. CARIBBEAN MENTAL HEALTH LEGISLATION

The Caribbean is no exception to the failures in psychiatric care in developing countries. The Caribbean islands, like most New World colonies, developed systems of mental health care patterned after the central institutions and asylums of their European conquerors. Despite efforts to decentralize services in Jamaica and Trinidad/Tobago in recent years, much of the Caribbean remains isolated from modern psychiatric strategies. Mental health laws in these countries reflect the prevailing antiquated systems of care which remain today.

The mental health legislation of the English-speaking Caribbean can generally be characterized by the following:

1. It is chronologically old, some dating back to the 1800s or the 1930s or 40s.
2. It is anachronistic, having no resemblance to modern principles of legal psychiatry.
3. It is based on a service delivery system dominated by a central institution.
4. It concerns itself primarily with the adjudication, not the treatment of mental patients.
5. Its language is archaic and terminology reflects disrespect for those it supposedly protects.
6. It does not concern itself with the rights of patients.
7. It does not make provision for or even mention alternative or community-based modes of service.
8. It is not guaranteed with economic resources.
9. It does not make clear whether it reflects all existing mental health care or services in the country.
10. It presently is not compatible with the principles expressed by the Caracas conference-deinstitutionalization, integration with primary care, local health systems implementation, and community participation.

There are some exceptions to these generalizations, but the prevailing spirit of the laws conforms to these statements.

The following pages describe the key elements of existing mental health legislation in the Caribbean, and evaluate it against standards of legal psychiatry previously mentioned.

A. Antigua and Barbuda

The Female Lunatics Protection Act of June 14, 1923 defines "lunatic" as an "idiot" or "person of unsound mind" and considers "institutions for lunatics" to be asylums, hospitals or

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38 Antigua's laws are described in detail here because they are illustrative of the other islands' legislation. Similarities and differences will be pointed out in the following sections. The substance of the mental health laws, such as adjudication procedures, terminology, hospital administration, licensed houses and patient maintenance, is fundamentally alike among most islands.
licensed houses. The act prohibits employees of these institutions from having or attempting to have carnal knowledge of any female under care or treatment as a lunatic. Such action constitutes a misdemeanor and carries a two year imprisonment if convicted.

The Act obviously contains anachronistic and degrading terminology. Countries who have revised laws have done away with terms such as "lunatic" and "idiot." The Act, however, while it does not exactly guarantee rights, is one of the first to provide protection for patients in some way. It is most likely one of the first to protect institutionalized females from sexual harassment.

The law definitely needs updating to make it harmonious with today’s concepts of such legislation.

The Mental Treatment Act of October 1, 1957 refers to the mentally ill as "insane" or "of unsound mind," but includes the following categories and definitions in this group:

1. any epileptic or other person suffering from disease or derangement of the mind to such an extent as to put him in a condition varying from his normal self...so as to render him dangerous or inconvenient to himself or others.

2. any idiot…a person so defective in mind from birth as to be unable to guard himself against common physical dangers.

3. any imbecile…from birth mental defectiveness not amounting to idiocy yet so pronounced that he is incapable of managing his affairs.

4. any moral defective where there exists vicious or criminal propensities and who requires care, supervision and control for the protection of others.40

Later in the law this terminology is ordered stricken from use, but does not refer to a formal modification.41

The rest of the law mainly provides for the adjudication, but not the care and treatment, of the mentally ill. It describes the procedures followed in most of the islands for the disposition of cases required to be brought to the magistrate, and the 23 forms used. Enquiries as to the state of mind of the person of unsound mind are held in the same way as criminal cases. The magistrate may order detention in an institution for observation for a period not exceeding 14 days, with eight-day extensions up to two months. The magistrate appoints two registered medical practitioners to examine the "suspected" person and certificates attesting to his unsoundness of mind must be signed. In an urgent situation, the magistrate may order the person detained for observation without medical certification. False statements in these proceedings can result in fines of $960 or jail terms of one year.42


41 Ibid., p. 1881.

42 Ibid., p. 1885.
Mental hospitals and licensed houses are the only places granted custody of these persons of unsound mind. The island Administrator may make regulations as to the management of hospitals and patients; admission, absence on parole and discharge of patients; and payments in respect of them. The Medical Super-intendent of the mental hospital may order the discharge or transfer of patients and any medical officer may order the transfer of patients from general to mental hospitals if they are suspected of being of unsound mind. In this case the magistrate must be notified and is given three days to confirm or annul such order.

If patients escape from mental hospitals or licensed homes, staff and/or police are entitled to retake them. Licensees are bound to take proper care of patients until they die or are discharged. If the licensee is desirous of being discharged of the patient, he must notify the magistrate. In this case, or if the patient is mistreated or neglected, the magistrate may remove the patient to a mental hospital or other licensed house.

Criminals/prisoners "of unsound mind" are to be handled like any other such person.

The property of "insane" persons may be confiscated and applied to the expenses of maintenance and support of such people.

The law does not guarantee patient rights, but there are penalties for offenses perpetrated against "insane" persons:

- for striking, ill-treating or wilfully neglecting a patient: a fine of $96 or six months imprisonment.

- for permitting the escape of a patient: a misdemeanor, fine of $100 or five years imprisonment.

- for obstructing visits of the Board of Visitors (inspectors) or medical officers: $50 or three months imprisonment.

Mental patients may be transferred to other colonies in the Caribbean, but not to any country outside the British Commonwealth.

Voluntary patients may be received in mental hospitals without being adjudicated, and may leave the institution after giving 72 hours notice. If these patients become incapable of expressing themselves as to continuing treatment, they are to be discharged after 28 days. At that point they are dealt with by the above legal procedures or offered temporary treatment.

A Visiting Committee of three members, at least one of which must be a doctor, advises the Medical Superintendent on general administration of the mental hospital.

Antigua’s laws, as do most of the islands’, use antiquated terminology and anachronistic practices placing them far from contemporary psychiatric care. Stigmatizing terms like "lunacy" and "unsound mind" are used even after revisions.

