

# WHO-AIMS

**WHO-AIMS REPORT ON  
MENTAL HEALTH SYSTEM  
IN ANTIGUA AND BARBUDA**



**World Health  
Organization**



**MINISTRY OF HEALTH  
ANTIGUA AND BARBUDA**

**WHO-AIMS**  
**REPORT ON THE**  
**MENTAL HEALTH SYSTEM**  
**IN ANTIGUA AND BARBUDA**

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

Antigua and Barbuda  
2009

The data was collected in 2009 based on data for 2007



**World Health  
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**MINISTRY OF HEALTH  
ANTIGUA AND BARBUDA**

*PAHO/ECC Barbados office*

*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) James King  
The Mental Hospital  
King.s@candw.ag*

*2) Shirley Alleyne  
Non-Communicable Diseases and Mental Health Advisor  
Barbados and the Eastern Caribbean Countries  
PAHO/WHO, Barbados  
alleynes@ecc.paho.org*

*3) Shekhar Saxena  
WHO Headquarters  
saxenas@who.int*

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The WHO-AIMS team at WHO Headquarters includes: Benedetto Saraceno, Shekhar Saxena, Tom Barrett, Antonio Lora, Mark van Ommeren, Jodi Morris, Anna Maria Berrino and Grazia Motturi.

The WHO-AIMS project is coordinated by Shekhar Saxena.



## Executive summary

The World Health Organization Assessment Instrument for Mental Health Systems (WHO/AIMS) was used to collect information and structure the report on the mental health system in Antigua and Barbuda. The overall goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring change. Antigua and Barbuda can use this information to formulate information-based mental health policy and plans, as well as update its Mental Treatment Ordinance. More specifically, the information is useful for monitoring progress in implementing mental health reform policies, service delivery, as well as user/consumer/family/stakeholder involvement in mental health promotion, prevention, care, and rehabilitation.

The Mental Treatment Ordinance is dated 1 October 1957. There is no mental health policy to set priorities, reduce the burden of mental disorders in the population, and protect the human rights of persons with mental illness. There is no mental health plan to define and monitor objectives, strategies, timelines, and resource requirements for delivery of mental health services. The Ministry of Health is responsible for the financing of health care in the country. In 2007, approximately 4% of its annual health budget was appropriated to mental health services. No data is available to estimate the extent of use and out-of-pocket spending on private mental health services. There is no mental health unit in the Ministry of Health. No human rights review body exists and none of the mental health service delivery facilities had an external human rights review. Mental health workers were not oriented in the set of basic human rights of persons with mentally illness who received treatment in the health care system.

Access to mental health services is even across the country. There is one 110-bed Mental Hospital. Acute care is accessed through 8 primary health care centers that are strategically located to serve distinct catchment areas. Institutional care can also be accessed at the Holberton Hospital where no beds are designated for psychiatric patients. No trained mental health professional is assigned to the Holberton Hospital. In 2007, the overwhelming majority of mentally ill persons in Antigua and Barbuda carried a diagnosis of schizophrenia and related disorders. The service delivery facilities do not routinely generate, analyze, and disseminate quantitative data representing a defined list of mental health indicators. There is no nationally published report on the prevalence and burden of mental disorders.

One non-governmental agency, The Child and Family Guidance Centers, provides diagnosis, care, and treatment to children aged 5-18 years who experience emotional problems, mental health problems, and/or physical abuse or similar events.

There are two residential facilities—one caters to persons with substance abuse and the other for youths aged 17 years and younger with mental retardation. There is no forensic inpatient facility. Four forensic patients are hospitalized at the Mental Hospital, serving at 'Her Majesty's Pleasure'. The Mental Hospital operates an ad hoc day treatment facility for walk-in patients.

Psychotropic medicines are available to address the symptoms of mental illness. These include antipsychotics, antidepressants, mood stabilizers, anxiolytics, and antiepileptics. There is no risk-benefits assessment of the effects of long-term use of psychotropic medicines. The drug accessibility policy guarantees that all persons suffering from chronic conditions including cancer, hypertension, diabetes, sickle cell disease, cardiovascular diseases, *mental illness*, asthma, glaucoma, and leprosy are entitled to receive related medications free of charge under the Medical Benefits Scheme (MBS). Pharmacotherapy is the predominant treatment modality for the management of mental and behavioral disorders. Health regulations authorize primary health care physicians to prescribe and/or continue prescriptions for psychotropic drugs.

