



“In Search Of Care”

*Experiences and Needs
of the
Mentally Ill*

A Publication of Mensana
Mental Health Support Group

November 26, 2004

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Introduction

Mensana is a mental health support group which was formed in July 1997. Two mothers of sons with schizophrenia initiated it, with assistance from a sympathetic psychiatrist. The group seeks to offer practical as well as moral support to persons affected by mental illness including relatives and care-givers.

Since its inception, Mensana has been a forum for persons affected by mental illnesses to learn how to cope, to gain access to needed services and get much needed information. The group has also been engaged in advocacy to have an impact on national mental health policies and to influence implementation of these policies to achieve improved mental health services in Jamaica in general and the South East Health Region in particular.

Since 2003, following on the Minister of Health's announcement of a planned programme of de-institutionalization – returning current patients of Bellevue Hospital to their communities, Mensana has sought to participate in the process of planning for, and implementation of this programme so that disaster may be avoided. We have hosted stakeholder consultations and made written submissions to the relevant authorities.

A year later, we continue to be concerned about the lack of a structured process for the involvement of stakeholders in the on-going planning and implementation process. And, we are concerned that sufficient resources are not available at the community level. There are not enough mental health nurses, little or no coordinated community-based services, limited community education and sensitization, too few rehabilitation programmes and supported living facilities, limited family support services, little scope for social work follow-up and intervention, few training and employment opportunities among other things.

The stories which follow illustrate people's real experiences. These experiences and perspectives give readers an insight into what is missing from the current systems of care as well as what is possible with effective community-based systems of care for the mentally ill.

Bellevue's Phase-out-Any Alternative?

The proposed phase-out of Bellevue Hospital is of grave concern to care-givers. Some patients need life-long custodial care as they are a danger to themselves, to care-givers and to society. These patients often refuse all medication; pills are thrown away. For such persons to be out-patients defeats the purpose.

Should a mentally ill patient burn down his caregiver's house, with or without the caregiver in it, maim or kill a member of society, won't it be too late for effective custodial care? The numerous and recent cases of crimes committed by mentally ill persons that have been reported in the press and elsewhere speak for themselves. What does the government propose to do with them? Those individuals will probably be treated as criminals and be incarcerated at taxpayers' expense.

Which custodial care would be of more benefit to the government, to the patients themselves and to society - lifelong custodial care with proper treatment in a mental institution, or lifelong custody in a jail cell after the tragedy?

Or can their now old and ailing parents/caregivers, at this stage of their lives, be expected to cope with these patients? Some mentally ill patients need lifelong custodial care - in a psychiatric ward - not a prison cell. I am in my eighties and I would not be able to cope if my son were removed from Bellevue and returned to live with me.

Accessing Medication

32-year-old "Kisha" has been diagnosed with schizophrenia. She has been prescribed 10mg of Clopixol tablets to be taken twice per day. However, the pharmacists say that the drug is not available and the distributor says that it is on back order.

Kisha's condition has deteriorated because she is not adequately medicated.

Issues/Questions

- Ability of elderly care-givers to cope and the need for alternative housing
- The need for close medical monitoring to make adjustments in medication etc happen quickly

Public Service to the Mentally Ill - My Experiences

As a mentally ill patient the services provided by the public sector have been found wanting. I have been served by Bellevue on one occasion and Ward 21 several times.

On more than one occasion after realizing that I was getting ill and needing the attention of hospitalization on the Ward, I went directly to the Ward. On one occasion, even though I expressed distress and an urgency to be seen, I was kept waiting on the Doctor who was seeing another patient. In my impatience and need to just lie down, I left. Naturally, I was forcefully taken in the hospital a day or so later after showing obvious signs of critical distress.

