

WHO-AIMS

WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
IN SAINT VINCENT AND THE
GRENADINES



World Health
Organization



MINISTRY OF HEALTH
SAINT VINCENT AND THE GRENADINES

**WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
IN SAINT VINCENT AND THE GRENADINES**

Report of the Assessment of the Mental Health System in Saint Vincent and the Grenadines using the WHO-AIMS Instrument for Mental Health Systems (WHO-AIMS)

Saint Vincent and the Grenadines
2009

The data was collected in 2009 based on data for 2007



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The WHO-AIMS project is coordinated by Shekhar Saxena.

Executive summary

Saint Vincent and the Grenadines is an archipelago of islands and islets located in the Eastern Caribbean. The main inhabited islands are Saint Vincent (the mainland), Bequia, Mustique, Union Island, and Canouan. In 2007, the total population was estimated at 100,237.

The World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information and structure the report on the mental health system in Saint Vincent and the Grenadines. The overall goal of this process is to provide an objective assessment of the system on 6 domains: policy and legislative framework; mental health services; mental health in primary health care; human resources; public education and links with other sectors; and monitoring and research.

There is no mental health policy; there is a draft mental health plan (2002). The Mental Health Act was legislated in 1989 and amended in 1991. The primary source of mental health financing is tax-based. In 2007, approximately 5% of the national health expenditure was directed towards the 160-bed Mental Health Center, the sole mental health hospital and the entity responsible for delivery of mental health services. One hundred percent of the population has free access to at least one psychotropic medication of each therapeutic category (anti-psychotic, anti-depressant, mood stabilizer, anxiolytic, and antiepileptic). Primary health care physicians are allowed to prescribe or continue use of psychotropic medicines. No human rights policy or human rights review body exists. None of the mental health treatment facilities ever had an external review/inspection of human rights protection of patients with mental disorders and no mental health worker received training in this area.

In the absence of a mental health authority in the Ministry of Health, the Chief Medical Officer and one psychiatrist provide advice to the government on matters related to mental health care.

Mental health care is not integrated with primary health care. Community-based mental health services are delivered by staff from the Center through scheduled clinics in five locations and home visits. There are no specialist services for children and adolescents with mental disorders. The majority of users treated in the outpatient setting were diagnosed with schizophrenia and related disorders. No psycho-social intervention is available in the outpatient setting. There are no day treatment facilities, community-based psychiatric inpatient unit, or community residential facilities for person with mental disorders. Patients with acute psychiatric disorders are admitted to the 190-bed Milton Cato Memorial Hospital (MCMH) where there are no trained mental health workers; the care of mentally ill patients is managed by the Center's staff. None of the beds at the MCMH are reserved for children and adolescents.

The Mental Health Center has 159.6 beds per 100,000 population; no beds were designated for children and adolescents. There were 381 admissions in 2007; the two diagnostic groups that dominated were: schizophrenia and related disorders (71%) and mental and behavioral disorders due to psychoactive substance use (24%). Of the 130 long-stay patients, 58% spent more than 10 years in the institution and 23% spent 5-10 years. Two forensic patients are institutionalized in the Center at “Her Majesty’s Pleasure.”

There were 47 human resources in mental health per 100,000 population. In 2007, there were 2 psychiatrists in the country. The entire cadre of trained mental health workers is concentrated at the Center. None of the primary health care physicians, nurses, of non-doctor/non-nurse primary health care workers received at least two days of refresher training in any aspect of psychiatry/mental health. One physician (not specialized in psychiatry) had at least two days of refresher training on psychosocial (non-biological) interventions. No other mental health worker participated in that refresher training. No mental health worker had refresher training in the rational use of psychotropic drugs or child/adolescent mental health issues.

No consumer or family associations exist. NGOs, such as the Marion House (a center that provides substance abuse counseling), the Salvation Army, and catholic churches provide services for vulnerable populations that include persons with mental illness. There are no programs to provide employment for persons with mental disorders outside the mental health facility. Legislative provisions prohibit discrimination against persons with physical and mental disabilities in employment, education, access to health care, and the provision of other state services.

Except with the agency responsible for criminal justice, the agency responsible for mental health has no forged no formal links with other relevant sectors. No primary or secondary school has a trained mental health counselor.

There was no formally-defined list of individual data items that ought to be collected by mental health facilities. Data are not collected on number of involuntary admissions or number of users who are physically restrained and/or secluded. The Center is the repository for the records for its users as well as for those who are treated in the community. The mental health data generated at the Milton Cato Memorial Hospital is included in the hospital’s computerized data base. The sources of mental health data are not merged and analyzed to inform public policy and decision-making for reform of mental health services. In the last five years, a study was conducted in the country on “The Epidemiology of first-episode psychosis in Saint Vincent and the Grenadines.” No mental health publications on the country exist in indexed journals.

The priority next steps to reform the mental health services will include development of a mental health policy and plan; training; identification of a core set of mental health indicators for data collection; development of a mental health information system; securing the services of a child psychiatrist and/or child psychologist; and securing a part-time medical records officer for the mental hospital.

Background

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was developed by the Evidence Research team of the Department of Mental Health and Substance Abuse, World Health Organization (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 Saint Vincent and the Grenadines. Data was collected in 2009 and is based on the year 2007.