The human resources cadre in mental health consisted of forty-six health workers. This included three medical doctors, not specialized in psychiatry. Neither the primary health care facilities nor the Mental Hospital has a dedicated social worker or occupational therapist. Apart from the psychiatrist, no other category of mental health worker benefited from refresher training in areas related to psychiatry/mental health. The resident psychiatrist, who is also the Medical Superintendent of the Mental Hospital, had at least two days of refresher training in the rational use of psychotropic drugs and on child and adolescent psychiatry. There were no training activities related to the application of psychosocial skills or behavioral interventions.

No legislative and financial provisions exist for persons with mental disorders. There is no user/consumer association. The National Association of Mental Health advocates for the rights of mentally ill and devises strategies to bring about changes to benefit that vulnerable population. Public education and awareness campaigns are conducted by diverse stakeholders targeting a cross-section of the population. There are formal collaborative links with the key service providers such as the primary health care network, child protective services, and the social welfare department. There is at least one prisoner per month in treatment contact with a mental health professional inside the prison.

The available health indicators are insufficient to provide timely, accurate, and relevant health information. There is no mental health information system to facilitate evidence-based decisions, program planning, monitoring and evaluation of services. There is no research on mental health published in indexed journals.

In order to put the above information into context, the existing situation in Antigua and Barbuda is being compared to that which exists in six Eastern Caribbean countries. Antigua and Barbuda is among the four countries without a mental health policy and among the three countries without a mental health plan; it is among the three countries with a mental hospital. In addition, it is among four countries with a resident psychiatrist and among five countries where the available human resources in mental health does not include a dedicated social worker.

The national health authorities in Antigua and Barbuda appreciate this current assessment since it collected essential information to facilitate evidence-based mental health reform strategies and monitor the impact of changes.

This baseline assessment is a tool for seeking broad-based support from national, regional and global levels for developing, improving, and monitoring mental health service delivery in Antigua and Barbuda.

## **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 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 Antigua and Barbuda. Data was collected in 2009 and is based on the year 2007.

One week was assigned for the data collection phase. (February 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 Antigua.
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 Antigua and Barbuda.
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 Antigua and Barbuda, there was no reporting system for mental health to respond to the need for timely, reliable, and accurate data. Consequently, with limited time, it was challenging to access data that accurately determined 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 managed the mental health delivery system at the primary care level, did not have a framework to inform them as to the type of indicators to collect to produce useful and reliable information. Consequently, much time was spent organizing and validating primary health care level data. Data was available at the hospital level, but only in the individual patients' admission charts. Much time was spent accessing, coding, and compiling the discharge data. The last annual report from the Mental Hospital was dated 2005. It included the number of admissions, discharges, and deaths but did not include diagnoses by variables such as age and sex.

There is one mental hospital in Antigua and Barbuda. There are no mental health outpatient facilities per se. As such, data from the primary health care clinics were substituted because mental health services were scheduled in these clinics.

The data were not reported using rates since the country's population (87,901) is less than 100,000.

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

## **Introduction**

Antigua and Barbuda is made up of three islands: Antigua, Barbuda and the small uninhabited rocky island of Redonda. Antigua and Barbuda is located in the Leeward Islands Group, to the south-east of Puerto Rico. Antigua occupies 64% of the land mass and accounts for approximately 98% of the population. The country's total area is 441.6 km<sup>2</sup> with Antigua measuring 280 km<sup>2</sup>, Barbuda. 160 km<sup>2</sup>; Redonda measures 1.6 km<sup>2</sup>. The total population was estimated 87,901 in 2007.

Antigua and Barbuda gained full independence in 1981. St. John's is the capital and main commercial center. The currency, the Eastern Caribbean dollar, is pegged to the United States dollar at US\$1= EC\$2.70. The economy continued to experience high growth as a result of improvements in tourism, construction, hotels, and the housing sectors.

Antigua and Barbuda has a stable democracy with two main political parties. It is governed by an elected parliament with the party holding the majority of elected seats forming the ruling government. The Prime Minister and his appointed ministers form the Executive arm of government with the Prime Minister having supreme authority. The decision-making body is comprised of fifteen cabinet ministers. Barbuda manages its affairs through the Barbuda Council which was set up by an Act of Parliament in 1976. Christianity is the predominant religion and there are no other significant religious groups.

The provision of health care is organized according to the British Westminster model and is headed by a Minister of Health who is a member of the governing Cabinet. The Chief Medical Officer serves as an advisor to the Minister and has responsibility for the coordination of the health service delivery in hospitals and clinics.

