WHO-AIMS

WHO-AIMS REPORT ON

MENTAL HEALTH SYSTEM IN ANGUILLA

2009

World Health Organization

MINISTRY OF HEALTH
ANGUILLA

WHO-AIMS

REPORT ON THE

MENTAL HEALTH SYSTEM

IN ANGUILLA

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

Anguilla 2009

World Health Organization

Organización Panamericana de la Salud
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MINISTRY OF HEALTH
ANGUILLA

WHO, Country Office in Anguilla
Pan American Health Organization (PAHO), WHO, Regional Office for the Americas (AMRO)
WHO Department of Mental Health and Substance Abuse (MSD)

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For further information and feedback, please contact:

1) Alma Hughes, Mental Health Focal Point, Ministry of Health: hughesalmaa@yahoo.com
2) Monique Rey, Senior Mental Health: Monique.rey2@gov.ai
3) Shekhar Saxena, WHO Headquarters: saxenas@who.int

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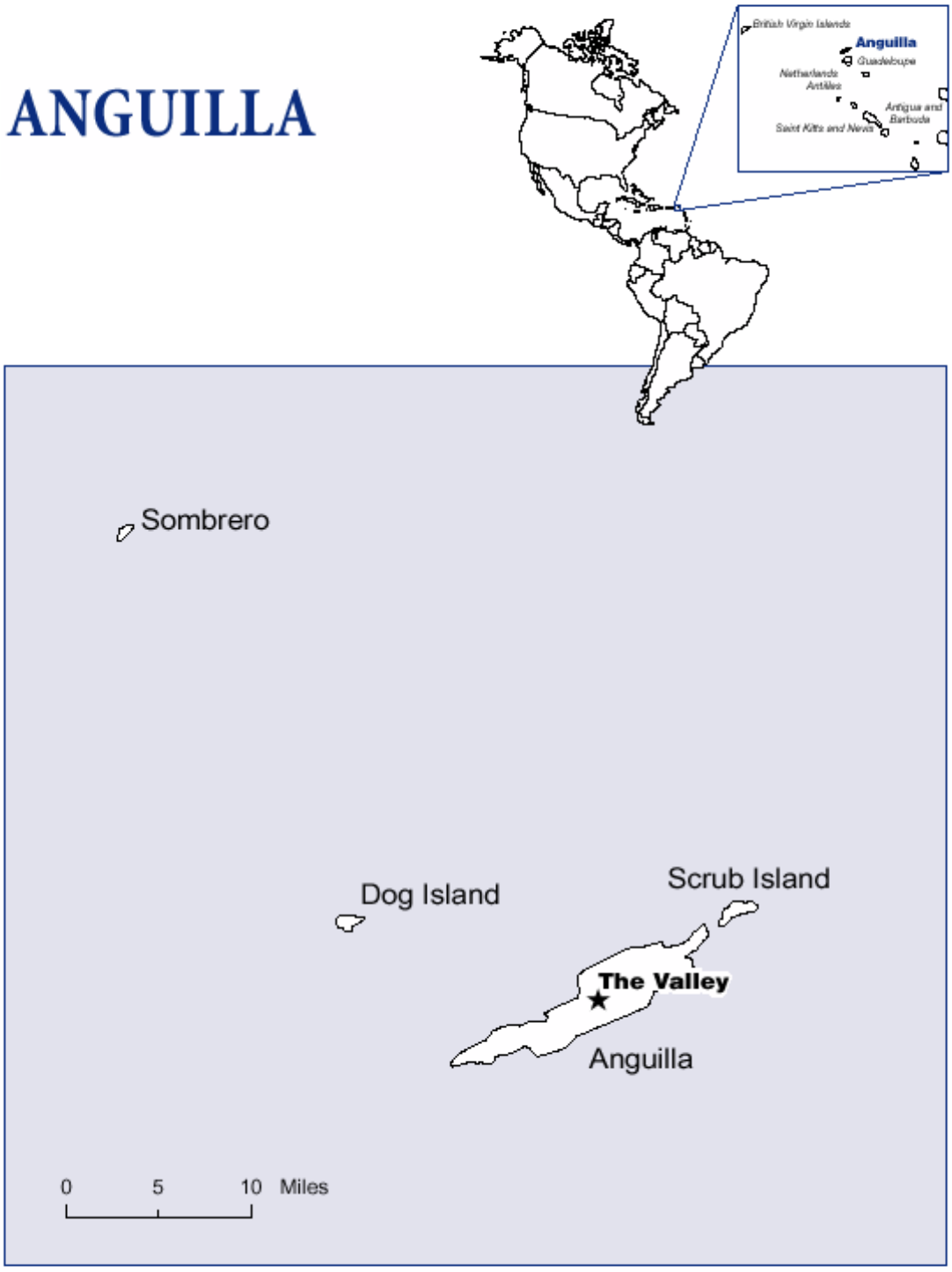

Sources: Second Administrative Level Boundaries Dataset (SALB), a dataset that forms part of the United Nations Geographic Database, available at: http://www.who.int/whosis/database/gis/salb/salb_home.htm, and the Digital Chart of the World (DCW) located at: http://www.maproom.psu.edu/dcw. The boundaries and names shown here are intended for illustration purposes only, and do not imply official endorsement or acceptance by the Pan American Health Organization.

Acknowledgement

The World Health Organization Assessment Instrument for Mental Health (WHO/AIMS) was used to collect information on the mental health system in Anguilla.

The project in Anguilla was carried out by Dr. Margaret Hazlewood, PAHO/ECC consultant. This final document is the product of the Ministry of Health, Anguilla and the PAHO/ECC office's efforts to collect, analyze, and disseminate information about the mental health system in Anguilla.

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The PAHO/ECC office and the national authorities in Anguilla wish to thank the World Health Organization for its remarkable foresight to design this WHO/AIMS instrument to assess the mental health systems in its Member States.