Antigua’s laws revolve around adjudication of the mental patient, not his care and treatment. Court-ordered requirements for admission to and discharge from mental hospitals are no longer considered current psychiatric thinking and practice, except in the case of those already
in the criminal justice system or in questions of guardianship. Legislation which is treatment-oriented, which puts decision-making in the hands of medical practitioners, which eliminates legal delays and focuses on patient needs is the order of the day.

Antigua’s legislation reinforces the pivotal role of the central institution as the custodian of the mentally ill. Aside from licensed houses, which also offer only custodial care, no mention is made of alternative services. Community-based care, use of beds in general hospitals for psychiatric patients, and integration with primary health care are not goals of the system described in Antigua’s laws. Nor is hope of converting its custodial-type hospital into a well-staffed, well-equipped, dynamic therapeutic community. If in fact such transformations have begun, it is not reported in the literature.

Antigua’s laws do guarantee some rights for individuals. Limitations on periods of involuntary confinement for observation and penalties for those who mistreat patients are attempts to make the law more humane and respectful of the dignity of the individual. Even voluntary patients are permitted to leave the hospital within 72 hours or, if unable to express their wishes, at least are discharged within 28 days. Appointment of a Board of Visitors to inspect hospitals and houses encourages checks and balances on their operations. The right to treatment, or to refuse treatment, and other contemporary liberties are not contained in these documents.

B. Bahamas

The Bahamas’ Revised Laws of 1987 include a Mental Health Act and Mental Health Regulations. These are revisions of the original Act of 1969 for the "care and treatment of mentally disordered persons" and repeals the Lunacy Act of 1938.

Terminology here is much more updated than Antigua. Patients are referred to as "mentally disordered" or "psychopathically disordered," which are defined as "mental illness, arrested or incomplete development of the mind, psychopathic disorder, and any other disorder or disability of mind." Promiscuity and other immoral conduct are no longer construed as symptoms of mental disorder.

The Act provides for voluntary or informal admission of patients for treatment in a hospital without application or order. With compulsory admission for observation, patients may be detained for 28 days on recommendation of two medical practitioners. Applications for this may be made by relatives, in which case patients may be held for only 72 hours. Guardianship cases are handled similarly.

A Mental Health Review Tribunal is created for purposes of authorizing private physician visits in hospitals, participating in guardianship hearings, and recommending discharge.

Mail may be withheld from patients if, in the opinion of the medical officer, receipt of it would interfere with treatment or cause unnecessary distress. If special treatment for patients is required, they may be transferred. Patients may be discharged by the medical officer upon reporting to the Minister. People involved in criminal proceedings may be detained in a mental hospital for fourteen days, with extensions up to forty-two days, after examination by a psychiatrist.
Judges may deem persons with mental disorders incapable of handling their property and affairs, and may order their maintenance or that of their families to be provided for by others. Property may be sold to pay expenses, businesses can be taken over by others, etc.

Penalties for ill-treatment of patients or unlawful detention of patients are $600 or two years imprisonment or both. There is a clause forbidding "unlawful sexual intercourse with any female mentally disordered person under care or treatment in a hospital or on leave of absence therefrom, or subject to his guardianship." 43

The more recent legislation of the Bahamas has modernized the language of mental health affairs, but its substance remains similar to that of the other islands. The central institution and procedures for admission to it and discharge from it dominate the law. Provisions for guardianship and administration of the patients’ property are also significant elements of the law.

Patients are protected by time limits on involuntary commitment (in this case only 28 days), penalties for ill-treatment by staff, and the activities of the Mental Health Review Tribunal. But again, these "rights" are only geared to persons already detained in a mental hospital. There are no provisions for outpatient rights or care, community-based services, deinstitutionalization, health promotion or prevention or data collection. There is no mention of economic resources to back the law.

C. Barbados

The Mental Health Act of 1980, which comes under the Revised Laws 1971 Edition, provides for the care and treatment of persons of "unsound mind". Sections cover adjudication, admissions to the mental hospital, hospital administration, management of patients’ property, and offenses for mistreatment of patients, as in the other islands’ laws. It sets up a Mental Health Review Board and, in this case, stipulates that the Minister of Health has responsibility for carrying out the objectives of the Act.

The Mental Health Regulations and Mental Health Rules of 1989, covered under Barbados’ Annual Laws 1989 define “seclusion” and require that patients be examined “as soon as possible" after admission to a mental hospital. They require that physical examinations be given every six months and that consent be obtained from patients’ relatives or guardians for certain modes of treatment. The Hospital Director in consultation with the Senior Consultant Psychiatrist shall appoint a committee known as the "Clinical Management Committee" to establish procedures for day to day operations. The regulations allow for patient mail to be opened and withheld. The rules deal largely with legal matters relating to patients, and not with their health.

Barbados has apparently modernized the language of its laws, but it is still concerned mostly with adjudication, admissions, and hospital operations. It is the first Caribbean country, however, to mention speedy examination of patients and provide for relative/guardian consent for treatment. It seems also that Barbados has decentralized some of its services and has treatment

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modalities such as occupational therapy and modern medications. But this is not expressed by the mental health laws. The laws therefore do not reflect actual practices in the country.

D. Belize

In its Revised Laws 1980 Edition, Belize provided for mental health care in its Medical Service and Institutions Act. The act sets up the Government Medical Service, with the Chief Medical Officer under the direction of the Minister of Health. It grants the Chief Medical Officer control of all institutions, including mental hospitals. The Act specifically provides for certification of "persons of unsound mind" and admission for observation.

It appears, from the information available, that mental health legislation in Belize is similar to that of the Caribbean islands, excepting that there is not a separate law for psychiatric concerns, and that they are included in the country’s health law. It appears from the law that the central institutional model is still the operant mode of treatment.