One week was assigned for the data collection phase. (June 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 respondents: 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 (located in Grenada), prior to the consultant's arrival in Saint Vincent and the Grenadines.
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 Saint Vincent and the Grenadines.
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 WHO-AIMS recommended format was used to prepare the draft report which was 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

There is no reporting system to compile and analyze the wealth of patient-related mental health data that are available at the Mental Health Center, the country's only psychiatric inpatient hospital and the institution responsible for community-based mental health services. There is no pre-defined minimum data set to guide the collection of mental health information. No annual reports were available and there was no information on mental health services in the Health Information Unit, Ministry of Health. In the absence of a health information system/computerized data base, the nursing staff, a medical records officer, and the consultant reviewed log books, patients' charts and processed the data manually. For this report, the clinical diagnoses were also coded manually using the International Classification of Diseases, Tenth Revision (ICD-10).

Taking these constraints into consideration and the expedience with which the data was required, the information herein best reflects the characteristics of the mental health service delivery system in Saint Vincent and the Grenadines.

Introduction

Saint Vincent and the Grenadines is an archipelago of islands and islets located in the Eastern Caribbean. Its geographic coordinates are 13° 15 N, 61° 12 W. These islands and islets are situated between the Atlantic Ocean and the Caribbean Sea, north of Trinidad and Tobago. Saint Vincent, the mainland, is 133 square miles while the Grenadine islands have a total of 17 square miles. Bequia, Mustique, Union Islands, and Canouan are the main inhabited islands. The capital is Kingstown which is located on Saint Vincent's southwest coast. In 2007, the population was estimated at 100,237.

Saint Vincent and the Grenadines gained political independence from the United Kingdom in October 1979. The State is governed under a parliamentary democracy within the British Commonwealth. There is a Governor-General, Prime Minister, and a Cabinet. The parliament consists of the politically-appointed Senate and the elected House of Representatives.

Saint Vincent and the Grenadines depends heavily on agriculture as a main source of income. Its chief exports are bananas, fruits, vegetables, and arrowroot. Much of its workforce is employed in the agriculture and tourism sectors. Remarkable economic achievements took place over the past six years within a wider context of deepening and broadening democracy; enhancing good governance; revolutionizing education; uplifting the conditions markedly in the areas of housing, health, the environment, sports, culture, technology, the utilities, air access and air transportation, maritime administration, and the maintenance of law and order. ¹The currency is the Eastern Caribbean dollar (EC\$) which is pegged to the United States dollar at US\$1=EC\$2.67.

Saint Vincent and the Grenadines is a member of several international organizations and agencies such as the Organization of Eastern Caribbean States (OECS), the Caribbean Community (CARICOM), the International Monetary Fund (IMF), the World Trade Organization, the United Nations (UN), and the World Health Organization (WHO).

In 2007, the crude birth rate was 18.2 births per 1,000 population and the crude death rate was 7.8 deaths per 1,000 population. Life expectancy at birth was 69.7 years for males and 74.0 years for females. Total fertility rate was 2.2 children per woman and infant mortality rate was 18.7 deaths per 1,000 live births.

The Ministry of Health has overall responsibility for the population's health and wellbeing. Public sector health care is delivered through 6 public hospitals, 3 privately-owned hospitals, and 39 outpatient clinics. All health centers service catchment areas and are easily accessible to their target populations. The Mental Health Center (MHC) is the only psychiatric hospital that provides psychiatric services in the country. It is also responsible for community mental health services that are delivered through 5 primary health care clinics and home visits.

¹ Saint Vincent and the Grenadines. Prime Minister and Minister of Finance 2007 Budget Address, December 2007.

Domain 1: Policy and legislation

Policy

There is no mental health policy. A draft proposal entitled “Strategic Choices for a mental health policy for Saint Vincent and the Grenadines” dated 1998 (Allan McNaught, 1998) outlines options for consideration in the formulation of a national mental health policy.

Plan

There is no mental health plan. In 2002, the Pan American Health Organization facilitated a multi-sectoral workshop to prepare a draft national Mental Health Plan 2003-2008. The goal of the plan is to reduce the burden of mental diseases in Saint Vincent and the Grenadines. The plan includes: objectively verifiable indicators, means of verification, assumptions, activities, and inputs/resources. At that time, the total cost for this 6-year plan was estimated at EC\$3,588,450.00 (US\$1,354,132.00). The proposed draft plan did not include indicators related to development of community mental health services, development of a mental health component in primary health care, human rights protection of users, time-frame, and monitoring and evaluation. This plan was never revised, finalized or used to guide service delivery.

There is no mental health disaster plan. The draft Mental Health Disaster Plan (2006) establishes a set of procedures to manage effectively and efficiently any disaster or emergency that occurs at the Mental Health Center, the sole inpatient mental health hospital in the country. In addition, there is a Mental Health Center Disaster Preparedness Committee that includes a cross-section of internal and external human resources and their assigned roles in the event of a disaster or emergency.