Executive summary

The World Health Organization Assessment Instrument for Mental Health Systems (WHO/AIMS 2.2) was used to collect information on the mental health system in Anguilla. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring change. This will enable Anguilla to develop information-based mental health plans with clear base-line information and targets. It will be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care, and rehabilitation.

Anguilla has a mental health policy and a legislative Act. There is no mental health unit in the Ministry of Health. There was no national mental health plan that sets out the goals, actions, priorities, timelines, and financing strategies for the promotion of mental health, preventing mental disorders, and treating people with mental illness. The Health Authority of Anguilla is responsible for the financing of health care services. Mental health services are subsumed under "community health." Allocation and expenditure for the delivery of mental health services are not delineated in the community health budget, except for the remuneration for nurses' salaries. However, commencing in 2009, the financing mechanism will be restructured to emphasize the budget for mental health services. Although there is no social insurance scheme, persons with mental illness have free access to psychotropic medications. The mental health policy and legislation do not include the promotion of human rights to protect the basic rights of the mentally ill. No human rights review body exists and none of the mental health service delivery facilities has had an external human rights review. Mental health workers are not trained in the procedural safeguards to protect the rights of mentally ill persons.

There is no mental hospital. The locus of care is in the primary health care setting. Approximately 82% of persons with mental illness were treated in three clinics serving distinct catchment areas. The overwhelming majority of mentally ill persons were diagnosed as having schizophrenia.

Access to mental health services is even across the country. Psychotropic medicines are available but there was no risk-benefits assessment of the effects of long-term use of psychotropic medications. The training of primary health care workers in the detection and treatment of mental disorders, pharmacology, and psycho-social rehabilitation has low priority and was non-existent.

There is 8 staff working in the area of mental health which included a medical doctor, not specialized in psychiatry. None of the physicians working in Anguilla has at least two days of refresher training in any aspect of mental health. There is no resident psychiatrist but a visiting psychiatrist from Barbados provided consultant services. The social worker is attached to the Department of Social Welfare and provided part-time services in mental health, as needed.

There are no consumer or family associations. There is no government or Non-governmental organization (NGO) support for assisted housing or hostels for the mentally challenged. NGOs have not played a role in the organization and delivery of mental health care or consumer empowerment.

The mental health nurses launched sporadically public education and awareness campaigns. They educated the general public and target groups about the nature of mental health to reduce discrimination against, and intolerance for mentally ill persons.

There are no systems in place to provide timely, accurate, and relevant mental health information. The available mental health indicators are not sufficient to inform efforts to improve mental health services through program planning, monitoring, and evaluation. There was no research on mental health published in indexed journals.

In Anguilla, the community-oriented approach to mental health has had a significant impact on the lives of persons with mental illnesses, their families, and other care givers. In the absence of a resident psychiatrist, only two mental health nurses form the nucleus of therapeutic and supportive care. The lack of a national mental health plan, focused funding, and an acute inpatient psychiatric setting within the general hospital, structured social supports, additional human resources, are ongoing concerns. Diagnostic and therapeutic services depend heavily on consultation and liaison services with a psychiatrist who is based in Barbados.

Although there is limited public education campaigns, the public remained largely uneducated about the magnitude of the problem. There are no publication or public briefings to inform of the prevalence, types, and effects of mental illness. There were no educational programs for primary health care workers to prepare them for the role of mental health workers.

In order to put the information above into context, the situation in Anguilla is being compared to that which exists in six Eastern Caribbean countries. Anguilla is among: two of the six countries with a mental health policy; three of the countries without a mental health plan; three without a mental hospital; and among two countries where it was difficult to estimate the total budgetary allocation for mental health services. All six countries have either draft or enacted mental health legislations. Anguilla is one of two of these countries that depend on the services of a visiting consultant psychiatrist. In the referenced six countries there were: no user/consumer or family associations; no work on human rights; no refresher training for mental health professionals; no mental health information system; and no research or published articles on mental health.

Anguilla is among most of the countries in the Eastern Caribbean where psycho-social and occupational therapies are not combined with drug therapy to enhance the worth of those for whom traditional social lifestyles appear elusive. It is among the countries where few formal links exist with HIV/AIDS programs, among others. In the Region, it is among the countries where there is a need to restructure the architecture of the public health system to include a unit to drive mental health activities in all spheres and among

stakeholders. It is among the countries where the tendency to discriminate against, stigmatize, and isolate the mentally is ill is as old as the first mental health Act and as contemporary as the data reflected in this report. Like the other countries, the national authorities in Anguilla are grateful for the assessment since it collected essential information to facilitate evidence-based improvements in policy and program directions as well as service delivery.

This baseline assessment is a tool for seeking support from national, regional, and global levels for developing and supporting mental health plans.

Background

The World Health Organization Assessment Instrument for Mental Health Systems (WHO/AIMS 2.2) was developed by the Evidence Research team of the Department of Mental Health and Substance Abuse, World Health Organization (WHO). It was developed with input from in-country and international experts as well as pilot trials in middle and low-income countries. WHO/AIMS is a comprehensive assessment tool for mental health systems that is designed to collect essential information to facilitate evidence-based improvements in policy and program directions as well as service delivery. WHO/AIMS 2.2 has six domains: policy and legislative framework, mental health services, mental health in primary health care, human resources, public information and links with other sectors, and monitoring and research. Within these domains, there are 28 facets with 155 items.

Data collection

WHO/AIMS was used to collect, analyze, and report data on the mental health system and services in Anguilla in 2007.

One week was assigned for the data collection phase. (March 2009).

Process

1. The instrument's questions were divided into ten sets, each targeting a specific respondent. The item number, characteristic, and salient content of the question were retained. Each set targeted one of the following respondent: Chief Medical Officer, Permanent Secretary (Ministry of Health), Chief Pharmacist; Chief Nursing/Principal Nursing Officer, Director of Mental

Health Clinical Services; Director of Mental Health Outpatient and Residential Facilities, Director of Mental Hospital, Director of Psychiatric Inpatient Unit, Director of Forensic Mental Health Services, Director of Social Services, and the Mental Health Focal Point.

