TRINIDAD & TOBAGO

The Burden of Mental Disorders in the Americas:
COUNTRY PROFILE

2019 population (millions) **1.39**
Life expectancy (years) **73.5**

Trinidad and Tobago is a country made up of two main islands (Trinidad and Tobago) and other smaller islands, located in the far south of the Caribbean, near the northern coast of Venezuela.

Between 1990 and 2015, the population grew by 6.4%, reaching 1.39 million in 2019. In 2019, life expectancy at birth was 73.5 years. Between 1990 and 2010, the population aged 60 and over increased by an average of 4.0% annually, compared with the annual reduction of 2.5% seen in the 5-19 age group.

The economy is predominantly industrial and highly dependent on the energy sector, although it has been shifting from oil dependence to an economy based mainly on natural gas.

THE DISEASE BURDEN AFFECTING MENTAL HEALTH

Mental, neurological, substance use disorders and suicide (MNSS) cause 16% of all disability- adjusted life years (DALYs) and 31% of all years lived with disability (YLDs).

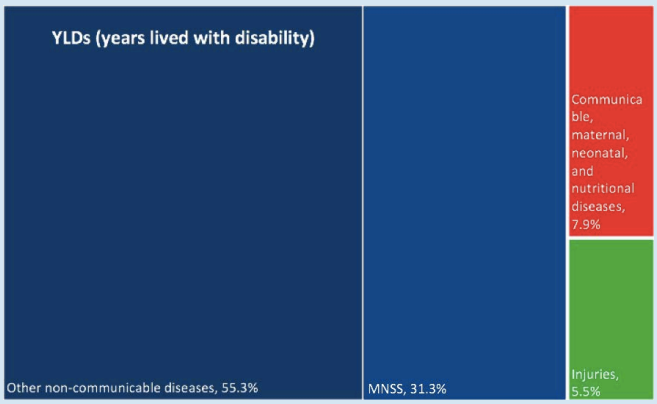


Figure 1. Distribution of YLDs with a focus on mental, neurological, substance use disorders and self harm (MNSS)

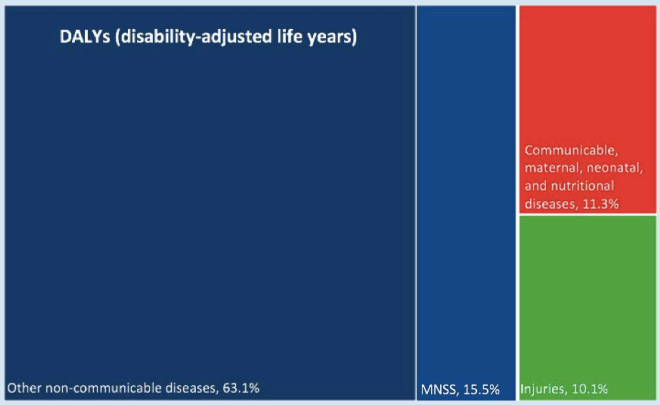


Figure 2. Distribution of DALYs with a focus on mental, neurological, substance use disorders and self harm (MNSS)

THE BURDEN AFFECTING MENTAL HEALTH ACROSS THE LIFETIME

Fig. 3 shows the changes in disease burden across age-groups. NCDs (in shades of blue) surpass 50% of the burden at 5 years old, and will remain the largest burden throughout the lifetime. MNSS account for more than a fourth of the total burden between 10 and 40 years of age, the largest burden of all NCDs during this period. Fig. 4 focuses exclusively on the burden resulting from MNSS. Until 5 years old, the MNSS burden is mostly due to epilepsy (52%) and autism (42%). Between 5 and 15 years old, the burden of conduct disorders, anxiety disorders, and headaches – including migraine and tension-type- gain prominence, with 17% of the MNSS burden each. Around 20 years of age, a pattern emerges that will remain stable throughout youth and adulthood: common disorders (anxiety, depression, self-harm and somatic symptom disorder) account for 48% (suicide accounts for around a fourth of MNSS burden between 20 and 35 years old), headaches for 19%, substance use disorders 14% (9% due to alcohol), and severe mental disorders (schizophrenia and bipolar disorders) 7%. The elderly suffer mostly from neurocognitive disorder due to Alzheimer's disease, which surpasses 50% of the burden around 80 years old and remains above 70% after 85 years old.

This is the second installment of the 2018 PAHO report, found here

Pan American Health Organization
World Health Organization
REGIONAL OFFICE FOR THE Americas