E. Dominica

The Mental Health Act of 1987 and the Regulations of 1988 are among the most modern of the Caribbean, as evidenced by their use of language such as "psychiatric hospital", "mental health regulations", "mental health officer", and "mental disorder", meaning mental illness.

In Dominica, voluntary patients may be admitted to a psychiatric hospital with their written application or that of a parent or guardian and one medical recommendation. Mental health officers and police are authorized to take a mentally ill person into custody, but must bring him to a psychiatric hospital within 24 hours, inform relatives, and make arrangements for them to see him. These patients may be held for only 72 hours, unless found to be in need of further treatment, in which case the psychiatrist may change his status to that of a medically recommended patient. Provisions are made for the administration of patients’ property if they are unable to do so due to the illness. Authority for the care, treatment, maintenance, custody, transfer, discharge, etc. of patients is vested in the Minister of Health.

Dominica’s Mental Health Regulations mention items not found in those of the other countries. "Every patient on admission if he is competent, is to be told of his rights under the Act and the nature of his detention." Patient valuables are safeguarded by the Administrator. No other country mentioned searching patients for possession of narcotics or weapons. Patients must be examined by medical officers within 24 hours of admission. And voluntary patients have the right to refuse any kind of treatment. Consent for electro-convulsive therapy must be given by the patient or his guardian.

It is clear that Dominica’s laws represent a considerable effort in keeping with present day psychiatric care. They deal with patient rights, consent, being examined quickly, and short-term

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44 Beryl Walker-Whitson, Secretary, Caribbean Federation for Mental Health, a chapter of the World Federation for Mental Health, Alexandria, VA.

detention. The language used is not derogatory and conforms with WHO standards for appropriate terminology.

The legislation of Dominica, however, still focuses on the Psychiatric Hospital as the form of treatment. It would be interesting to find out if the country has in fact decentralized its service delivery as it modernized its laws.

F. Grenada

Grenada’s laws of 1958 contain the Mental Hospitals Ordinance and the Mental Hospital Regulations. Both documents contain some of the most antiquated language and practices in the Caribbean. The regulations, for example, cover the accommodation of various classes of patient under the headings "Pauper Lunatic" and "Transferred Lunatic". They describe details of the diet offered to hospital patients, which is primarily milk, cocoa, sugar, bread, and hot water, with some beef. 46

The Act, like other island legislation, concerns itself with inquiries into the state of mind of the mentally ill by a magistrate, adjudication and confinement in a mental hospital.

Grenada’s mental health legislation seems highly antiquated. Its subject matter and language require thorough revision to make it comparable with more modern concepts.

G. Guyana

In Guyana’s Revised Laws, 1953 edition, are the Mental Hospital Act of March 8, 1930 and the Mental Hospital Rules 1933. No recent legislation has been enacted in Guyana.

The legislation primarily makes provisions for administration and management of the country’s mental hospital, Berbice. Persons of "unsound mind" shall receive care there after the usual judicial inquiry by a magistrate and two medical certificates. Admission of voluntary patients is provided for in the Act, provided they commit to a minimum stay of one month. Patients must pay for their maintenance and are liable for support of their families while hospitalized. The Medical Superintendent is in charge, supplemented by a Board of Official Visitors.

Section 10, part 3 contains a clause common to many of the Caribbean islands’ laws: "Every constable, poor law commissioner, district commissioner, or Guardian of the Poor who has knowledge that any person, whether a pauper or not and whether wandering at large or not, is alleged to be of unsound mind, and is not under proper care and control or is cruelly treated or neglected by any relative or other person having the care or charge of him shall within seven days after obtaining such knowledge give information thereof upon oath in Form No. 1 in the schedule to the magistrate of the judicial district in which such person is or is residing." 47

The laws of Guyana pertain only to the central mental hospital model. They have repeated their former Act, the Lunatic Asylum Ordinance, and updated some language. No measures have apparently been taken to update the law comprehensively, relate it to present services, provide


for community-based treatment, and guarantee patient rights. Although attendants are directed to assure that no harm comes to patients during visits, there is no indication of protection of rights. Furthermore, antiquated concepts do remain, as in the definition of persons of unsound mind as "idiots or suffering from mental derangement."

H. Jamaica

Jamaica's Mental Hospital Act of August 13, 1873 has been amended several times, the last being in 1985. The Act gives the Minister of Health jurisdiction over Bellevue Hospital, the country's mental hospital, and rules and regulations pertaining thereto. It allows for a Board of Visitors to inspect the wards and investigate complaints. The Governor-General appoints a Senior Medical Officer who is responsible to the Minister.

The law ironically refers to the Medical Officer as someone "trained and accustomed to the modern treatment of the insane." 48

Jamaica's legislation provides for Mental Health Officers (any public officer so designated) to monitor the mentally ill in the community. These Officers may have such persons taken into custody by a constable and delivered to the nearest government clinic or hospital for any attention which may be necessary. A Justice may examine the "alleged lunatic" and upon certification by a medical practitioner, direct him to Bellevue Hospital. If friends or relatives swear to care for the "lunatic", this can be arranged.

The document makes provision for "private patients" to be admitted. Upon application, Resident Magistrates only may detain these patients, and the patients has the right to be taken before the magistrate who made the reception order.

Voluntary patients, or "boarders" may be admitted to Bellevue, but on 24-hour notice must be allowed to leave. If he is not permitted to do so, he shall be entitled to recover from the Senior Medical Officer twenty dollars as liquidated damages for each day or part of a day during which he is detained.49

The Senior Medical Officer has the power to send any prospective patient to the Public Hospital, if sick, to the Hansen Home if a leper, and to an alms-house if destitute. Patients must pay for their care and maintenance. Discharged destitute patients may be provided with the means to support themselves until they can return to their homes or friends, at a rate of ten cents per diem or eighty cents in the whole.