2. Interviews were scheduled, through the PAHO/Country Program Officer, prior to the consultant's arrival in Anguilla.
3. The consultant met with representatives of the Ministry of Health to explain the purpose, benefits, and contents of the WHO/AIMS as well as the procedures and requirements for its completion.
4. Personal working sessions and interviews were held with the available respondents; not all the categories of health personnel mentioned under 1) above are available in Anguilla.
5. The data was entered into the WHO-AIMS 2.2 Excel spreadsheet and discussed with the Non-Communicable Diseases and Mental Health Advisor, PAHO/WHO-Barbados Office.
6. The draft report was prepared and circulated to the national health authorities for comments and validation.
7. The final draft report was reviewed by the Regional Adviser for Mental Health, PAHO/WHO, Washington, D.C., prior to its submission to WHO-Geneva.

Limitations

In Anguilla, there are no fully developed organized processes and procedures to respond to the need for timely, reliable, and accurate health data. Specifically, there is no national health information and reporting system for mental health. Consequently, with limited time, it was challenging to access data that accurately determines trends in disease occurrence, quality of care, and human resource tracking. Mental health data was not routinely collected and integrated into a national data base. The community mental health nurses, who primarily managed the mental health delivery system, needed guidance as to the type of indicators to collect in order to provide useful and reliable information. There were no uniformly documented clinic-level data to reliably inform, for example, number of users and service utilization history. Discharge records and poorly organized clinic logs/cards provided the only information available for mental health reporting. Up to 2007, there were no written national reports or consultant briefings on mental health. Anguilla had limited trained human resources in mental health.

There is no mental hospital in Anguilla. As such, available data for mental health activities at the general hospital were substituted under the rubric of "community-based psychiatric inpatient unit." Similarly, since there are no mental health outpatient facilities, data from the primary health care clinics were substituted because mental health services are scheduled in these clinics.

The data were not reported using rates since the country has a population of far less than 100,000.

With these limitations, the data reported herein best reflect the characteristic of the mental health infrastructure and service delivery mechanism in Anguilla.

Introduction

Anguilla, a small (35 square miles) low-lying, limestone island in the Eastern Caribbean, is part of the Leeward Islands in the British West Indies. It stretches for 16 miles from tip to tip and spans 3 miles across its widest point. It is surrounded by several offshore cays. Its highest point is Crocus Hill, which rises 65 m above sea level. The territory has no distinct urban and rural settlements.

Anguilla became a separate British Dependent Territory in 1980. It is a self-governing territory with a ministerial system of government. The Constitution provides for a governor, an executive council, and a House of Assembly. The capital and administrative center is the Valley. Its primary ports of entry are Wallblake Airport and the Blowing Point Ferry Terminal. The main language of the country is English. The total population was estimated at 13,677 in 2007. Christianity is the predominant religion and there are no other significant religious groups in Anguilla. According to the 2001 population census, 72% of the population is Anguillan while 28% is non-Anguillan. The latter population includes citizens from the United States, United Kingdom, Nigeria, and other Caribbean islands. Since 2006, there has been an influx of Chinese and Indian workers to meet the labor requirements which is driven by the rapidly expanding tourism industry.

There are no direct forms of taxation in Anguilla. The currency, the Eastern Caribbean dollar, is pegged to the United States dollar at US$1 = EC$2.68.

Anguilla is an associate member of the Caribbean Community (CARICOM) and of the Organization of Eastern Caribbean States (OECS). It is signatory to major conventions such as the European Convention on Human Rights (ECHR); U.N. Convention against; The UN Convention on the Rights of the Child; and the U.N. Convention on the Elimination of Racial Discrimination.

The crude birth rate was 14.3 per 1,000 population (2005) and the crude death rate was 2.6 per 1,000 population (2007). Life expectancy at birth was 81.1 years for females and 76.5 years for males (2006). Total fertility rate was 1.7 children per woman (2006). The adult literacy rate is 95.4%.

The Minister of Social Development has the overall responsibility for the population's health. In 2004, the government placed the delivery of health services under the Health Authority of Anguilla (HAA). The management responsibilities delegated to the HAA includes: financial; human resources; and operational delivery of health care services.

The government of Anguilla relies on primary health care as the key for attaining health for all. The island is divided into three health districts and each district is managed by a center manager who is a public health trained nurse. There were four health centers and one polyclinic spread among the three health districts. All health centers are easily accessible to the entire population. The Princess Alexandra Hospital is the only general hospital and there is no mental hospital. There was no mental health outpatient facility, day treatment facility or community-based psychiatric inpatient unit.

The Ministry of Health has committed to strengthen mental health programs; establish a framework for providing mental health services; mitigate the impact of mental health disorders; sensitize the general public about mental health issues; establish a mental health information system for mental health program and delivery; and reduce substance abuse[1].

Domain 1: Policy and Legislative Framework

Policy

The National Mental Health Policy was approved by the Executive Council in 2005. The policy is based on international conventions and principles. It guided the provision of mental health services and enactment of the Mental Health Act of 2006. The policy seeks to maintain a system of mental health services in accordance with 15 core principles. Among these are:

1) *Organization of services*: a) community mental health is the cornerstone of mental health services to provide services in the least restrictive environment possible; b) development of a mental health component in primary health care. The Valley Health Center was renovated and expanded to serve as the locus of community mental health services.
2) *Involvement of users and families*: community-based organizations should compliment the mental health services provided by the Health Authority of Anguilla. Mentally disordered persons have a right to be fully involved and to make decisions about their treatment.
3) *Equity of access*: Mental health services should view the individual as a whole person delivering the necessary level of support regardless of race, gender, religion, sexual orientation, age of degree of disability.
4) *Monitoring system*: mechanisms for implementing and evaluating mental health service program should be established. A Review Panel will be appointed by the Ministry of Health to review admission certificates, renewal certificates, and issues pertaining to treatment, when warranted.