On another occasion I again needed to be hospitalised. I felt weak and had lost the hope and desire to live. I had never felt so weak and ill before. I went directly to the Ward explained to a doctor (who had treated me before) that I could not hold out. She responded: "You know the rules, go to casualty because you have to have had an appointment." I could hardly make it on my own. At casualty I knew the wait would be even longer than waiting on a Doctor at Ward 21, so I went to see a social worker, explained my feeling of despair. Instead of being sent/taken directly for medical attention I was subjected to a lot of questions (more waiting and more distress).

Finally I was accompanied to casualty (as a phone call to the Ward, by the social worker, resulted in the same response I had received before – go to casualty) after being informed that the person accompanying me was a social worker and that I was a patient and needed immediate attention, in a matter-of-fact way, the social worker was advised that I needed to join the line. I did, and was left alone while the social worker attended to other business at her office. She was not able to wait with me just then. I felt like I was dying and said so. After waiting at casualty for one more hour by myself, I left. Naturally I got worse and was taken to Bellevue about 2 days later.

At Bellevue I arrived at about 8:00am. And even though the relevant staff was present, the person who took me there was told she had to wait until 9:00am when the office would be officially opened. Meanwhile all around could see and hear that I was mentally unstable – an embarrassing position to be in even in my mentally deranged condition.

The above is by no means an exhaustive account of the defective medical care meted out to me while being served by the public medical institutions. The efficiency and effectiveness of the system need serious improvement, not to ignore the necessity of educating these service providers about considerate, understanding and sensitive response/care which, in fact, impacts on the speedy improvement of the patient.

Issues/Questions

- Admissions processes – are they appropriate for persons who are mentally ill?
- Does the mental health plan include a programme of training for health professionals and workers?

"TRIPLE WHAMMY"

My son first experienced kidney failure at age twenty-two. Prior to that he was a strong, footballer - he was on the Jamaica under sixteen football team - but he had a knee injury that put paid to his career in football. The injury was repaired abroad and although he went back to playing he had lost out on some years between sixteen and nineteen. He went on to university and finished a degree.

The next big disappointment for him was the kidney failure. We don't know what caused the failure - they say it is some kind of auto-immune condition. When we made him come home we didn't realize how depressed he was.

He had had counseling but he thought that the doctors abroad had said that he would be dead in five years! The doctors here disagreed and said that he would be kept going with dialysis. So for a while he was doing o.k. Then he started smoking ganja - he was about twenty three/twenty-four - all the things that were helping him and were good he suddenly saw them as not good; he wouldn't take the doctors' advice; he had bouts of depression and aggression; he started getting paranoid - seemed to be hearing voices - the whole works.

So at that point he not only had a physical illness, he had started showing signs of a psychiatric illness. He wouldn't see a psychiatrist. When he got bad we had to get the mental health team to come; they overpowered him and took him to hospital. We had to pay the mental health nurses who did it privately. The arrangement was made by the doctor who said, "These people will do it for a price". His stay in the hospital really helped him then he was able to convince a junior doctor that he was well enough to be discharged and so he was. He has been able to convince many doctors that he is fine when he is not.

I believe that if someone is paranoid, doctors shouldn't depend on what they say entirely, they need to speak to the family. If they speak to him alone, he sounds intelligent, he has a university education, he fools them!

He stopped smoking for a while and was doing much better so I agreed with his brother to send him to stay with him in the US. Then he started smoking again and got very ill there and injured his brother badly. When we got him seen by psychiatrists there they said nothing was really wrong with him - he was having ganja induced psychotic episodes and all he needed to do was stop smoking and he'd be fine. So he was not hospitalized. So both here and abroad families are treated as if they have sinister motives for wanting to have their relative hospitalized.

Since being home he has had a job which we arranged and we were paying the salary. Because of bad handling of the arrangement by someone he found out and was devastated! Then he went for interviews for a job he really wanted but eventually didn't get the job and again was disappointed.