Jamaica's law is a mixture of old and new, making it a strange combination for today. Apparently, representatives of the mental health community have been meeting recently to consider revision of the laws. Lack of human resources has been the primary reason for not modernizing laws or otherwise granting patient rights.50

48 Mental Hospital Act of Jamaica, revised 1985, Section 7, p.7.
49 Ibid., Section 27, p. 18.
50 Beryl Walker-Whitson, Secretary, Caribbean Federation for Mental Health.
Jamaica began to decentralize its mental health services in the 70’s, but this is not reflected in the law, except for mention of Mental Health Officers and government clinics, besides Bellevue Hospital. There are clinics in general hospitals for mental patients and other therapeutic services in the parishes.\textsuperscript{51} The University of the West Indies in Kingston has 21 beds and another ward in Montego Bay has 25.\textsuperscript{52}

It would be advisable to review the mental health laws in Jamaica to update language, harmonize the law with existing services and provide for rights, promotion, prevention and other contemporary factors.

I. Saint Kitts and Nevis

St. Kitts and Nevis have, the old style law where traditional functions are addressed: adjudication of persons of unsound mind; medical certification; enquiries as to lunacy; admission of accused persons for observation; licensed homes; maintenance of insane, offenses in regard to those hospitalized, and voluntary patients. The language of this \textit{Lunacy and Mental Treatment Act} of July 1, 1956 is in keeping with its content: the words lunacy, idiot, pauper patient, criminal lunatic are used throughout.

The spirit of the law, equating the mentally ill with criminals, reflects the attitude of most previous lawmakers in the Caribbean: "For the purposes of such enquiry the Magistrate shall have the same powers as if the person alleged to be of unsound mind were a person against whom a complaint for an offence punishable on summary conviction had been laid."\textsuperscript{53}

In these islands, persons may only be detained for observation for fourteen days, with eight day extensions up to two months. Provisions are made for admission to or discharge from licensed homes, and offenses for mistreatment of insane persons are listed, the most common being $100 or six months imprisonment or both.

Suddenly, in Section 40.1 of this Act, the language and intent shift: "A person who is suffering from mental illness and is likely to benefit by temporary treatment...may, on application...without being adjudicated,...be received as a temporary patient in a mental hospital for the purpose of treatment therein."\textsuperscript{54}

This country’s law is comparable with Antigua’s and the others which have little relationship to present day psychiatry. It is possible to say that the language is degrading, the functions from another era, and the intent completely misplaced in today’s world. Mental health legislation should be updated with a new concept, whether or not they have incorporated new services into their mental health system.

\textsuperscript{51} Ibid.

\textsuperscript{52} Ibid.


\textsuperscript{54} Ibid., Section 40.1, p. 1740.
J. **Saint Lucia**

Saint Lucia's *Mental Health Act of August 16, 1895* is contained in its Revised Laws 1957 Edition, along with the *Mental Hospital Regulations of May 27, 1911*.

The regulations describe administrative procedures for the mental hospital situated at La Toc, which was appointed to be a colonial mental hospital and mental hospital for prisoners in the 1800s. They narrate the duties of the Superintendent, Steward (who lives on the premises), and even the subordinate staff. They direct the staff to "suggest occupations and amusements to the patients but take no personal part in any without permission of the Steward" and to "show all possible kindness to the patients." 66

The language of the Act contains reference to definitions of epileptics, idiots, imbeciles, and feeble-minded. "Moral defectives" are those who are found "wandering at large, are not under proper care or control, and are likely to commit a crime." The procedures are the same as in the other islands regarding magistrate powers, enquiries, retaking of escaped patients, confinement for observation, temporary treatment, etc. A Visiting Committee offers some protection for patient grievances.

St. Lucia has gone part way in modernizing its mental health legislation. Originally developed during the colonial period, the laws maintain much of the original language and intent. But in the 50s, for example, the country struck the expressions "lunatic" and "lunatic patient" from the law. It also did away with "criminal lunatic" and "criminal lunatic asylums". At the time it could go no further than to change these to "persons of unsound mind". Now it must go a step further and adopt modern terminology.

In other respects, the law resembles that of other islands and makes no mention of patient rights, community services, or any other contemporary topics.

K. **Saint Vincent and the Grenadines**

St. Vincent has several pieces of legislation. The earliest on file was the *Lunatics Ordinance of 1934*, which basically outlined the staff duties for the St. Vincent Mental Home (referred to as the Colonial Lunatic Asylum). In 1960 *Mental Hospital (Fees) Regulations*, referring to the mental hospital at Villa in the Parish of St. George, provided for fees for patients in private wards. ($3 per day).

*The Mental Health Ordinance, 1959*, providing for the custody and treatment of persons of unsound mind, has terminology resembling St. Lucia’s, but repeals the use of "lunatic" and "asylum". The procedures for adjudication, admission, voluntary and temporary patients, criminals, maintenance, etc. are similar to other islands’. In 1968, *Ordinance No. 35* changed the name of the island’s psychiatric hospital to St. Vincent Mental Health Center.

*The Mental Health Act of 1989* went further to modernize St. Vincent’s treatment of the mentally ill. It changes terminology to "mental illness" and "mental health" and provides for the

56 St. Lucia. *Regulations for the Toc Mental Hospital, Schedule A.*, p. 862, Revised Laws of 1957.
protection of patients’ property. Mental Health Officers, as in Jamaica, are created, as well as a Mental Health Review Board. This gazetted law was not available for review.

St. Vincent has taken steps to redesign its mental health practices and laws over the past decades. It is moving in the direction of Dr. Bhaskaran’s requirements for effective legislation. But changing terminology and creating Review Boards is not enough. Efforts to decentralize services, insure patient rights and guarantee that modern treatment methods be available must be included.

L. Trinidad and Tobago

Last, but not least of the islands, Trinidad and Tobago framed a Mental Health Act in 1975. This legislation contains similar categories as the other islands (detention, admission, etc.), but clearly breaks with tradition in its use of terminology, its review functions, and its less complex procedures.