Issues pertinent to human resources; advocacy and promotion; human rights; protection of users; financing, and quality improvements were not addressed explicitly in the 2005 policy.

The Policy calls for the construction of a 10-bed inpatient psychiatric ward to be erected at the Princess Alexandra Hospital for mentally ill persons requiring hospitalization.

Plans

No mental health plan or disaster/emergency preparedness plan for mental health existed.

[1] Pan American Health Organization. Health in the Americas 2007, Vol. II – Countries. Washington, DC: PAHO; 2007

Legislation

The Mental Health Act, came into force on 31 October 2006 and is enshrined in the Revised Statutes of Anguilla, Chapter M72. The Act addresses issues related to: admission and detention of a person suffering from mental disorders; administration – duties towards the patient, communication by and to patients; visiting hours; treatment and security of patients; leave of absence from the facility; return of formal patients to the facility; and transfer to Anguilla and transfer out of Anguilla. In addition, the Act addresses treatment and control of patients (mental competence, competence to make treatment decisions, treatment decisions on behalf of formal patients, objection to treatment, and control of patient without his/her consent). Discharge of patients (removal after discharge) and the appointment of a Review Panel are also items in the law. The Act includes standardized documentation, such as: an admission certificate, renewal certificate, competence to make treatment decisions; warrant order and other pertinent forms. The Governor in Council may make regulations prescribing other forms and their use. The accreditation of professionals and facilities is not mentioned in the Act.

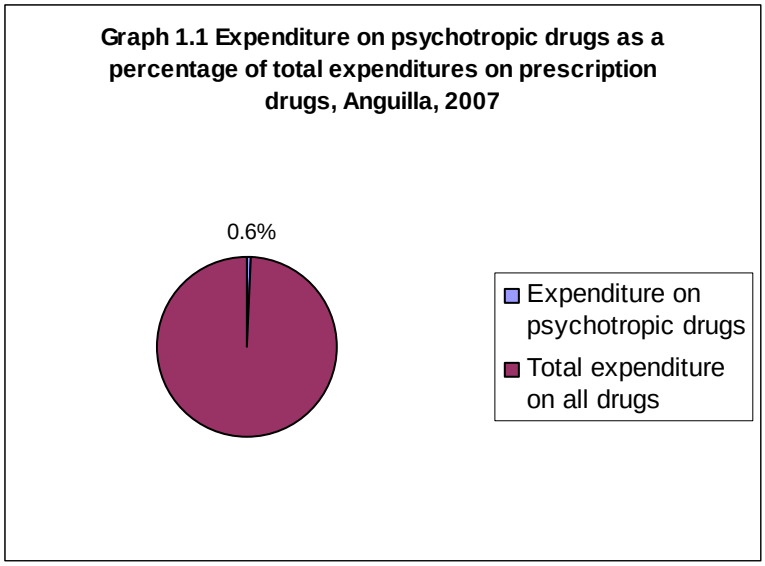
Human rights policies

There was no national human rights policy or human rights review body to assess the human rights protection of users of mental health services in Anguilla. Consequently, none of the community-based mental health treatment facilities ever had an external review/inspection of human rights protection of patients nor had mental health staff been trained in this area. No mechanisms were in place to impose sanctions on facilities or persons who violate patients' rights. The appointment of a review panel is discussed in Part 6 of the 2006 Mental Health Act. The purpose of the review panel is to hear applications on matters related to: competence to make treatment decisions; objection to treatment; application for hearing regarding certificates (admission and renewal); and review of certificates after six months.

Financing of mental health services

The national public health appropriation in 2007 was EC$17 million. The Ministry of Social Development devolved the operational delivery of all health services to The Health Authority of Anguilla (HAA), a statutory body. The HAA received a government subvention for the financing of health care services which include mental health. The HAA's accounting system could not extrapolate an estimate of the Authority's expenditure on mental health services. "Mental health" was subsumed under "community health" and the corresponding budget was not further disaggregated. The only line item relevant to mental health was the salary for the community mental health nurses. The Government of Anguilla earmarked EC$300,000 for completion of a 10-bed inpatient psychiatric unit at the Princess Alexandra Hospital.

There were no social insurance schemes. Notwithstanding, all persons with mental illnesses had free access to antipsychotics, anxiolytics, antidepressants, mood stabilizers, and antiepileptic drugs. Expenditure of prescription drugs in the public sector was EC$1,491,769 in 2007; of this amount, EC$8,538 was spent on psychotropic drugs.



Domain 2: Mental Health Services

Organization of mental health services

There was no mental health authority in the country or a director of mental health programs. Two mental health nurses and the visiting consultant psychiatrist formed the core of the mental health service delivery system in Anguilla. Community mental health services are organized in terms of catchment/service areas.

Mental health outpatient facilities

There were no outpatient facilities exclusively for treatment of persons with mental illness. Primary health care services were provided in the three health districts through four health centers and one polyclinic. Core mental health services were provided in three of these health centers. The mental health nurses and the primary health care physicians managed the assessment and treatment of persons with mental health illness. During scheduled visits to Anguilla, the visiting consultant psychiatrist reviewed assessed patients, and reviewed/updated case notes. Emergencies were referred to the Princess Alexandra Hospital. In the absence of a mental hospital or other inpatient facility, Her Majesty's Prison continued to be used as a place of safety for the mentally ill.
There were no outpatient mental health facilities or services exclusively for children and adolescents. In 2007, three children were assessed and treated in the community health centers. A social worker was assigned on a part-time basis to the health centers and a few mentally ill patients received psychosocial intervention. Psychosocial counseling was

also carried out by the two mental health nurses. These nurses conducted home visits and assisted their clients through the social service administrative processes. In 2007, a total of 128 clients were assessed, treated, and counseled in the three community health centers. Forty-seven percent (60) were females. Six percent (8) had mental and behavioral disorders due to psychoactive substances; 51% (65) had schizophrenia and other related disorders; 12% (15) had mood affective disorders; 15% (19) had neurotic, stress-related and somatoform disorders; 1% (1) had disorder of adult personality and behavior; and 16% (20) had other mental illnesses.