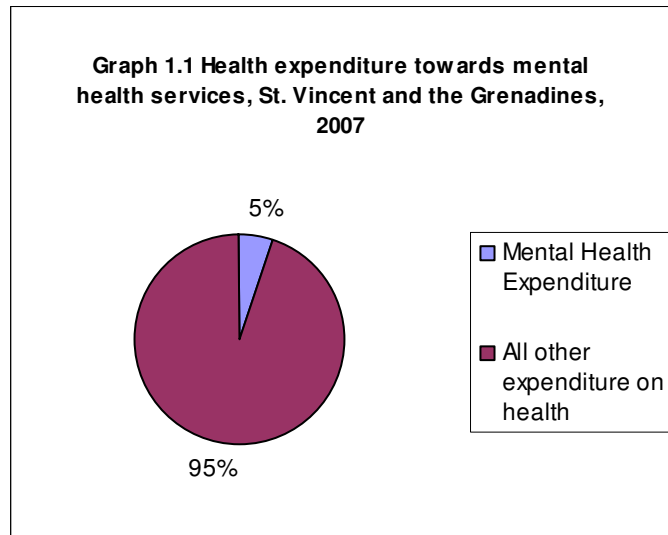
Legislation

The Mental Health Act, which was legislated in 1989 and amended in 1991, is enshrined in the Laws of Saint Vincent and the Grenadines, Revised Edition (1990), Chapter 228. The sections of the Act are: Part I, Admission to psychiatric hospital; Part II, Mental Review Board; Part III, Approved Homes; Part IV, Protection of Property of Persons Suffering from Mental Disorder; and Part V, Miscellaneous. The Act does not include: access to the least restrictive care; rights of mental health service consumers, family members, and other care givers; accreditation of professionals and facilities; mechanisms to oversee involuntary admission and treatment practices; and mechanisms to implement the provisions of the mental health Act. No standardized documentation (instruments or forms) is included in the Act.

Financing of mental health services

The primary source of mental health financing is tax-based. Five percent of the national health care expenditure by the Ministry of Health was directed towards the Mental Health

Center (MHC). Patients suffering from mental disorders received care through public disability benefits. No national data were available to show the extent of use of private mental health service providers and out-of-pocket spending on these services. One hundred percent of the population had free access to essential psychotropic medicines in the categories of anti-psychotics, antidepressants, anxiolytics, mood stabilizers, and anti-epileptic drugs.



Human Rights

There were no national-level or regional-level review bodies on human rights. The Mental Health Center never had an external review/inspection of human rights protection of patients. Part II of the Mental Health Act makes provision for a Mental Health Review Board. The Act states that: “the duties of the Board shall be to: a) review, not less than once a year, the case of every medically recommended patient who has been detained for more than one year; b) review every six months the case of every hospital order patient who has been detained for more than six months; c) consider every application made under Section 15*; inspect, not less than once a year, every psychiatric hospital, psychiatric ward and approved home; and e) carry out any other inquiry into mental health as the Minister may require.”² The referenced Board was never constituted. None of the human resources working in mental health had any exposure to training on the set of basic rights for the protection of persons with mental illness.

Domain 2: Mental health services

² Government of St. Vincent and the Grenadines, Laws of Saint. Vincent and the Grenadines, Revised Edition 1990, Chapter 228, Mental Health Act, page 10.

*Section 15 states that a person detained as a medically recommended patient, or any person on behalf of such patient, may apply to the Board of its review of its cases; it also outlines the courses of action at the Board’s disposal.

Organization of mental health services

There was no mental health authority in the country. The Chief Medical Officer and one psychiatrist functioned as the main authorities. They provided advice to the government on matters related to policy, legislation, service planning, and service management. Mental health services, at all levels, were delivered through the Mental Health Center.

Mental health outpatient facilities

There were no mental health outpatient facilities *per se*. The staff from the Mental Health Center conducted 5 outpatient mental health clinics. Two of these clinics were held monthly in primary health care centers; one held monthly in the prison; and two clinics were held weekly both at the general hospital and the Mental Health Center. Three hundred and sixty-six users attended the outpatient mental health clinics. The average number of contacts per user was 9. Of all the users treated in the mental health clinics, 37% were females; 3% were aged 17 years or younger. The majority of users treated in the outpatient mental health clinics were primarily diagnosed with schizophrenia and related disorders (68%) and mental and behavioral disorders due to psychoactive substances (20%). All outpatient mental health clinics had access to at least one psychotropic medicine of each therapeutic category (anti-psychotic, anti-depressant, mood stabilizer, anxiolytic, and antiepileptic). None of the outpatient mental health clinics offered psychosocial intervention.

Staff from the Mental Health Center visited routinely 293 persons (226 males and 67 females) in their homes. Of these, 185 were diagnosed with schizophrenia; 74 with schizophrenia and substance abuse; 7 with mental retardation; and 5 with mental retardation and substance abuse.

Day treatment facilities

There were no mental health day treatment facilities in the referenced year.

Community-based psychiatric inpatient unit

No community-based psychiatric inpatient unit existed in the country. Patients with acute psychiatric disorders were admitted to the general medical wards at the 190-bed Milton Cato Memorial Hospital (MCMH). Since there were no trained mental health professionals at MCMH, the staff from the Mental Health Center managed the care of patients admitted in that hospital. None of the beds at MCMH were reserved for psychiatric patients or for children and adolescents with psychiatric disorders. There were 196 admissions in 2007, averaging 7 admissions per month. Forty-three percent of the admissions to MCMH were females. Twenty-one users (17 females and 4 males) were 17 years or younger. The diagnoses on discharge from MCMH were primarily from the following three diagnostic groups: mental and behavioral disorders due to psychoactive substance use (40%); other mental disorders (30%); and schizophrenia and related disorders (14%). On an average, patients spent 4.4 days per discharge. None of the

patients received psychosocial interventions during the referenced year since the social worker was away on study leave. MCMH had at least one psychotropic medicine of each therapeutic category (anti-psychotic, anti-depressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

Community residential facilities

There were no community residential facilities in the country.