This is a "mental health" act, not a mental hospitals act. Its purpose is therefore more comprehensive. It refers to patients as "mentally ill" and having "mental disorders". It defines "mentally ill" as "a person who is suffering from such a disorder of mind that he requires care, supervision, treatment and control, or any of them, for his own protection or for the protection or welfare of others. Superintendents have become Psychiatric Hospital Directors. It mentions that the Minister may designate any part of a general hospital to be a psychiatric ward.

Patients may be of the following categories: urgent, voluntary, medically recommended, ordered by the Court, ordered by the Minister, on application of a Mental Health Officer. Any person may make an application for admission on behalf of a mentally ill person. Such person must be admitted within three days, and must be examined within 24 hours.

If a person refuses to be admitted, the law permits a police officer or others designated by the Director to apprehend him. There is therefore no right to refuse treatment.

Both a Psychiatric Hospital Tribunal and a Mental Health Review Tribunal are established to review the cases of medically recommended patients and hear discharge requests. A member of the Review Tribunal is appointed by the President on advice of the Trinidad and Tobago Association for Mental Health. Patients may attend hearings. If deemed not in need of further care and treatment in a hospital, the Tribunal may order the patient discharged.

Mental health officers may be appointed amongst psychiatric social workers, district health visitors with six months experience in social work and psychiatric nursing, and other nurses.

Stiff penalties are assessed for offenses against patients: $10,000 and two years imprisonment for sexual intercourse with a mentally disordered patient who is in someone’s custody, $1,000 and three months for allowing patients to escape or for negligence.

Trinidad and Tobago have what appears to be the most progressive law in the English-speaking Caribbean. Its language is contemporary and conforms to international standards. It defines types of patients and the illnesses in kinder and gentler terms. It specifically mentions allocating part of a general hospital for psychiatric use. The Tribunals are given broad powers and
members partly come from the community. Hearings are open to patients. It sounds like their intention is to make much use of Mental Health Officers who come from social work and nursing backgrounds.

As progressive as these laws are, for the region, they still do not contain the elements found in more developed countries. While Trinidad and Tobago do operate community mental health facilities, they have not legislated this. Health promotion, prevention, training of mental health manpower and other aspects of current practices are not considered in the law.
V. CONCLUSIONS

Mental health legislation in the Caribbean is generally antiquated and often bears no resemblance to modern standards as outlined in Section IV., "The Law and Mental Health". The analysis of such legislation revealed a pattern closely related to England's Lunacy Laws, which dealt primarily with adjudication of patients involuntarily admitted to mental hospitals.

In general, the laws of the Caribbean make no allusion to psychiatric service delivery, community-based services, national mental health policy, standards of care and treatment, designation of authority for mental health care, and provision of patient rights. They simply provide the rules for their original colonial system of treatment: the central hospital.

But, as evidenced by the reforms of Trinidad and Tobago, Dominica and Jamaica, vast potential for legislative modernization exists in the islands. By borrowing ideas from these progressive countries, and those of their Latin American neighbors put forth in Caracas, the islands can move toward redesigning their mental health laws and systems of care.

Hopefully, this document will lend support to that process.
APPENDIX I

BHASKARAN'S MODEL FOR ESSENTIAL REQUIREMENTS OF MENTAL HEALTH LEGISLATION

1. It must be humane and respect the dignity of the individual.

2. It must reflect currently accepted principles in psychiatric thinking and practice.

3. It must insure that the mentally ill are not neglected, ill-treated, sexually abused, and unnecessarily deprived of their liberty, rights, and privileges.

4. It must provide for management of the affairs and property of the "incompetent" mentally ill.

5. It must insure that the mentally ill person is not denied the benefit of psychiatric treatment just because his guardian is unwilling or disinterested or incapable of arranging for treatment.

6. It must insure that the mentally ill person does not do harm to himself and/or others.

7. The use of stigmatizing terms like "lunacy", "insanity", idiocy" "asylum", etc. should be totally avoided. For purposes of legislation the term "mental illness" should be used in a comprehensive sense and should include "mental subnormality" (retardation) and "sociopathic personality disturbance".

8. It must insure that an essentially healthy person is not forced to subject himself to psychiatric treatment by unscrupulous others.

9. It must make provision for treatment of the mentally ill, through a wide range of service facilities such as mental hospitals, private nursing homes, outpatient services, psychiatric departments in general hospitals, day hospitals, home-care programs.

10. It must help in making psychiatric treatment readily acceptable to the public by:
   - avoiding stigmatizing and degrading legal requirements for admission and discharge from hospitals;
   - insuring that mental hospitals are operated by qualified psychiatrists, satisfy the minimally required criteria in terms of accommodation, living conditions, equipment, staff, and are run along the lines of a "therapeutic community";
   - providing for care and treatment of the mentally ill with dangerous, violent or criminal propensities under conditions of special security in institutions separate from ordinary mental hospitals or in separate wings of jails.

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11. Admission to a mental hospital or other psychiatric facility for treatment of mental illness on a voluntary or informal basis, should in no way be different from admission to a general hospital for treatment of physical illness. This applies just as well to discharge.

12. Legislation must provide for admission and treatment of the mentally ill who are unwilling to undergo treatment on a voluntary basis, and whose treatment is considered necessary in the interests of their health and/or who are likely to harm themselves and/or others. Procedures for these "formal" admissions must be less cumbersome and unstigmatizing. It should be possible to admit such patients on the basis of:

   ▶ an application by the nearest relative or friend to the superintendent of a mental hospital, supported by

   ▶ two independent medical certificates by psychiatrists or medical practitioners certifying that the person is suffering from mental illness and should be admitted in the interest of his health or because he is likely to do harm to himself or others.

On the basis of this application, the superintendent shall have powers to detain the patient for not more than one month. A certificate of renewal, after personal examination of the patient, may extend detention as follows:

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<th>Certificate</th>
<th>Detention Period</th>
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<tbody>
<tr>
<td>first certificate</td>
<td>not more than 2 additional months</td>
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<tr>
<td>second</td>
<td>not more than 3 additional months</td>
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<tr>
<td>third</td>
<td>not more than 4 additional months</td>
</tr>
<tr>
<td>each subsequent</td>
<td>not more than 6 additional months</td>
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</table>

An involuntary patient may be transferred to voluntary status if the superintendent feels his mental state warrants it.