Then he got baptized and in a funny way that religiosity has made his illness more difficult to manage. He says he is now more able to communicate spiritually on a higher plane and so he doesn't need medication. He started to paint. His paintings had very tortured images. We were told by a pastor to destroy them because we were encouraging demons. So we followed his advice and destroyed them. It was terrible! To this day, six years later he has not forgiven us, no matter what we say. He says his paintings were worth millions - it's like we destroyed part of his soul.

Right now he is ill enough to be hospitalized but there are no hospital beds for him to be admitted. We used to put the medication in his food but we were told not to because he needed to develop enough insight to know that he had to take it on his own. It's been so difficult to know what to do - I tried putting him out of the house but I can't do it. You're damned if you do and damned if you don't!

Now his dad has left - he said he isn't able to cope any longer. In addition to everything else my son has started to take crack - he steals things from the house - I have to lock up everywhere. Now what is there to help my son? What service is there to address his multiple problems? I've been waiting for three weeks now to get a bed for him in the hospital - we don't even have enough beds.

Issues/Questions

- The need for family counseling as an integral part of health care
- What plans are there for services for persons with multiple diagnoses?
- Religiosity and the mentally ill – are religious groups being targeted for sensitization?
- Need for employment opportunities and rehabilitation services

WHO CARES? ¹

I was one of the street “madmen” you used to see. I was filthy, stink and frightening. I hurt somebody one time and I do not remember and in retaliation, the friends doused me in gasoline and set me on fire. Someone called an ambulance and the hospital bandaged me and sent me back on the street.

¹ Reprinted with permission from The Disabled in Jamaica, Volume 1, **The Treatment of the Mentally Ill: Issues, Solutions and Systems**; a publication of the Independent Jamaica Council for Human Rights, February 2001. first published in the June 1, 1996 issue of the Western Mirror

One day an ambulance appeared and invited me up to a place called “CUMI”. By that time my shirt had welded into the large burned area on my back and I was in terrible pain. By that time I didn’t care if they locked me up, or beat me up (at CUMI), I had to take a chance. The voices in my head screamed at me not to go - but for some reason I went anyway.

“Mrs CUMI” (I learned later she was Nurse Crooks) and Nurse Oram from this house on Brandon Hill, put me in the shower and slowly salt-bathed the shirt out of my burn wound. I did not strike back because I knew Nurse Crooks was doing it because she cared if I lived or died. My eye was inflamed and infected and I had things that no one else could see crawling on my body and I had to try to brush them off.

I used to have a good job and family and friends who cared for me, but my illness robbed me of all the people in my life and all my belongings. It had been a long time since somebody cared about me. After the torture of soaking the shirt off my back, I was given medicine and a meal and a place at the night shelter. Nurse Crooks and Nurse Oram dressed my wounds and I was off the street where it had been dangerous for me. Although it seemed like it happened all at once, it took five months for me to begin going to CUMI regularly and during the time on and off the street I had my face slashed.

I began to get to know the other clients at CUMI and to do things with them at the Brandon Hill Centre. Nurse Crooks made contact with my family and soon my relatives began to come and visit me and bring me things that I needed. Nurse Oram would take us swimming at the beach as a group and I started to work with CUMI on cleaning and bushing projects.

After I had been on my injection for a few weeks, the voices in my head began to fade. I wasn’t afraid of people as much and the strange things I used to see were not there anymore. For the first time in a long time people seemed to understand me. I was getting three meals a day, gaining weight and growing stronger. Clean water and clean food made my stomach settle. Dressed in the new clothes provided by CUMI, when I went downtown people didn’t recognize me...they didn’t remember who I was – the ‘madman’ (better known as *Stash*).

Now, two years later with the help of CUMI, I have contact with my family again and may soon be going home. CUMI (through the people of Montego Bay) have clothed me and fed me and have seen that I get medical care. They have replaced the big tent we used to sleep in. It’s now a solid prefabricated building. Over the months that it took for my mind and body to heal with medicine, CUMI showed me how to live a normal life again.