Mental Hospital

The 160-bed Mental Health Center (MHC) is the only psychiatric hospital providing mental health services to the population in the country for a total of 159.6 beds per 100,000 population. None of the beds in the Center were reserved for children, adolescent, or forensic patients. The discharge diagnoses for the 381 patients admitted to MHC belonged primarily to two diagnostic groups: schizophrenia and related disorders (71%) and mental and behavioral disorders due to psychoactive substance use (24%). One patient, under 17 years of age, was admitted in 2007. Children and adolescents were seldom hospitalized in MHC as focused efforts are made to manage them in the outpatient setting or to hospitalize them in the Milton Cato Memorial Hospital. A few (1-20%) of patients received one or more psychosocial interventions. MHC stocked at least one psychotropic medicine of each therapeutic class (anti-psychotics, anti-depressant, mood stabilizer, anxiolytic, and antiepileptic medicines).

There were 130 long-stay patients. Of these 58% spent more than 10 years; 23% spent 5-10 years; and 19% spent 1-4 years. The consensus was that the majority of long-stay patients can be managed in the community but having no sustained social, family, or community support system they accumulated in the Center. Institutionalization with pharmacotherapy prevailed for the indigent and homeless with chronic mental disorders. On average, 9 patients were admitted on a weekly basis and of these, 1 was usually a new admission.

Time constraints prevented the manual calculation of the cumulative number of days spent in hospital by all patients. MHC did not have a health information system, a computerized data base or a medical records officer.

Forensic and other residential facilities

There were no forensic inpatient units in the country. Forensic patients were integrated in the general population at the MHC. There were two forensic patients in the Center and they are institutionalized at “Her Majesty’s Pleasure.”

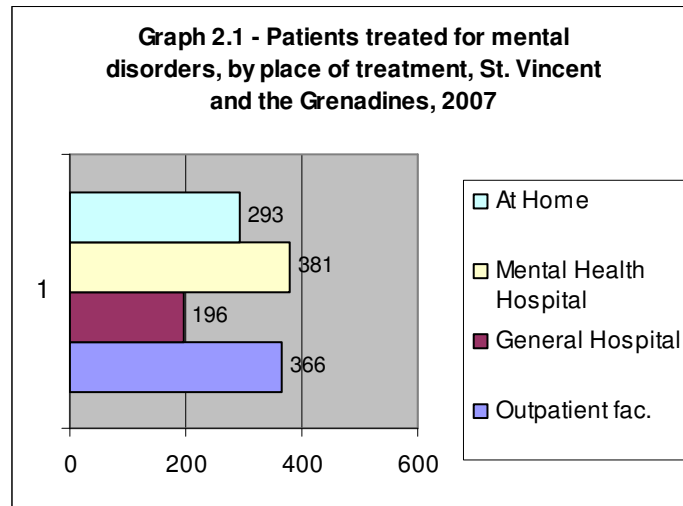
The Lewis Punnett Home is a residential home for the aged poor and its residents include the homeless, chronically infirmed, disabled, and mentally and physically handicapped persons. There were 102 residents and of these 21% were diagnosed with mental retardation and 9% with dementia. In addition, there were 6 private residential nursing

homes that cater to the elderly with chronic diseases including dementia. None of these institutions had beds assigned to persons with mental disorders.

Human rights and equity

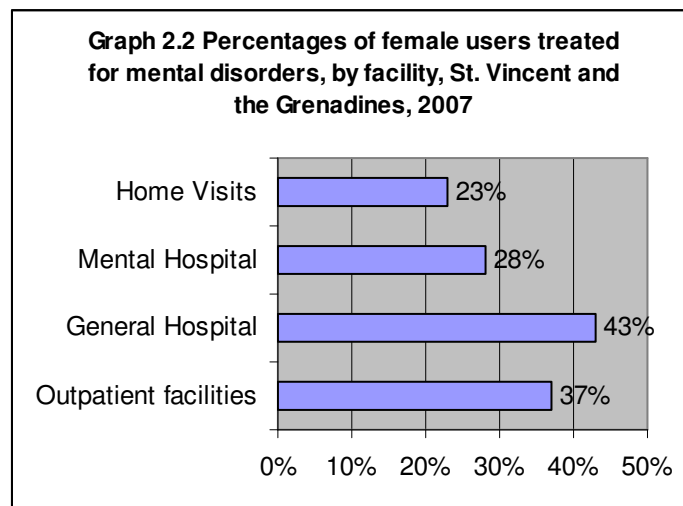
Data were not collected to indicate the proportion of involuntary admissions to Mental Health Center or the Milton Cato Memorial Hospital. Similarly, data were not collected on the percentage of patients who were secluded and/or physically restrained in these two institutions. One hundred percent of the psychiatric beds are located in the largest city. Inequity of access to mental health services based on service location, language, ethnicity, or religion is not an issue in Saint Vincent and the Grenadines.