Day treatment facilities

No day treatment facilities existed in Anguilla.

Community-based psychiatric inpatient unit

No community-based psychiatric inpatient units existed in the country. Persons with acute mental illness who required hospitalization are assessed, admitted, and treated in the medical ward at the 31-bed Princess Alexandra Hospital. There were no beds designated for psychiatric patients. There was no trained mental health staff assigned to the hospital. During scheduled visits to Anguilla, the visiting consultant psychiatrist assessed patients and the community mental health nurse monitored their day-to-day management and provided psychosocial counseling.

The data presented under the rubric "community-based inpatient psychiatric unit" reflects an analysis of the discharges from the Princess Alexandra Hospital in 2007. Twenty-eight clients (20 males and 8 females) with mental disorders were admitted to the Princess Alexandra Hospital with total length of stay of 89 days, averaging 3.2 days per discharge. There were two adolescent males (ages 14 and 16 years). Thirty-nine percent (11) of the admissions were diagnosed with substance abuse; 18% (5) with mood affective disorders; 14% (4) with schizophrenia and related disorders and 4% (1) with neurotic stress related disorders. Twenty-five percent (7) fell in the category "other mental illnesses."

There were two mentally ill patients who, in the distant past, required hospitalization. They were sent to Antigua, (another island in the Eastern Caribbean), for hospitalization. To date, they are confined in that country's psychiatric hospital with their related expenses covered by the government of Anguilla. The hospital's pharmacy had at least one psychotropic medicine of each class (antipsychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines).

Community-based residential facilities

There were no community based residential facilities. However, Tender Loving Care, a home for elderly persons, housed one female with psycho-geriatric problems.

Mental Hospital

There was no mental hospital in Anguilla.

Forensic and other residential inpatient units

There was no forensic or other residential inpatient unit in the country. There were four inmates with psychiatric illnesses among the prison population. Their psychiatric care and treatment were managed by the visiting consultant psychiatrist and the community mental health nurses who visited the prison on a daily basis to administer medications. No residential facilities existed for persons with mental retardation or substance abuse problems.

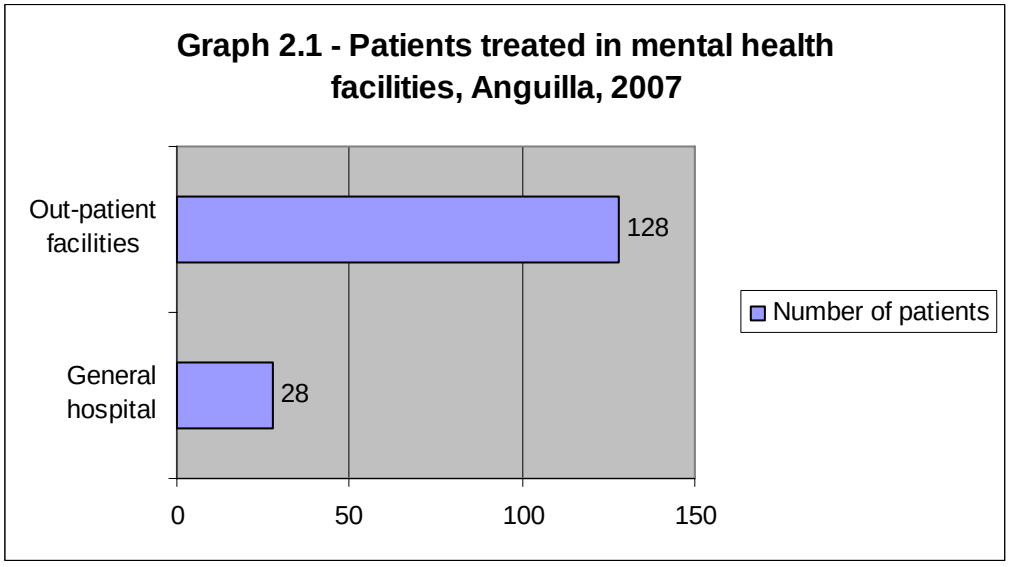
Human rights and equity

Data were not recorded on admission status (voluntary or involuntary admission) or on use of restraint or seclusion. According to best estimates by the health information unit, almost all admissions were involuntary and restraint and seclusion was used if the patient was combative.

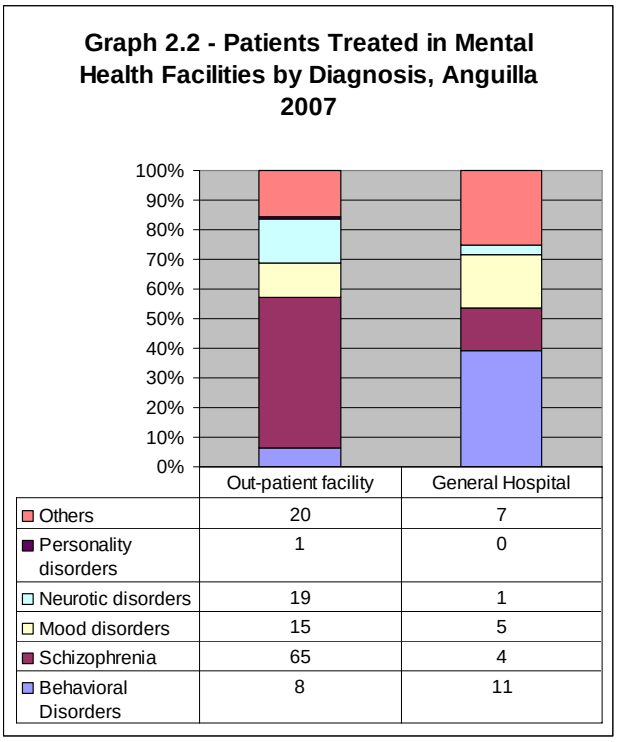
Summary charts

Summary for Graph 2.1

The majority of patients were treated in the three primary health care clinics (outpatient facilities)