13. The legislation must provide for easy admission of an involuntary patient to a mental hospital on grounds of emergency via a single medical certificate testifying that emergency involuntary admission is indicated. This emergency admission will be legally valid only for 4 days from the date of admission, at which time the patient must be transferred to the voluntary or involuntary category or discharged.

14. The medical superintendent should have powers to discharge a person with medical advice for further treatment and rehabilitation when detention is no longer necessary.

15. Legislation must provide for a Mental Health Review Board, comprising a magistrate, psychiatrist, a lawyer and informed layman for purposes of hearing appeals from involuntary patients or their guardians regarding forced admission to a mental hospital or their prolonged detention. Provision must also be made for appeal to a high court judge against the decision of the Review Board. Every involuntary patient and his guardian must be informed of this right of appeal, at the time of admission, in non-technical language.
The Review Board may also be entrusted with the task of reviewing the cases of mentally ill criminal patients at periodic intervals, to ensure that they are not condemned to stay in mental hospitals longer than necessary.

16. While, in most cases, courts of law need not enter into the picture with regard to admission and discharge of mental patients, there are certain instances where the court’s intervention is unavoidable, as for example in arranging for:

a. psychiatric examination of persons charged with penal offenses which are the consequences of mental illness or where the person is unable to stand trial on grounds of mental illness.

b. admission and treatment of criminal mental patients and prisoners who develop mental illness while serving a sentence.

c. admission and psychiatric treatment of those who are too dangerous to be at large and for whose safe custody and psychiatric treatment no relative or friend is forthcoming.

d. psychiatric examination of persons whose mental competence to manage their own affairs is under question

e. transfer of guardianship.

17. Provision must be made for psychiatric testimony when a mentally ill person is involved in criminal or civil litigation. **Attempted suicide should not be considered a punishable offence** but an indication of a crisis situation, the person needing emotional support and psychiatric treatment.

18. Legislation must specify the authority to be charged with the responsibility for psychiatric services and inspection of facilities. Authority for treatment must limited to licensed persons and facilities.

19. Provision must be made for custody and care of involuntary patients while they await admission in a mental hospital. This is especially important in developing countries where facilities are grossly inadequate in relation to communities’ needs.

20. Provision must be made for the charges of patient maintenance from the guardian, the patient or alternate sources.

If progressive and humane legislation with regard to the mentally ill and their care is to really achieve its purpose, efforts must be directed at the same time to:

a. converting custodial-type mental hospitals into well-staffed, well equipped, dynamic therapeutic communities;

b. establishing community-based therapeutic facilities for the treatment and rehabilitation of the mentally ill;

c. training adequate numbers of professional personnel in the field of mental health.
d. mobilizing the active participation of general practitioners and other professions in the community mental health service.

e. educating the community in matters of mental illness and mental health.

The above tasks will be made easier if the body charged with responsibility for framing mental health legislation is the same as the one organizing mental health services in the country. A commissioner for mental health at the national level, working with representatives from social welfare, law, education, and justice could plan for orientation courses in psychiatry, with particular reference to laws, for medical practitioners and law enforcement.
APPENDIX II

ICD-9- CM CLASSIFICATION OF MENTAL DISORDERS\(^{57}\)
(without inclusion and exclusion terms)


Italics indicate specific ICD-9-CM codes and their categories not included in DSM-III-R. The lozenges symbol ( ) printed in the left margin preceding the disease code denotes a four-digit rubric unique to ICD-9-CM. The content of these rubrics in ICD-9-CM are not the same as those in ICD-9.

MENTAL DISORDERS (290-319)

PSYCHOSES (290-299)

ORGANIC PYCHOTIC CONDITIONS (290-294)

290 Senile and presenile organic psychotic conditions

290.0 Senile dementia, uncomplicated
290.1 Presenile dementia

290.10 Presenile dementia, uncomplicated
290.11 Presenile dementia with delirium
290.12 Presenile dementia with delusional features
290.13 Presenile dementia with depressive features

290.2 Senile dementia with delusional or depressive features

290.20 Senile dementia with delusional features
290.21 Senile dementia with depressive features

290.3 Senile dementia with delirium
290.4 Arteriosclerotic dementia

290.40 Arteriosclerotic dementia, uncomplicated
290.41 Arteriosclerotic dementia with delirium
290.42 Arteriosclerotic dementia with delusional features
290.43 Arteriosclerotic dementia with depressive features

290.8 Other specified senile psychotic conditions
290.9 Unspecified senile psychotic condition

291 Alcohol psychoses

291.0 Alcohol withdrawal delirium
291.1 Alcohol Amnestic Syndrome
291.2 Other alcoholic dementia
291.3 Alcohol withdrawal hallucinosis
291.4 Idiosyncratic alcohol intoxication
291.5 Alcoholic jealousy
291.8 Other specified alcoholic psychosis
291.9 Unspecified alcoholic psychosis

292 Drug psychoses

292.0 Drug withdrawal syndrome
292.1 Paranoid and/or hallucinatory states induced by drugs

292.11 Drug-induced organic delusional syndrome
292.12 Drug-induced hallucinosis

292.2 Pathological drug intoxication
292.8 Other specified drug-induced mental disorders

292.81 Drug-induced delirium
292.82 Drug-induced dementia
292.83 Drug-induced amnestic syndrome
292.84 Drug-induced organic affective syndrome
292.89 Other

292.9 Unspecified drug-induced mental disorder

293 Transient organic psychotic conditions

293.0 Acute delirium
293.1 Subacute delirium
293.8 Other specified transient organic mental disorders

293.81 Organic delusional syndrome
293.82 Organic hallucinosis syndrome
293.82 Organic affective syndrome
293.89 Other

293.9 Unspecified transient organic mental disorder

294 Other organic psychotic conditions (chronic)

294.0 Amnestic Syndrome
294.1 Dementia in conditions classified elsewhere
294.8 Other specified organic brain syndromes (chronic)
294.9 Unspecified organic brain syndrome (chronic)
OTHER PSYCHOSES (295-299)