Summary charts



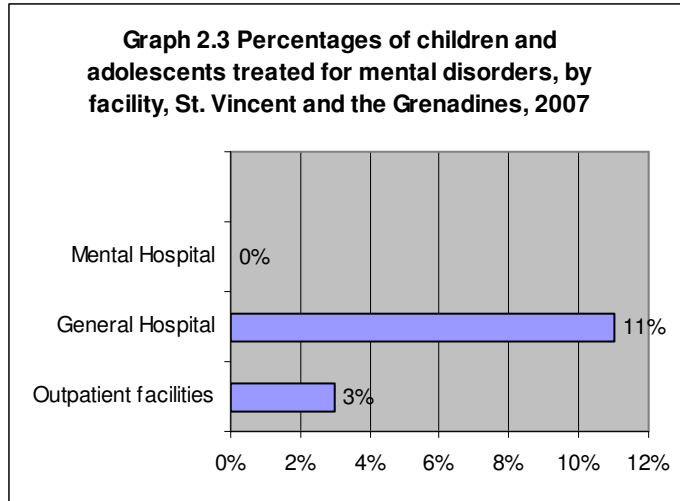
Summary for Graph 2.1

One thousand two hundred and thirty-six patients were treated for a variety of mental disorders in 2007. Almost the same percentage of persons was treated in the mental hospital (31%) as in the outpatient facilities (30%).



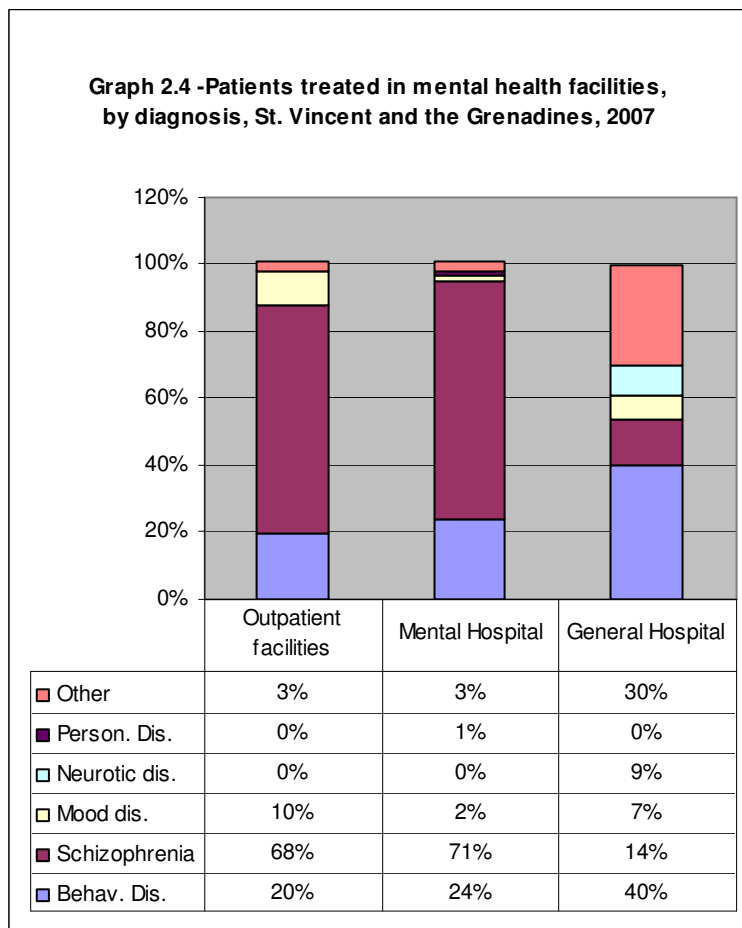
Summary for Graph 2.2

Females were less likely to be hospitalized in the Mental Health Center than males. The majority of women were treated in the acute-care and outpatient facilities.



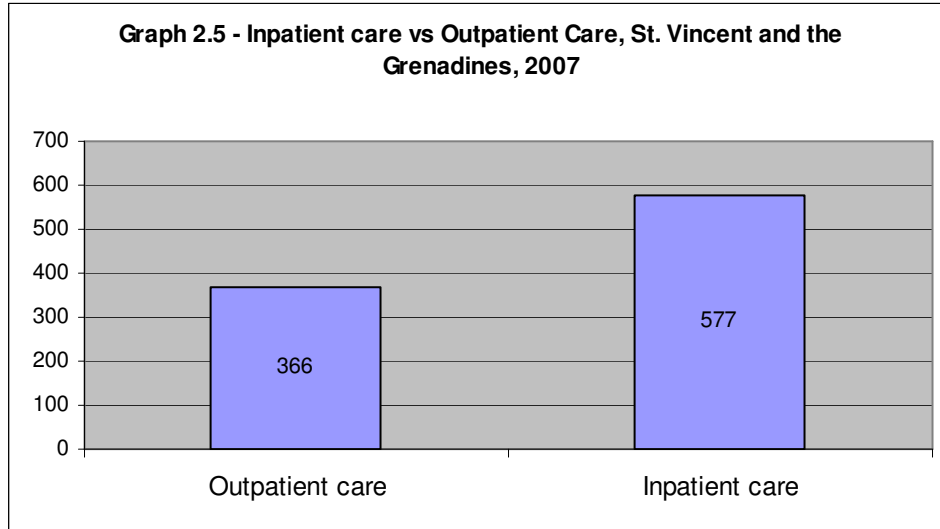
Summary for Graph 2.3

The mental health team preferred to hospitalize children and adolescents with mental disorders in the general hospital as opposed to the mental hospital. Only 1 adolescent was hospitalized in the Mental Health Center in 2007.