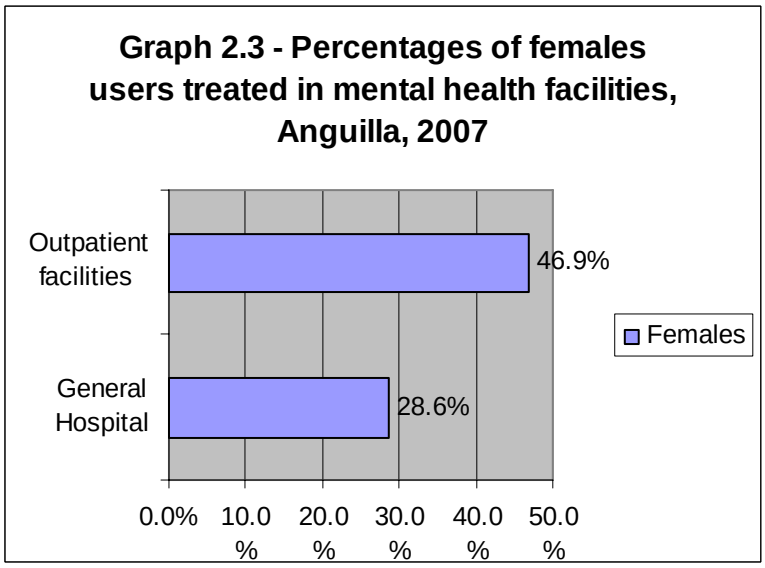


Summary for Graph 2.2
The majority of mentally ill persons in Anguilla carried a diagnosis of schizophrenia (69 patients or 44%), followed by mood and neurotic disorders (20 each or 13%); and 12% (19) had mental and behavioral disorders. Other related diagnoses accounted for 18% (28).

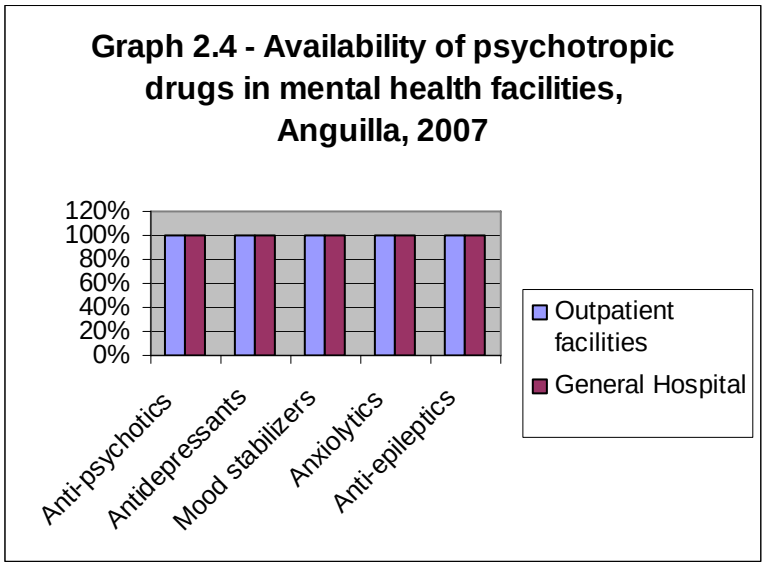


	Out-patient facility	General Hospital
Others	20	7
Personality disorders	1	0
Neurotic disorders	19	1
Mood disorders	15	5
Schizophrenia	65	4
Behavioral Disorders	8	11

Summary for Graph 2.3
Of the 128 persons who sought treatment in the primary health care setting, 60 were females; 8 females were among the 20 persons who required hospitalization.



Summary for Graph 2.4
At least one medication from each class of psychotropic drugs was available in all inpatient and outpatient facilities. The purchase of drugs is centralized through the Regional Organization of Eastern Caribbean States Pharmaceutical Procurement Services (OECS/PPS) which allows drugs to be purchased at competitive prices. However, a limited amount of drugs was purchased directly from overseas vendors.



Domain 3: Mental Health in Primary Health Care

Training in mental health care for primary care staff

The seven primary care physicians were educated in different countries outside the English-speaking Caribbean. Data were not available with respect to the number of hours devoted to mental health in their respective curricula. None of those physicians had at least two days of refresher training in any aspect of mental health.

Approximately 3% of the training hours for registered nurses was devoted to mental health. Two (15%) of the 13 primary health care nurses had at least two days refresher training in psychiatry/mental health. None of the non-doctor/non-nurse primary health care workers received continuing education training in mental health.

Mental health in primary health care

The majority of persons received mental health treatment in the primary health care system. All primary health care clinics are physician-based and none had assessment and treatment protocols for key mental health conditions. Referrals were made from the physician-based primary health care clinics and there was interaction between the primary health care physician and a mental health professional but not on a monthly

basis. None of the primary health care clinics or the Princess Alexandra Hospital had interaction with a complimentary/alternative/traditional practitioner.