295 Schizophrenic disorders

295.0 Simple type
295.1 Disorganized type
295.2 Catatonic type
295.3 Paranoid type
295.4 Acute schizophrenic episode
295.5 Latent schizophrenia
295.6 Residual schizophrenia
295.7 Schizo-affective type
295.8 Other specified types of schizophrenia
295.9 Unspecified schizophrenia

296 Affective psychoses

296.0 Manic disorder, single episode
296.1 Manic disorder, recurrent episode
296.2 Major depressive disorder, single episode
296.3 Major depressive disorder, recurrent episode
296.4 Bipolar affective disorder, manic
296.5 Bipolar affective disorder, depressed
296.6 Bipolar affective disorder, mixed
296.7 Bipolar affective disorder, unspecified
296.8 Manic-depressive psychosis, other and unspecified

296.80 Manic-depressive psychosis, unspecified
296.81 Atypical manic disorder
296.82 Atypical depressive disorder
296.89 Other

296.9 Other and unspecified affective psychoses

296.90 Unspecified affective psychosis
296.99 Other specified affective psychoses

297 Paranoid states

297.0 Paranoid state, simple
297.1 Paranoia
297.2 Paraphrenia
297.3 Shared paranoid disorder
297.8 Other specified paranoid states
297.9 Unspecified paranoid states
298 Other nonorganic psychoses

298.0 Depressive type psychosis
298.1 Excitative type psychosis
298.2 Reactive confusion
298.3 Acute paranoid reaction
298.4 Psychogenic paranoid psychosis
298.8 Other and unspecified reactive psychosis
298.9 Unspecified psychosis

299 Psychoses with origin specific to childhood

299.0 Infantile autism
299.1 Disintegrative psychosis
299.8 Other specified early childhood psychoses
299.9 Unspecified

NEUROTIC DISORDERS, PERSONALITY DISORDERS, AND OTHER NONPSYCHOTIC MENTAL DISORDERS (300-316)

300 Neurotic disorders

300.0 Anxiety states

300.00 Anxiety state, unspecified
300.01 Panic disorder
300.02 Generalized anxiety disorder
300.09 Other

300.1 Hysteria

300.10 Hysteria, unspecified
300.11 Conversion disorder
300.12 Psychogenic amnesia
300.13 psychogenic fugue
300.14 Multiple personality
300.15 Dissociative disorder or reaction, unspecified
300.16 Factitious illness with psychological symptoms
300.19 Other and unspecified factitious illness

300.2 Phobic disorders

300.20 Phobia, unspecified
300.21 agoraphobia with panic attacks
300.22 Agoraphobia without mention of panic attacks
300.23 Social phobia
300.3 Obsessive-compulsive disorders
300.4 Neurotic depression
300.5 Neurasthenia
300.6 Depersonalization syndrome
300.7 Hypochondriasis
300.8 Other neurotic disorders

   300.81 Somatization disorder
   300.89 Other

300.9 Unspecified neurotic disorder

301 Personality disorders

301.0 Paranoid personality disorder
301.1 Affective personality disorder

   301.10 Affective personality disorder, unspecified
   301.11 Chronic hypomanic personality disorder
   301.12 Chronic depressive personality disorder
   301.13 Cyclothymic disorder

301.2 Schizoid personality disorder

   301.20 Schizoid personality disorder, unspecified
   301.21 Introverted personality
   301.22 Schizotypal personality

301.3 Explosive personality disorder
301.4 Compulsive personality disorder
301.5 Histrionic personality disorder

   301.50 Histrionic personality disorder, unspecified
   301.51 Chronic factitious illness with physical symptoms
   301.59 Other histrionic personality disorder

301.6 Dependent personality disorder
301.7 Antisocial personality disorder
301.8 Other personality disorder

   301.81 Narcissistic personality
   301.82 Avoidant personality
   301.83 Borderline personality
   301.84 Passive-aggressive personality
   301.89 Other

301.9 Unspecified personality disorder
302 Sexual deviations and disorders

302.0 Homosexuality
302.1 Zoophilia
302.2 Pedophilia
302.3 Transvestism
302.4 Exhibitionism
302.5 Trans-sexualism
302.6 Disorders of psychosexual identity

302.70 Psychosexual dysfunction, unspecified
302.71 With inhibited sexual desire
302.72 With inhibited sexual excitement
302.73 With inhibited male orgasm
302.74 With inhibited female orgasm
302.75 With premature ejaculation
302.76 With functional dyspareunia
302.79 With other specified psychosexual dysfunctions

302.8 Other specified psychosexual disorders

302.81 Fetishism
302.82 Voyeurism
302.83 Sexual masochism
302.84 Sexual sadism
302.85 Gender identity disorder of adolescent or adult life
302.89 Other

302.9 Unspecified psychosexual disorder

303 Alcohol dependence syndrome

303.3 Acute alcoholic intoxication
303.9 Other and unspecified alcohol dependence

304 Drug dependence

304.0 Opioid type dependence
304.1 Barbiturate and similarly acting sedative or hypnotic dependence
304.2 Cocaine dependence
304.3 Cannabis dependence
304.4 Amphetamine and other psychostimulant dependence
304.5 Hallucinogen dependence
304.6 Other specified drug dependence
304.7 Combinations of opioid type drug with any other
304.8 Combinations of drug dependence excluding opioid type drug
304.9 Unspecified drug dependence
305 Nondependence abuse of drugs

305.0 Alcohol abuse
305.1 Tobacco use disorder
305.2 Cannabis abuse
305.3 Hallucinogen abuse
305.4 Barbiturate and similarly acting sedative or hypnotic abuse
305.5 Opioid abuse
305.6 Cocaine abuse
305.7 Amphetamine or related acting sympathomimetic abuse
305.8 Antidepressant type abuse
305.9 Other, mixed, or unspecified drug abuse