Every day after sleeping at the night shelter I walk through town (at six in the morning) and up the hill to the CUMI Day centre on Brandon Hill. In the morning I mop or dust or sweep or clean the washroom – I shower and do my laundry and change my clothes and have breakfast.

After breakfast we get our medication and if there is ‘work crew’ we go out on the job and do bushing, cleaning, gardening or earth-moving...any contract CUMI can get. If

there is no work we play dominoes or cards or draughts and sometimes sing songs and listen to the music of a young guitarist who visits every week. Volunteers from Faith Fellowship do a devotional service, help with personal care and haircuts as well as make contacts with the street people. At noon we have lunch and then three days per week some of us take box lunches down to the street people. When we hand them out we invite the street people to come up to CUMI.

At night we go down to the shelter and have a meal after it opens at 7pm. We have a little black and white television set and games and the staff give us our medication that the nursing staff have packaged for us. On certain nights members of Christ for the Nations come down and talk with us and tell us about their lives. Their workers are from all over the world. On the weekend a young guitarist comes and we sing. At Christmas and Easter, church groups and service clubs bring down special food and we sing and have services.

There is much more to tell about CUMI but this is enough for now. Nurse Crooks, Nurse Oram and Nurse Pal – the people who support CUMI – saved my life. If CUMI had not been there to reach out to me, I would have probably died of infection. I know now that in the days I was on the street, I must have looked as though I was worthless. But even then, I was a person. It was just that my mind was sick. At that time only God and Mrs. Crooks and Mrs. Pal and my family (who could not reach me) recognized me as a human being. There is medicine for the mind, but someone has to care.

Issues/Questions

- To what extent is the mental health plan seeking to use a strategy of multi-stakeholder involvement in the process of providing care?
- How can we mobilize the existing resources in communities to meet the needs of persons with mental illnesses?

"RESURRECTION"²

We were on a routine street pick-up, on our second or third trip back to town (with the Parish Ambulance) from the CUMI Day Centre on Brandon Hill. With each trip we picked up four or five street people whom our volunteer (Mark Lawrence, Faith Fellowship) had identified. The people we had dropped off were being supervised in their bathing and re-clothing by another Faith Fellowship volunteer, Joan Cunningham, as the clients prepared for lunch.

² Ibid. First published in the October, 2, 1996 issue of the Western Mirror

At Sam Sharpe Square, we approached a man in a turban, holding a staff like Moses, carrying a bucket full of his meager belongings. He asked what we were doing. Mark explained it to him and invited him to come up and bathe and receive a new set of clothes. Despite (or because of) long experience in psychiatry, I found the man to be mildly threatening in his manner but he was very willing to go into the ambulance with Mark and me.

His shower required some supervision, though he asked us pointedly if we found him “malodorous”. We agreed that he was not. Our rehabilitated clients helped him remove and burn his street clothes. He was a well-spoken man but quite suspicious and acted in bizarre fashion in the shower. Dressed in clean clothes, he was interviewed and gave us virtually no information, identifying himself as: Matthew, Mark, Luke and John, “three in one–four in one....” he explained, “it is good to know as a mature person... to understand the temporal, sometimes people are not so much...”

He surveyed the operations of CUMI with thoughtful distrust and demanded that we explain things to him, especially the content of the food. He showed signs of hearing voices in his head, believing strange things, and had disordered thinking, he was unsure what year it was.

Having made the decision to maintain contact with CUMI he was assessed and commenced treatment. As his medication began to take effect, he became a helpful and pleasant man with a very gentle character, but everything did not go easily from the start. At first he felt he had to exorcize our food (he probably felt it had demons), then he would disappear in the early afternoon without his medication and would be disturbed and agitated the next day. Eventually he stabilized sufficiently, so that he could be admitted to the Night Shelter, but even there, he had to be sent away one night because of misbehaviour. He remained obsessed with food and religion and insisted on asking about herbs and what was in the food we served. From February when we first met him, until April, he made steady progress. The madness melted away and a delightful Christian man emerged

He finally told us his name (we'll call him Lukee). He was remarkably gentle with the other clients and seemed to understand their behaviour exceptionally well. They responded well to his gentleness and kindness. He became a very willing worker, helping to clean the night shelter and bushing projects and was very careful in the early-morning clean-up of the centre.