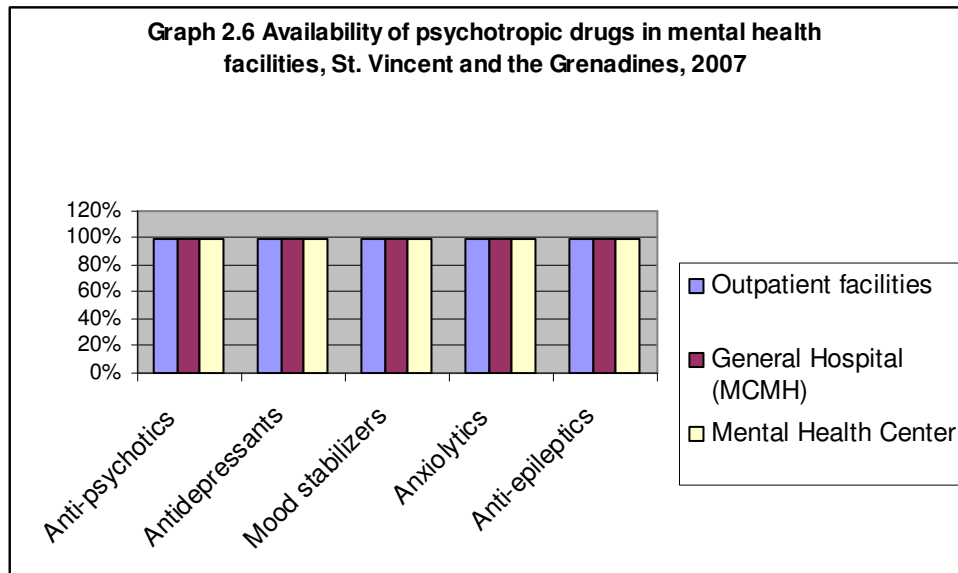
Summary for Graph 2.4

The majority of users assessed at the mental hospital and in the outpatient setting had a diagnosis of schizophrenia and related disorders whereas the majority of users treated in the general hospital had a primary diagnosis of mental and behavioral disorders due to use of psychoactive substances.



Summary for Graph 2.5

Mental health services are not fully integrated into the primary health care system. The lack of a well-resourced community-based mental health program supported a growth in the inpatient population.



Note: MCMH – Milton Cato Memorial Hospital

Summary for Graph 2.6

Psychotropic drugs are widely available in all types of facilities.

Domain 3: Mental health in primary health care

Training in mental health care for primary health care staff

Physicians who were trained at the University of the West Indies estimated that 1% of their training was devoted to psychiatry. Similar information was not available for the physicians who were trained in other countries such as the Philippines, India, and Cuba. Three percent of the registered nurses' training was devoted to mental health concepts and clinical practice. None of the primary health care physicians, nurses, or non-doctor/non-nurse primary health care workers received at least two days refresher training in any aspect of psychiatry/mental health.

Mental health in primary health care

Mental health clinics are offered at five sites: 2 primary health care centers, the prison, Milton Cato Memorial Hospital, and the Mental Health Center. None of the mental health clinic sites had assessment and treatment protocols for key mental health conditions. The burden of care for mental health services resided with one psychiatrist, nursing staff, and aides at the Mental Health Center. Between 21-50% of primary care physicians made on average at least one referral per month to a mental health professional. Similarly, 21-50% of primary health care physicians interacted with a mental health professional at least monthly in the referenced year. None of the physician-based primary health care centers or mental health facilities had interaction with a complementary/alternative/traditional practitioner. There are no non-physician-based primary health care centers. Although a primary care physician is not stationed full-time at the primary health care centers, he/she maintains full responsibility for the assessment, treatment, and follow-up care for all patients seen in these centers. Primary health care nurses cannot refer patients to the mental health services; such referrals are made by primary health care physicians

Prescription in primary health care

Primary health care physicians are allowed to prescribe and/or continue prescription of psychotropic medications without restriction. Nurses and non-doctor/non-nurse primary health care workers are not allowed this privilege. Psychotropic drugs of each therapeutic category (anti-psychotic, anti-depressant, mood stabilizer, anxiolytic, and anti-epileptic drugs) were available at almost all (81-100%) of sites where mental health clinics were scheduled.

Domain 4: Human resources

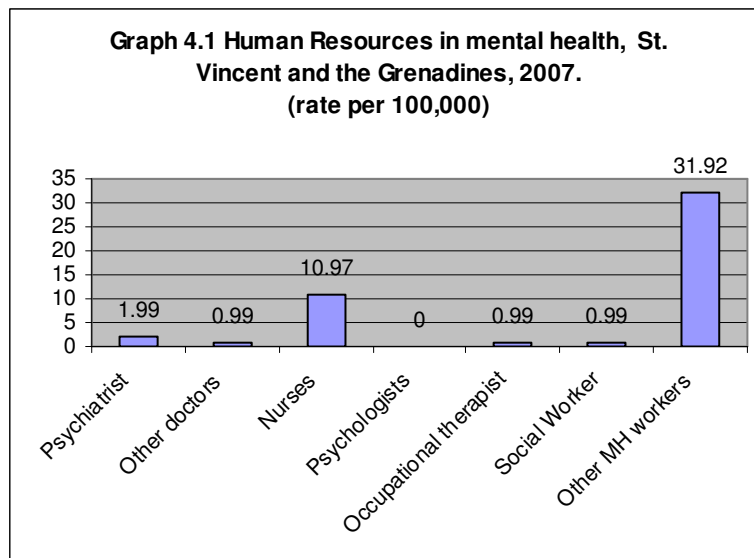
Number of resources in mental health care