306 Physiological malfunction arising from mental factors

306.0 Musculoskeletal
306.1 Respiratory
306.2 Cardiovascular
306.3 Skin
306.4 Gastrointestinal
306.5 Genitourinary

306.50 Psychogenic genitourinary malfunction, unspecified
306.51 Psychogenic vaginismus
306.52 Psychogenic dysmenorrhea
306.53 Psychogenic dysuria
306.59 Other

306.6 Endocrine
306.7 Organs of special sense
306.8 Other specified psychophysiological malfunction
306.9 Unspecified psychophysiological malfunction

307 Special symptoms or syndromes, not elsewhere classified

307.0 Stammering and stuttering
307.1 Anorexia nervosa
307.2 Tics

307.20 Tic disorder, unspecified
307.21 Transient tic disorder of childhood
307.22 Chronic motor tic disorder
307.23 Gilles de la Tourette’s disorder

307.3 Stereotyped repetitive movements
307.4 Specific disorders of sleep of nonorganic origin

307.40 Nonorganic sleep disorder, unspecified
307.41 Transient disorder of initiating or maintaining sleep
307.42 Persistent disorder of initiating or maintaining sleep
307.43 Transient disorder of initiating or maintaining wakefulness
307.44 Persistent disorder of initiating or maintaining wakefulness
307.45 Phase-shift disruption of 24-hour sleep-wake cycle
307.46 Somnambulism or night terrors
307.47 Other dysfunction of sleep stages or arousal from sleep
307.48 Repetitive intrusions of sleep
307.49 Other

307.5 Other and unspecified disorders of eating
307.50 Eating disorder, unspecified
307.51 Bulimia
307.52 Pica
307.53 Psychogenic rumination
307.54 Psychogenic vomiting
307.59 Other

307.6 Enuresis

307.7 Encopresis

307.8 Psychalgia
307.80 Psychogenic pain, site unspecified
307.81 Tension headache
307.89 Other

307.9 Other and unspecified special symptoms or syndromes, not elsewhere classified

308 Acute reaction to stress
308.0 Predominant disturbance of emotions
308.1 Predominant disturbance of consciousness
308.2 Predominant psychomotor disturbance
308.3 Other acute reactions to stress
308.4 Mixed disorders as reaction to stress
308.9 Unspecified acute reaction to stress

309 Adjustment reaction
309.0 Brief depressive reaction
309.1 Prolonged depressive reaction
309.2 With predominant disturbance of other emotions
309.21 Separation anxiety disorder
309.22 Emancipation disorder of adolescence and early adult life
309.23 Specified academic or work inhibition
309.24 Adjustment reaction with anxious mood
309.28 Adjustment reaction with mixed emotional features
309.29 Other

309.3 With predominant disturbance of conduct
309.4 with mixed disturbance of emotions and conduct
309.8 Other specified adjustment reactions

309.81 Prolonged posttraumatic stress disorder
309.82 Adjustment reaction with physical symptoms
309.83 Adjustment reaction with withdrawal
309.89 Other

309.9 Unspecified adjustment reaction

310 Specific nonpsychotic mental disorder due to organic brain damage

310.0 Frontal lobe syndrome
310.1 Organic personality syndrome
310.2 Postconcussion syndrome
310.8 Other specified nonpsychotic mental disorders following organic brain damage
310.9 Unspecified nonpsychotic mental disorder following organic brain damage

311 Depressive disorder, not elsewhere classified

312 Disturbance of conduct, not elsewhere classified

312.0 Undersocialized conduct disorder, aggressive type
312.1 Undersocialized conduct disorder, unaggressive type
312.2 Socialized conduct disorder
312.3 Disorder of impulse control, not elsewhere classified

312.30 Impulse control disorder, unspecified
312.31 Pathological gambling
312.32 Kleptomania
312.34 Intermittent explosive disorder
312.35 Isolated explosive disorder
312.39 Other

312.4 Mixed disturbance of conduct and emotions
312.8 Other specified disturbances of conduct, not elsewhere classified
312.9 Unspecified disturbance of conduct

313 Disturbance of emotions specific to childhood and adolescence
313.0 Oversanxious disorder
313.1 Mixery and unhappiness disorder
313.2 Sensitivity, shyness, and social withdrawal disorder
313.21 Shyness disorder of childhood
313.22 Introverted disorder of childhood
313.23 Elective mutism

313.3 Relationship problems

313.8 Other or mixed emotional disturbances of childhood or adolescence

313.81 Oppositional disorder
313.82 Identity disorder
313.83 Academic underachievement disorder
313.89 Other

313.9 Unspecified emotional disturbance of childhood or adolescence

314 Hyperkinetic syndrome of childhood

314.0 Attention deficit disorder

314.00 Without mention of hyperactivity
314.01 With hyperactivity

314.1 Hyperkinesis with developmental delay
314.2 Hyperkinetic conduct disorder
314.8 Other specified manifestations of hyperkinetic syndrome
314.9 Unspecified hyperkinetic syndrome

315 Specific delays in development

315.0 Specific reading disorder

315.00 Reading disorder, unspecified
215.01 Alexia
315.02 Developmental Dyslexia
315.09 Other

315.1 Specific arithmetical disorder
315.2 Other specific learning difficulties
315.3 Developmental speech or language disorder

315.31 Developmental language disorder
315.39 Other

315.4 Coordination disorder
315.5 Mixed development disorder
315.8 Other specific delays in development
315.9 Unspecified delay in development

316 psychic factors associated with diseases classified elsewhere
MENTAL RETARDATION (317-319)

317 Mild mental retardation

318 Other specified mental retardation
   318.0 Moderate mental retardation
   318.1 Severe mental retardation
   318.2 Profound mental retardation

319 Unspecified mental retardation
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