Figure 3. Burden of disease, by disease group and age

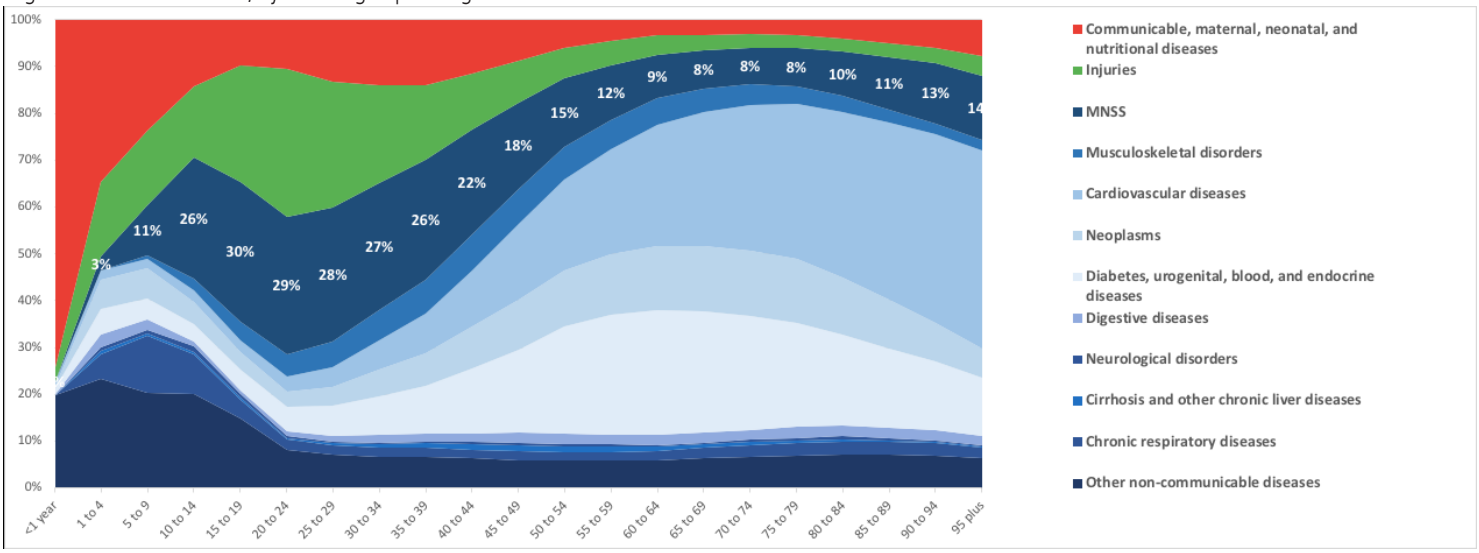
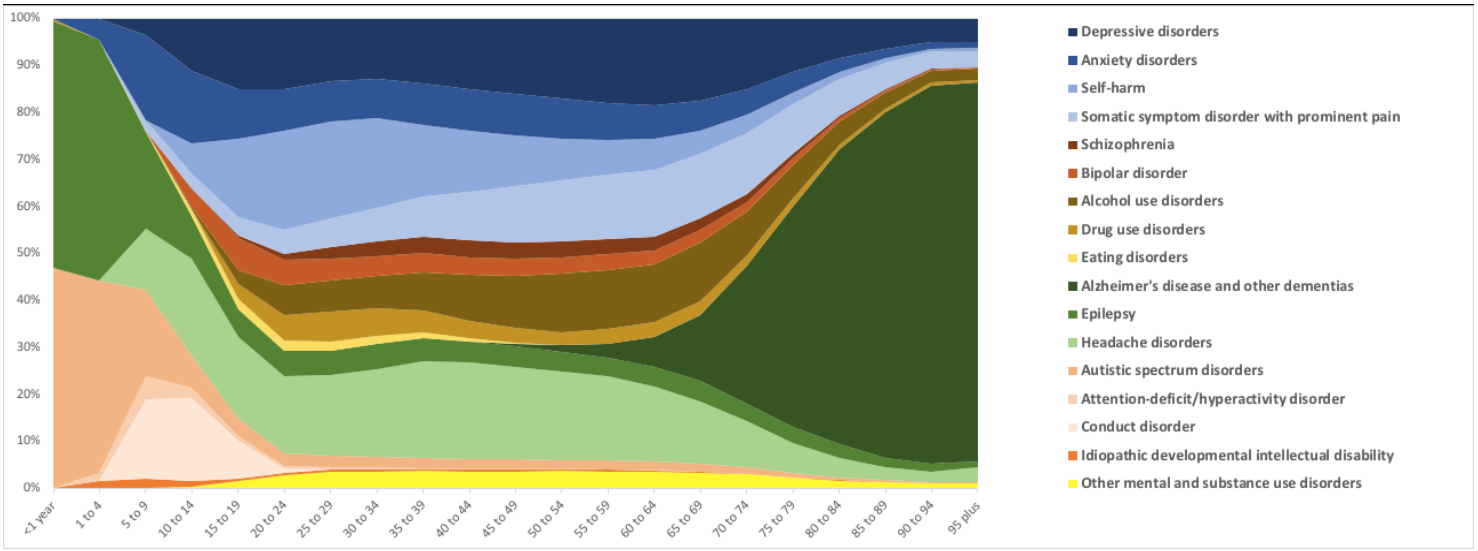


Figure 4. Burden of disease, by MNSS and age



THE BURDEN AFFECTING MENTAL HEALTH IN MEN AND WOMEN

The top three disorders in terms of disability-adjusted life-years –accounting for 40 to 55% of total MNSS burden- are not the same for men and women: While men are mostly affected by self-harm and suicide, alcohol use disorders and headaches, women are mostly affected by headaches, depressive and anxiety disorders.

Men		Women	
Disorder	DALYs per 100 000	Disorder	DALYs per 100 000
MNSS (all)	4979	MNSS (all)	4397
Self-harm and suicide	945	Headache disorders	993
Alcohol use disorders	578	Depressive disorders	780
Headache disorders	551	Anxiety disorders	502
Depressive disorders	546	Somatic symptom disorder with prominent pain	445
Alzheimer's disease and other dementias	390	Alzheimer's disease and other dementias	367

Conclusions:

Considering these estimates, primary care providers should receive training and tools to prioritize detection and treatment or referral for the common disorders highlighted above for each age-group and sex. For the severe disorders –such as autism, schizophrenia, bipolar disorder and Alzheimer's– as well as for severe, comorbid, or complex presentations of other disorders –e.g. depression during pregnancy, substance use in public service professions, etc.– primary care providers and families need access to adequate supports, such as:

- Referral and/or supervision platforms that allow for continued treatment in the community, including the use of digital technology to increase access to distant geographically concentrated resources.
- Emergency, inpatient, and residential services for the management of high-risk acute situations and high-need patients. These services should be community-based as much as possible, including for crisis management, inpatient treatment in general hospitals, supported housing, and residential services.