The health care services are provided both by public and private institutions. The country is divided into six medical districts and a District Medical Officer is appointed to provide medical services in each district. The provision of primary health care is delivered through health centers that are located within 3.2 km radius of every major community.

The pharmaceutical service has a National Drug Formulary that is prepared by the National Drug Formulary Committee. A total of 360 generic drugs are available in the national formulary. The drug accessibility policy guarantees that all persons suffering from chronic conditions including cancer, hypertension, diabetes, sickle cell disease, cardiovascular diseases, mental illness, asthma, glaucoma, and leprosy are entitled to receive related medications free of charge under the Medical Benefits Scheme (MBS). In addition, persons in the age group 0-16 years, and those who are unable to work by virtue of age, are entitled to free medications.

The disabled population is of special interest to the government since they continued to face a multitude of barriers that limit their access to education, employment, housing, transportation, health care, rehabilitation, and recreation. It is estimated that 1% of the

population, or approximately 700 persons, were disabled and many of them lived below the poverty line.

Antigua and Barbuda is a signatory to the Convention on the Rights of Persons with Disabilities. The country is a member of the Caribbean Community (CARICOM), the Organization of Eastern Caribbean States (OECS), the Pan American Health/World Health Organization (PAHO/WHO), among others.

## **Domain 1: Policy and Legislative Framework**

### **Policy**

There is no mental health policy.

### **Plan**

There is no mental health plan and no disaster/emergency preparedness plan for mental health.

### **Legislation**

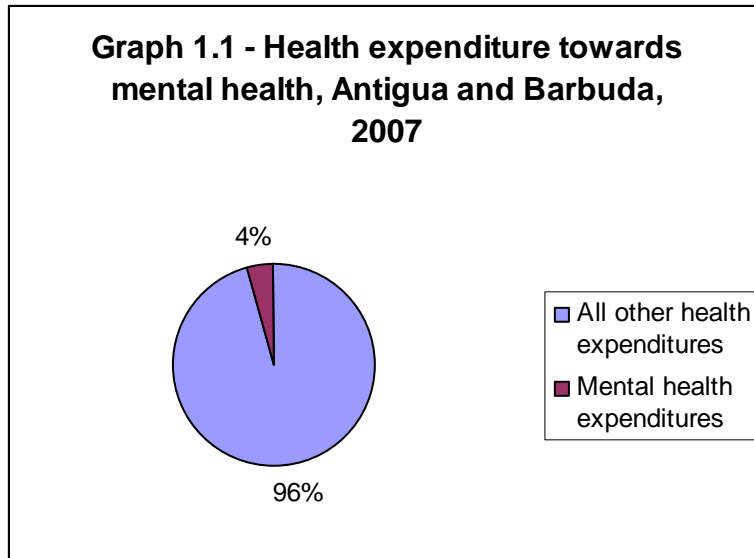
The Mental Treatment Ordinance is dated 1 October 1957. It is enshrined in the Revised Laws of Antigua, Chapter 233. Some of the issues addressed in the Ordinance relate to: Adjudication of persons of unsound mind; mental hospital; interim orders; criminals of unsound mind; and treatment of voluntary patients at an institution. The Ordinance defines a “person of unsound mind” as: any epileptic, idiot, imbecile, feeble-minded person; and a moral defective person; the definitions for these categories are noted in Part I. Some of the standardized forms in the Ordinance are: “Order for sale of insane person’s real estate and application of proceeds for his maintenance;” and “Admission as a voluntary patient.” The Ordinance does not address: 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; mechanisms to implement the provisions of the mental health legislation.

### **Human rights policies**

There were no national or regional-level review bodies on human rights. There was no yearly external review/inspection of human rights protection at the Mental Hospital. No mechanisms were in place to impose sanctions on facilities or persons who violate patients’ rights.

### **Financing of mental health services**

In 2007, the Ministry of Health’s expenditure on mental health services was EC\$2,557,037, representing approximately 4% of the total annual health budget. The appropriation for the mental hospital was subsumed under “mental health services,” and was not listed as a line item therein. For 2009, the budgetary allocation for mental health was increased to EC\$5,287,497. The Medical Benefits Scheme included mental health as one of its nine priority diseases for which related medications are free of charge. As such, all persons with mental illness had free access to antipsychotics, anxiolytics, antidepressants, mood stabilizers, and antiepileptic drugs.