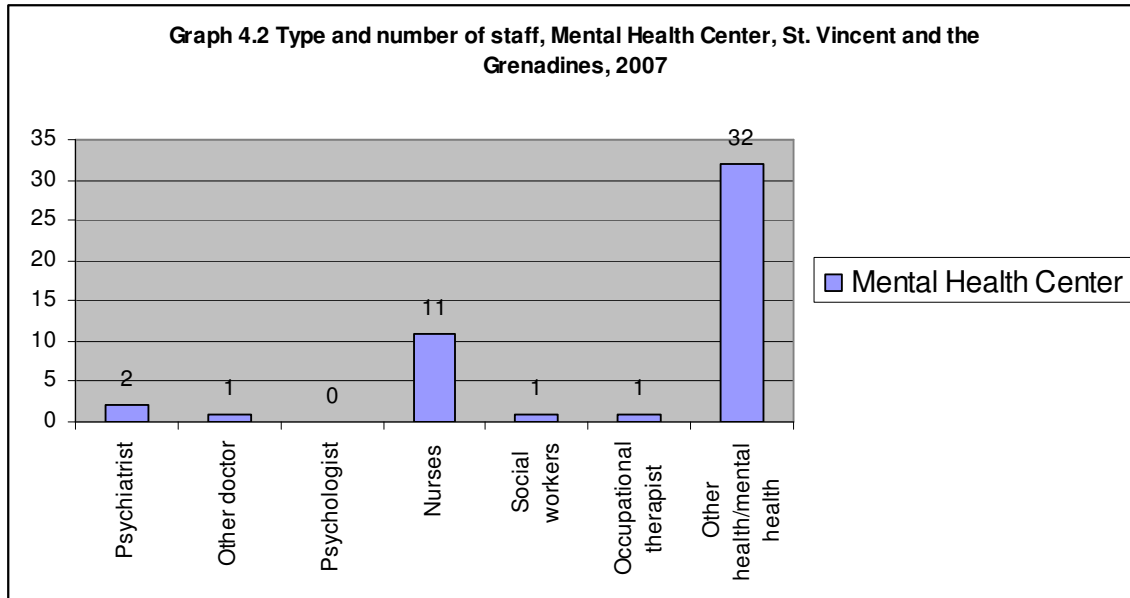
The total number of human resources working in the mental health facility or private practice per 100,000 was 47. The breakdown according to profession/per 100,000 population was as follows: 1.99 psychiatrists, 0.99 medical doctors, not specialized in

psychiatry; 10.97 nurses; 0.99 social workers; 0.99 occupational therapists (a volunteer) and 31.92 other health or mental health para-professionals. There were no psychologists in 2007. The psychiatrists worked for the government-administered mental health facility and in private practice.

One social worker, 11 nurses, and 1 occupational therapist were assigned to the Mental Health Center . The only mental health inpatient facility is located in the largest city and the number of mental health professionals per mental hospital bed was: psychiatrist, 0.01; other medical doctor, not specialized in psychiatry, 0.01; nurses, 0.07; social worker and occupational therapist, 0.01, and other health or mental health workers, 0.20.

No trained mental health workers were attached to the primary health care centers or the Milton Cato Memorial Hospital. Nine physicians, not specialized in psychiatry, rotated in the medical wards where persons with psychiatric and related disorders are admitted.





Training professionals in mental health

One nurse completed post-graduate training in mental health from an academic institution. In terms of refresher training, one medical doctor, not specialized in psychiatry, had at least two days of refresher training on psychosocial (non-biological) interventions. No mental health personnel attended refresher training in the rational use of psychotropic drugs and child/adolescent mental health issues. No psychiatrist emigrated from the country within five years of the completion of training.

Consumer and family associations

There were no user/consumer or family associations in the country. Marion House (a center that provides substance abuse counseling) as well as the Salvation Army and catholic churches' feeding programs for vulnerable groups benefited the mentally ill.

Domain 5: Public education and links with other sector

Public education and awareness campaigns on mental health

There were no coordinating bodies to oversee public education and awareness campaigns on mental health and mental disorders. The Ministry of Health promoted public education and awareness campaigns on mental health and mental disorders in the last five years. These campaigns targeted the general population, health care providers, teachers, and social services staff. Mental Health week is celebrated once per year to promote awareness about mental health issues.

Legislative and financial provisions for people with mental disorders

In 2007, there were no financial provisions for housing for people with mental disorders. Legislative provisions prohibit discrimination against persons with physical and mental disabilities in employment, education, access to health care, and the provision of other state services. The social welfare system provided support for persons with mental and physical disabilities but the proportion given to persons solely because of a disability due to a mental disorder could not be estimated.