Within about three months we came to discover that Lukee had a brother who had the same mental illness and he eventually came to the centre for treatment. The years of madness had taken their toll and Lukee needed time to rest and recover and get his daily routine normalized. It then became necessary for him to try to put his life back together again. As he began to retrace his steps, a string of painful losses became evident. Having owned a house with his brother, Lukee returned to visit, only to find that the house had been captured and the new occupants were putting additions onto the house. He came back to the Centre very distressed and asking what he could do. Also, as he sought his baby-mother, he discovered that she had died.

Memories returned - of the crops he planted and the goats he kept and the time he returned from a period of illness to discover that his goats were missing. He learned that a neighbour had them and he went to retrieve them. He was very grateful that the neighbour had cared for the goats during his illness. When he approached the neighbour to pay for the keeping of the goats, the neighbour said they were his goats. Lukee said he would go to the police. The neighbour threatened that Lukee "would never identify him. . ." but Lukee did not know what he meant till he was nearly blinded in a chemical attack which left him visually impaired. He is unable to read the letters on a typewriter keyboard.

Despite the tragedy (and with no bitterness) Lukee went methodically about reclaiming his bank account and attempting to explore legal channels for reclaiming his house (with the help of a local Community-Police Sergeant who is very supportive of CUMI). Perhaps the most touching event took place when he went back to his village to see his children. As he walked up the road toward the house where his son was living (with a maternal aunt) the boy (now 10 years old) called out "It's Daddy! It's Daddy! " The neighbours told him to be quiet, that he was seeing 'duppy'. Lukee later found out that the word had been spread around the village that he was dead. It was a stirring reunion.

Now he had a new reason to get back to full health: to help his son! Today, 8 months after first contact on the "street pick-up" Lukee is working as a part-time cook for 25-35 people per meal, three meals per day. He has proven himself an excellent worker for his employer. He can produce 35 delicious, nutritious, low-cost meals, on time, week after week, at times working 7-day weeks. He has also been hired as a part-time day-helper doing domestic work and is valued as a hard worker, whether supervised or unsupervised. He is also doing live-in security/helper work and is traveling to the village to bring school clothes (purchased with money he has earned) and financial assistance for his son.

A sweet smile, a good sense of humour - he is even able to calm staff when they are distressed in difficult and stressful circumstances at the Centre.

MENSANA'S PERSPECTIVES AND RECOMMENDATIONS

Mensana works to promote and enhance the **capabilities** of persons with mental illnesses who, with appropriate services, can:

- Remain healthy
- Have positive life outcomes
- Make decisions concerning their lives
- Live as independent and productive citizens to varying degrees

The group supports the goal of the National Mental Health Policy to shift emphasis away from institutionalization and towards community-based services. However, the success of the latter approach depends on a well-resourced, multi-stakeholder process with a variety of types of services available to affected persons.

Since 2001 Mensana has hosted a number of fora, which have helped to shape its perspectives on community-based mental health policy and programmes. In March 2001 the group brought to Jamaica, with the help of PAHO, Mr. Steve Lurie, Executive Director of the Toronto Chapter of the Canadian Mental Health Association. He shared best practices in, and lessons learned from, community mental health services in Canada. In addition to the information he shared at the forum he also left literature to support the research being done to create a local draft Mental Health Policy that was being prepared by Psychiatrist, Dr. Wendel Abel. In addition to Steve Lurie, local agencies, such as Committee for the Upliftment of the Mentally Ill (CUMI) and the Clarendon Association for Street Persons (CLASP) also presented on their initiatives and lessons learned. All presenters stressed that important factors contributing to mental health are:

- work and/or other meaningful daily activities
- access to on-going social and medical support and
- welcoming places and people in the life of persons with mental illnesses.