## **Domain 2: Mental Health Services**

### **Organization of mental health services**

There was no mental health authority in the island or a director of mental health programs. Primary health care services were organized in terms of catchment/service areas and delivered through 29 primary health care centers.

### **Mental health outpatient facilities**

There were no outpatient facilities exclusively for treatment of persons with mental illness. Mental health care was provided through 7 primary health care centers and the prison—all 8 clinics are held once per month. In addition, the Child and Family Guidance Center, a non-governmental agency, provided diagnosis, care and treatment to children (5-18 years) and their families who experienced emotional problems, mental health problems, and/or physical abuse or similar events. All mental health services in the public sector were managed by the Medical Superintendent of the Mental Hospital, primary health care physicians, community mental health nurses, and ancillary staff. All seven primary health care centers had access to mobile mental health teams to conduct home visits and provide care in the community; prisoners were treated in the prison complex. There was no social worker or occupational therapist assigned to either the Mental Hospital or the primary health care centers.

In 2007, 174 persons were assessed and treated through the seven primary health care centers and the prison for a total of eight hundred and seventy-six user contacts. Ninety-six (55%) were females. Nine percent (15) had mental and behavioral disorders due to psychoactive substances; 66% (114) had schizophrenia and other related disorders; 13% (23) had mood (affective) disorders; 6% (11) had neurotic, stress-related and somatoform

disorders; 2% (3) had disorders of adult personality and behavior; and 5% (8) had other related mental illnesses. Quantitative data from the Child and Family Guidance Center were not available. However, through formal correspondence, it was noted that children between the ages of 5-18 years were referred for the following conditions: withdrawal, depression, abuse (physical, emotional, sexual), neglect; maladaptive behavior related to drug or substance abuse; hyperactivity-ADD, ADHD; teenage pregnancy; mental health issues (bipolar disorder, GAD, and schizophrenia).

### **Day treatment facilities**

The Mental Hospital operated a walk-in, day treatment facility for a few mentally ill patients. In 2007, three males and one female used the facility solely for “day support” services.

### **Community-based psychiatric inpatient unit**

There was no community-based psychiatric inpatient unit. However, persons with acute mental illnesses were treated at the Holberton Hospital. This hospital had no beds designated for psychiatric patients.

### **Community residential facilities**

Crossroads is privately-run, 32-bed residential facility specifically for people with substance abuse (including alcohol) problems. Although it caters mostly to persons from the United States, spaces were reserved for Antiguan citizens. Amazing Grace is an 11-bed residential facility for youths aged 17 years and younger with mental retardation.

### **Mental Hospital**

There was one mental hospital with a 110 beds—no beds were reserved for children and adolescents. Assessment and treatment protocols were available at the Mental Hospital. At the end of 2007, one hundred and twenty-five patients were treated at the Mental Hospital. Females accounted for 30% (38). Three patients under the age of 17 years were admitted in 2007. In the assessment year, eighty-six discharges were classified with the following diagnoses: mental and behavioral disorders (13%); schizophrenia, schizotypal and delusional disorders (34%); mood (affective) disorders (17%); neurotic, stress-related and somatoform disorders (3%); and other mental illnesses (2%). Of the discharges, 43% (37) were females. None of the patients received psychosocial interventions. The Mental Hospital had a least one psychotropic medicine of each therapeutic class (antipsychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility.

### **Forensic and other residential inpatient units**

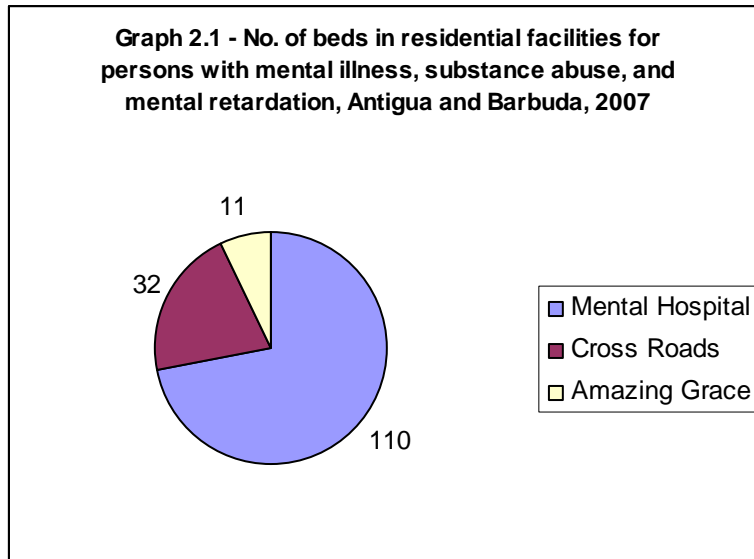
There was no forensic or other inpatient mental health unit in the country. There were four forensic patients in the Mental Hospital with indefinite hospitalization under ‘Her Majesty’s Pleasure’.