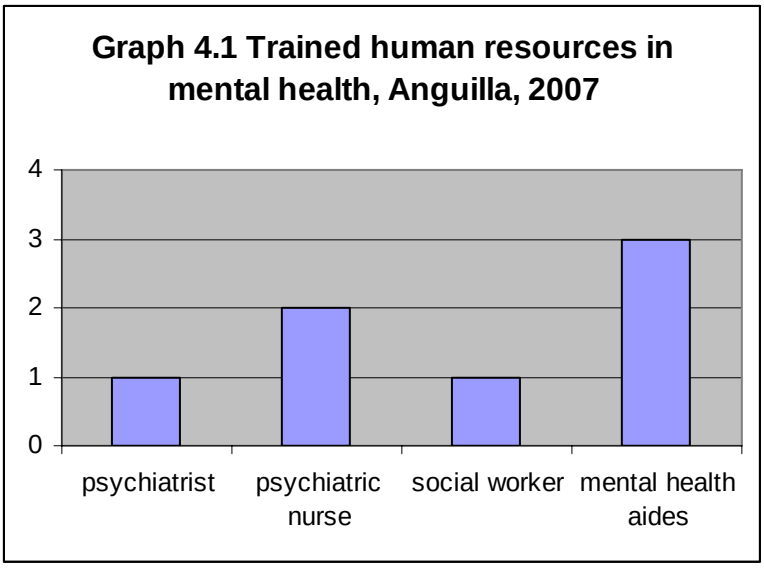
Prescription in primary health care

Health regulations do not authorize nurses and non-doctor/non-nurse primary health care workers to prescribe psychotropic medications. Primary health care doctors are allowed to prescribe psychotropic drugs without restrictions. All physician-based primary health care clinics and Princess Alexandra Hospital had access to at least one psychotropic medication of each therapeutic category (that is, antipsychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic).

Domain 4: Human Resources

Number of human resources in mental health care

There was 9 staff working in the area of mental health in Anguilla. There was one visiting consultant psychiatrist (from Barbados) who visits the island on an average of four times per year. During a typical four-day visit, he spent approximately 50% of his time in the primary health care centers; the remaining time on-island was spent among the prison, home visits, school consultations, and administrative matters. In addition there was one (1) internist *not specialized* in psychiatry/mental health (assigned to the general hospital); one (1) primary health care physician; two (2) trained psychiatrist nurses; one (1) part-time social worker; and three (3) mental health aides. There was no psychiatrist with private practice in the island. There were no psychologists or occupational therapists. There was no trained mental health professional at the Princess Alexandra Hospital. Assessment, care, and treatment of mentally ill persons who are admitted to the hospital were done by the internist (not trained in psychiatry) in consultation with the community mental health nurses. If warranted, the visiting consultant psychiatrist might further assess the patient during his routine visit to Anguilla.



Training professionals in mental health

There were no training programs at the national level to train physicians, mental health nurses, social workers, or occupational therapists. The cadre of nurses in the public sector was trained in the CARICOM Region. The two community mental health nurses must attend at least thirty hours of continuing education activities annually. Most of the physicians were trained outside of the Region (Philippines, Cuba and the U.S.A.); only one was trained in Jamaica. The consultant psychiatrist was trained in the U.S.A. No mental health professional graduated from an academic or educational institution in 2007. None of the mental health professionals participated in a refresher course that addressed: the rational use of psychotropic drugs, psycho-social (non-biological) interventions, or child and adolescent mental health issues. No psychiatrist emigrated from the island within 5 years of completion of overseas training.

Consumer and family associations

There were no user/consumer or family associations. No non-governmental agency was involved in the drafting of policies, legislation, mental health advocacy, or provided community and individual assistance (such as counseling, housing, or supportive services) for the mentally ill.

Domain 5: Public Education and Links to other Sectors

Public education and awareness campaigns on mental health

There were no coordinating bodies that oversee public education and awareness campaigns on mental health or mental disorders. The mandate of the inactive Anguilla Mental Health and Physical Disabilities Association is to unify efforts in the community to establish an effective system of mental health and disabilities services. The community mental health nurses had, from time-to-time, promoted public education and awareness

activities targeting the general public, children, adolescents, and women. Similar activities targeted professional groups such as teachers, and social services staff.

Legislative and financial provisions for persons with mental disorder

There were no legislative provisions concerning: a) legal obligation for employers to hire a certain percentage of employees that are disabled; b) protection from discrimination (dismissal, lower wages) solely on account of a mental disorder; c) financial provisions concerning priority in housing and in subsidized housing schemes for people with mental disorders; and d) protection from discrimination in allocation of housing for people with severe mental disorders.

The Dependent Adults Act, 2005 and the Dependent Adult Regulations, 2005 made by the Governor in Council and enacted by the Legislature of Anguilla, provide for guardianship of the persons of dependent adults and trusteeship of their estates and to provide generally for related matters.

The Hospitals and Poor Relief Act, 2004 under the Revised Statutes of Anguilla, Chapter H5 defines "poor and destitute persons" as "any and every person, who, by reason of infancy, old age, illness, disease, bodily infirmity, or mental incapacity, is unable to maintain himself or herself.[2] These two Acts indirectly benefit persons who are mentally ill.