Mensana followed up on that forum with a stakeholders' workshop aimed at identifying and bringing together representatives of existing agencies implementing a variety of programmes in communities – such as those provided by churches, community-based organizations, and non-governmental organizations as well as state agencies. The objective was to begin a process of establishing a coordinated network of support services to which persons with mental illnesses might be referred and which could be a driving force for the establishment of a body of good practice in community-based mental health policy, planning and service delivery.

The workshop benefited from presentations on recommended policies for Montserrat, which had had its catastrophic volcanic eruption, and needed advice on management of the mentally ill population. Lessons were learnt from presentations made by persons with mental illnesses who spoke about the things that were assisting them to cope and function well in the community.

From the personal stories, like those outlined above, lessons concerning the factors that

- Advocates for the mentally ill include persons with mental illnesses and their families, the police, concerned individuals and non-governmental organizations
- The need for mental health services to be supported by appropriate legislation and policy
- **Good practice** includes the provision of a mix of types of services to meet different functioning levels and needs
- Mental health policy and programmes should be **client-centered**
- The model being developed emphasises meeting social as well as medical needs, mobilises community resources, emphasises collaboration among stakeholders and is driven by a mixed, stakeholder advisory group.
- The importance of organizing stakeholders around discrete activities based on clear definitions of skills and roles
- The importance of mental health being mainstreamed in general health planning and development processes
- The importance of including stakeholders in the mental health planning process from the beginning

contribute to persons recovery and their achieving good life outcomes were:

- Family support or a supportive family surrogate
- Work (employment/occupation) based on the skills the person had before their illness or on training in new skills following their illness; and, a supportive work environment
- Support groups (social/recreational etc)
- Acceptance and understanding of the problem/illness by the individual, family and community
- Medication (taking it consistently)
- Spirituality (balanced)
- Education (of the general public and specific targeted groups)

Representatives of eight agencies attended the workshop and their reports on the services the agencies provide demonstrated that there is no need for us to reinvent the wheel in developing programmes at the community level. What is needed is for existing agencies to be mobilized, sensitized and supported in extending their services to persons recovering from mental illness.

In February 2003, Mensana hosted another stakeholders' consultation in the context of growing concern and anxiety about the planned closure of the Bellevue Hospital and about the future of mental health care in Jamaica. The objective of the forum was to bring stakeholders together to discuss the issues and to arrive at workable solutions. Some thirty-five persons attended. Represented among the participants were family members/care-givers, persons with psychiatric conditions, psychiatrists, psychologists, social workers, representatives from the Ministry of Health, staff of the Bellevue Hospital and the Jamaica Workers Union that represents the staff of the Bellevue Hospital.

A number of issues for consideration were identified by various presenters. These included the following.

- The absence of consultation with the general hospital staff and the need for transparency
- The need for a transparent process and a systematic plan to facilitate smooth transitions for staff, patients, families and communities
- The need for community education and preparation to be the first thing to be implemented
- The need for information on what plans there are for the few patients who cannot be returned to communities e.g. those with fixed delusion who act out and who cannot go home or to infirmaries, those with families with very limited incomes and/or elderly caregivers
- The need for income supplementation for poor care-givers by ensuring their registration with government's welfare programmes
- The need to address fears related to job security among all levels of employees at Bellevue. There is a need for detailed information on the numbers needed, numbers to be deployed, numbers to be made redundant
- The need to speak with the clients at Bellevue to explain and prepare them for the changes that are to come
- Some of the proceeds of whatever development is to be done at Bellevue should be put towards needed mental health services
- The need to clarify the future of specialist training (for psychiatric nurses, social workers etc) which Bellevue now provides
- There is need for more detailed information on staffing to support the Plan especially for staff for acute care, which is now short
- There is limited coordination of services
- The "community mental health services" have been reduced to persons being given medication with psycho- social rehabilitation being almost non-existent
- The need for definition of the "community" to which people will be returned
- The need for social networking to make the overall plans/systems work – the experience of assisting the mentally ill in prisons has been one where the Independent Jamaica Council for Human Rights (IJCHR) has had to play multiple roles as other social services do not 'trip in' automatically.
- No beds are currently available in the infirmaries for placing the mentally ill who have been released from the prisons

General recommendations came out of the consultation. These were as follows.