Links with other sectors

The Ministry of Health had formal collaboration to address the needs of people with mental issues with the agency responsible for criminal justice; no formal collaboration existed with any health or other non-health sector. None of the primary or secondary schools had either a part-time or full-time mental health counselor. A few schools had either a part-time or full-time guidance counselor. Few (1-20%) of primary and secondary schools had school-based activities to promote mental health and prevent mental disorders. A few police officers (1-20%) participated in educational activities on mental health in the last five years, but no judges or lawyers participated in such activities. An estimated 2-5% of prisoners were diagnosed with a psychotic disorder and less than 2% with mental retardation. The sole prison had at least one prisoner per month in treatment contact with a mental health professional, either within the prison or in the community. There were no programs that provided employment for persons with mental disorders outside the mental health facility.

Domain 6: Monitoring and research

There was no formally-defined list of individual data items that ought to be collected by all mental health facilities. The Center is the repository for its users' records as well as for those who were treated in the community. The Center routinely collected data on number of beds, inpatient admissions, days spent in hospital, and diagnosis. It did not record data on the number of involuntary inpatient admissions or number of users who were physically restrained and/or secluded. The data generated by the Center and the clinics were recorded in log books but not compiled, analyzed and routinely disseminated. The clinical diagnoses were not coded with either the DSM-IV or the ICD-10.

The Milton Cato Memorial Hospital recorded, compiled, and analyzed data by number of bed, inpatient admissions, days spent in hospital, and diagnoses. No record was kept on number of involuntary admissions or number of patients who were physically restrained and/or secluded.

No information on mental health was transmitted to the Ministry of Health. No report covering mental health data was available from, or published by the government. One psychiatrist was involved in mental health research as a co-investigator in the last five years. The study was titled "The Epidemiology of first-episode psychosis in Saint

Vincent and the Grenadines.” There were no mental health publications on the country or region in indexed journals.

NEXT STEPS IN STRENGTHENING THE MENTAL HEALTH SYSTEM

The activities listed in Table 1 will require ongoing dialogue between the staff of the Mental Health Center, the Ministry of Health, and national stakeholders. The immediate priorities in the reform process are: policy and plan development; seeking technical support for a 3-month (part-time) course for primary health care workers, police officers, and prison officers to provide an overview of the principles of mental health care in a community-based mental health program; development of a mental health information system; securing the secondment of a part-time medical records officer, and sourcing a fellowship for a national of Saint Vincent and the Grenadines to study Child Psychiatry.

Table 1: Proposed next steps to strengthen mental health services in Saint Vincent and the Grenadines, 2009

DOMAINS	PROPOSED NEXT STEPS
Legislation and Policy	<ul style="list-style-type: none"> Continue the process to formulate a mental health policy Finalize both the mental health plan and the mental health disaster plan.
Mental health services	<ul style="list-style-type: none"> Identify sustainable programs and best practices to guide programs, plans, and activities. Integrate mental health into primary health care Discuss with the Ministry of Education the need for a child psychologist in the mental health team. Discuss the constitution of a Mental Health Review Board as legislated in the Mental Health Act.
Mental health in primary health care	<ul style="list-style-type: none"> Source technical assistance to develop operational guidelines for a community health center outreach program. Source technical assistance to conduct training for health and mental health workers
Human resources	<ul style="list-style-type: none"> Solicit a fellowship for a national to specialize in child and adolescent psychiatry. Request assistance to support a structured 3-month, part-time course for primary health care workers, police officers, and prison officers to provide an overview of the principles of mental health care in a community-based mental health program. Request technical cooperation to provide at least a two day training on human rights protection of persons with mental disorders.
Public education and links with other sectors	<ul style="list-style-type: none"> Increase the mental health system's link with other key stakeholders such as politicians, families, and consumers. Forge linkages with agencies responsible for domestic violence, HIV/AIDS, drug and alcohol abuse, and child welfare services.
Monitoring and research	<ul style="list-style-type: none"> Discuss with the Ministry of Health the development of an integrated mental health information system. Request the Ministry of Health to assign a part-time medical records officer for the Mental Health Center Source a core set of mental health indicators for data collection Source assistance to conduct a patient satisfaction survey Prepare an article for publication on mental health services in Saint Vincent and the Grenadines.

The WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information and structure the report on mental health services in Saint Vincent and the Grenadines. The Assessment provides a framework for assessing those services on six interdependent, conceptually interlinked and overlapping domains.

The Ministry of Health is responsible for the care, treatment and protection of persons with mental disorders. The budgetary appropriation for core mental health services, estimated at 5% of the total health budget, is allocated to the Mental Health Center, an inpatient psychiatric institution with responsibility for community-based mental health services. Mental health services are not integrated with primary health care. No data is available on out-of-pocket expenditure for privately-accessed mental health care.

In 2007, there were 2 psychiatrists in the country. The majority of persons treated for mental disorders were diagnosed with schizophrenia and related disorders. Psychotropic medications are available free or charge and primary health care physicians are allowed to prescribe or continue their use without restrictions.

There is no mental health policy but there is a draft mental health plan (2002). The legislative Act of 1989 was amended in 1991. Issues such as human rights protection for persons with mental disorders, advocacy, human resource development, data management, quality improvement, links with other sectors, and stakeholder/community involvement are areas in need of further attention.

Priority actions to reform the mental health services will include development of an appropriate mental health policy and plan; integration of mental health into primary health care; implementation of ongoing public awareness campaign; identification of a core set of mental health indicators for data collection; development of a mental health information system; and securing the services of a child psychiatrist and/or child psychologist; and securing of a part-time medical records officer for the mental hospital.