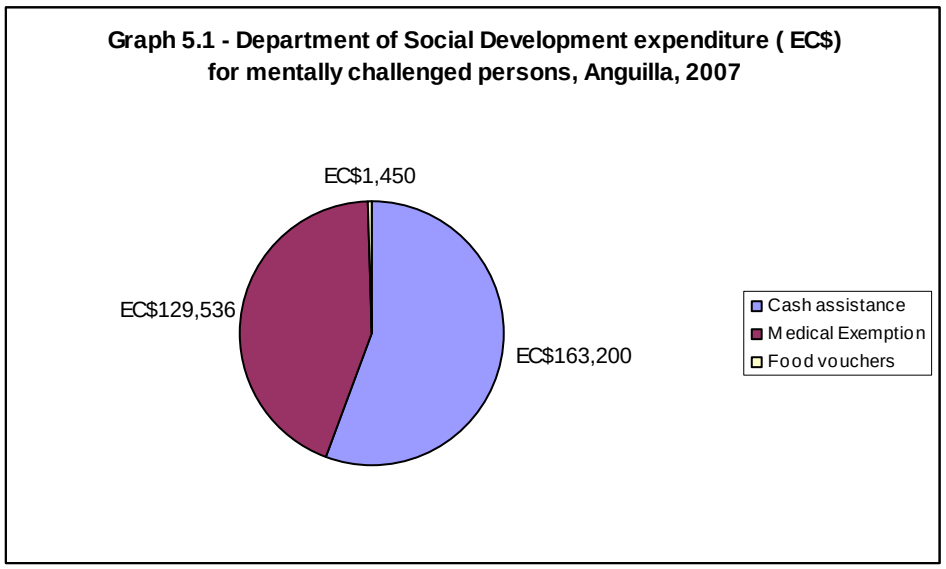
Links with other sectors

There were some formal collaborative programs with the department/agency responsible for primary health care/community health, reproductive health, child and adolescent health, education, welfare, and criminal justice. There were no mental health professionals assigned to either the primary or secondary schools. However, there was an educational psychologist that served the one secondary school and the 8 primary schools. In addition, there were three guidance counselors in the secondary school and one serving the primary schools. During scheduled visits to Anguilla, the consultant visiting psychiatrist met with the school psychologists to evaluate particular students.

Approximately 21-50 % primary and secondary schools had school-based activities to promote mental health and prevent mental disorders. The percentage of prisoners with psychosis was estimated to be less than 2% and none with mental retardation. Regarding mental health activities in the criminal justice system, the single prison had at least one prisoner per month in treatment contact with a mental health professional. As for training, a few (1-20%) police officers and no judges and lawyers had participated in educational activities on mental health in the last five years. Under the Hospitals and Poor Relief Act, 2004, the Department of Social Development is authorized to "grant relief to each poor and destitute person (not being an inmate of any hospital) who is unable to keep

[2] Revised Statutes of Anguilla, Chapter H5, Hospitals and Poor Relief Act, 2004, printed in the Attorney-General's Chambers, Anguilla.

himself and has no means of support, an allowance not exceeding such sum as may from time to time be fixed by the Governor in Chamber.[3] Under the provisions of this Act, the Department of Social Services actively seeks to assist persons with mental disorders providing them with social welfare benefits. The Department of Social Development provided assistance in the form of cash, medical exemptions, and food vouchers to fifty-two persons with some form of disability. Of these, thirty-three persons (63%) received assistance only because they were disabled due to mental disorders. The figures for 2008 provide the "best estimate" of the funds spent by the Department for mentally challenged persons. A total of EC$1,948,974 was spent on all persons receiving welfare benefits. Of this amount, EC$294,186 (15%) went to mentally challenged, unemployed persons: 56% for cash assistance, 44% for medical exemption, with a negligible percentage for food vouchers.



Domain 6: Monitoring and Research

There were no formally-defined list of individual data items that ought to be collected by the mental health facilities. The Princess Alexandra Hospital routinely collected and compiled data on the number of inpatient admissions, number of days spent in hospital and diagnoses but not on involuntary admissions or number of users who were physically restrained or secluded. The community health clinics routinely collected data on the number of users treated and diagnoses, but not on number of user contacts.

The government health department does not receive reports from the facilities that treat mentally ill patients. No report covering mental health was published by the government. No mental health professional was involved in mental health research or mental health research conducted in the last five years.

[3] Ibid.

Next Steps in Strengthening the Mental Health **Domain 6**

The Mental Health Unit at the Princess Alexandra Hospital accommodates ten beds for the acutely ill mentally disordered patients. This unit has not been fully commissioned as yet; however, it is in operation since June 2009. Standard operating procedures and protocols for hospitalization and treatment of the mentally disordered patients were developed in accordance to the Mental Health Act 2006. These procedures and protocols are awaiting approval and an effective implementation date.

The present Mental Health policy is due an update and revision. To be included in the revised policy will be:

- Needs assessment data
- Vision, Mission, Core Values and Objectives
- Mental Health promotion and prevention
- Early intervention
- Substance abuse including alcohol
- Psychosocial rehabilitation
- Partial hospitalization
- Rights protection and advocacy
- Medication and monitoring

Advocacy for ongoing national support for Mental Health Reform is required and should include Human Resources and Training, Quality Improvement and the development of National Quality standards for Mental Health Care and Organization of mental health services.

A Comprehensive Health Information system is being developed to capture essential health data from all levels of the Health care system. The Mental Health Information system will be integrated into the Health Information System and will be used to monitor and evaluate mental health services on the island.

A list of suitably qualified persons for the advisory committee is being formulated. Terms of Reference are being developed to guide the workings of the committee. This will be submitted shortly for approval and subsequent implementation.

Following the completion of the Mental Health Policy a Mental Health Plan will be developed to guide the mental health programmes within the Anguillian community. Priority areas being Mental Health Promotion and prevention, integrated community services, mental Health Information System, Alcohol and substance abuse.

Technical assistance is required from PAHO with the National Mental Health needs assessment survey of the Anguillian population. A fellowship is requested for a degree in mental health nursing and attachments for junior mental health nurses and officers.

The World Health Organization Assessment Instrument for Mental Health (WHO-AIMS) was used to collect information and format the report on the mental health system in Anguilla. This evidence-based assessment has helped the government to focus its plans and activities to meet priority targets for improving the mental health system.

The Mental Health Policy is dated 2005 and the Mental Health Act, October 2006. The Health Authority of Anguilla is responsible for the financing of health care services; mental health is subsumed under the component area of "community health." In 2007, there was no dedicated budget for mental health services.

There is no mental hospital—care is community-based with a visiting consultant psychiatrist and a mental health team responsible for mental health service delivery. The majority of patients were diagnosed with schizophrenia; psychotropic medications are widely available.

The obstacles to a comprehensive package of services for the mentally ill are being addressed and since 2007, much has been done to improve service delivery and protect the human rights of persons with mental illness. In 2009 an inpatient psychiatric unit which serves the acutely mentally ill was commissioned. A Mental Health Review panel has also been established to hear applications regarding patient competency, objection to treatment and detention.

The way forward will include the revision of the Mental Health Policy and the development of a comprehensive Mental Health Plan.