RECOMMENDATIONS

Issue

Care for acute illnesses: With respect to the plan to make acute care hospitalization in general hospitals be for approximately 14 days, it was questioned whether the time was

long enough for persons to be stabilized and ready to be returned home where caregivers may not be able to provide the degree of supervision needed.

Recommendations

- Develop a standardized protocol on admission and discharge procedures and plans and post-hospital placement options with relevant criteria for each patient, to be given to the family and to be discussed in family conferences before admission, during hospitalization and before release.
- Inform families of their right to information and case discussion
- Ensure provisions for direct admissions which do not require long hours in the general casualty or accident and emergency rooms - psychiatric patients who are acting out and who may be resisting hospitalization cannot spend long hours before being seen and admitted.
- General hospital staff must be trained and sensitized – the experiences of caregivers at general hospitals suggest that from the level of porters up, staff at these hospitals have very little understanding of and sensitivity towards persons with mental illnesses.
- Create suitable/applicable posts eg. for psychiatric social workers, at general hospitals
- Family/care givers should be counseled, about post hospital placement
- Establish post hospital acute care half-way house and supervised day facilities
- Ensure continuing education for adolescents who are hospitalized, and make special follow-up provisions for this group (e.g. social work contact with schools)

Issue : Rehabilitation of persons with chronic mental illnesses

Challenges were identified as being:

- Co-ordination of services and referrals
- How to integrate/mainstream persons with mental health problems into existing facilities/services/programmes in communities (e.g. training programmes, recreational programmes)

Recommendations: in conjunction with NGOs/community-based organizations such as churches, establish

- National public education programme for sensitizing and preparing communities and specific sectors in the wider community (employers, agencies providing various services into which persons with mental illnesses could be integrated) to respond appropriately to persons with mental illnesses
- Day rehabilitation centers
- Sheltered workshops
- Clubhouses

Provide

- More caseworkers
- Government subventions to NGOs/CBOs to assist them in their efforts to provide services. (There is already a model in Jamaica of government giving a subvention to private children's homes while the organization responsible for the home seeks supplementary funding to meet expenses. Such a system could be applied to mental health facilities)
- Education of police – develop training module to be delivered at the police training academy for pre and in-service training of police officers
- A plan for identifying and training volunteers in community based organizations e.g. churches willing to establish outreach services (this can be done in collaboration with groups such as Mensana)

Issue: Persons with dual diagnosis**Recommendations**

- Collaborate with the National Council on Drug Abuse
- Establish a specialized detox and treatment/rehab unit/s
- Carry out Sensitization and training of police
- Ensure out patient follow up
- Carry out on-going public education on impact of drugs (particularly ganja) on mental illness
- Treat as a priority group for supervised housing facilities

General Recommendations

- Ensure dissemination and discussion of the budget for the expansion and maintenance of the necessary services
- Establish a mechanism for receiving the input of related professional associations (e.g. the Jamaica Psychological Society, Social Workers Association etc) in the planning and implementation process
- Develop and disseminate information on a specific plan related to the monitoring and evaluation of de-institutionalization. Individuals should be followed up to determine the success of their placement and to make adjustments where necessary.
- Establish a body with representation from relevant stakeholders (government, NGOs, legal, medical, persons with illnesses etc) to advise on and monitor the implementation of the plans for mental health reform. A committee similar to the National Aids Committee was suggested.