### **Human rights and equity**

Thirty-nine persons (45%) were admitted involuntarily. The usual average length of stay for new, acute patients was 2-4 weeks. It was estimated that about 70 patients were hospitalized for over 10 years. Between 2-5% of the admitted patients were placed in seclusion and between 0-1% were restrained. The issue of inequity of access based on geographical location, linguistics, ethnicity and religion was not relevant in Antigua and Barbuda.

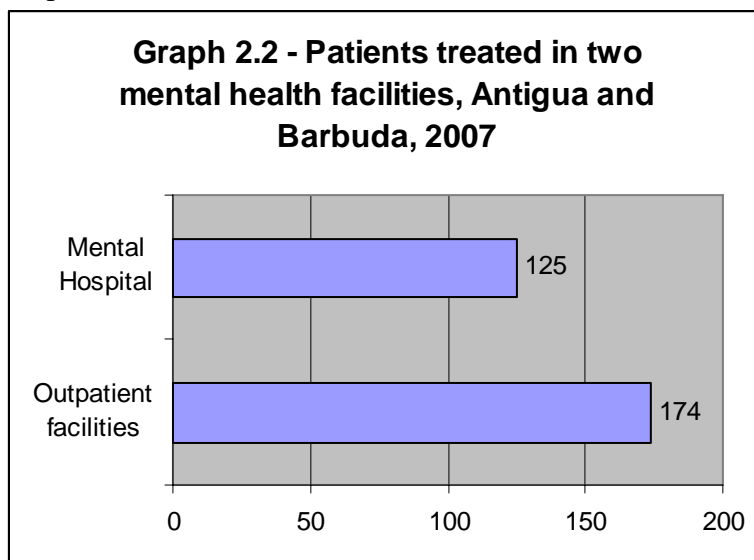
## Summary charts

Graph 2.1



The majority of beds in the country are located in the mental hospital. Two residential facilities have beds that are specifically for persons with substance abuse (Cross Roads) issues and mental retardation (Amazing Grace).

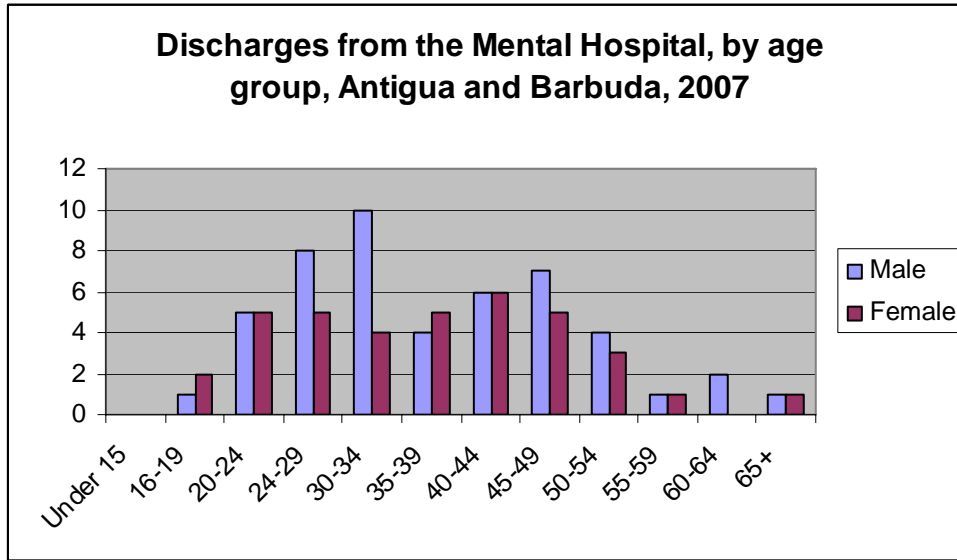
Graph 2.2



### Summary for Graph 2.2

The majority of patients were treated in the primary health care setting. The occupancy at the Mental Hospital exceeded its bed capacity of 110 beds.

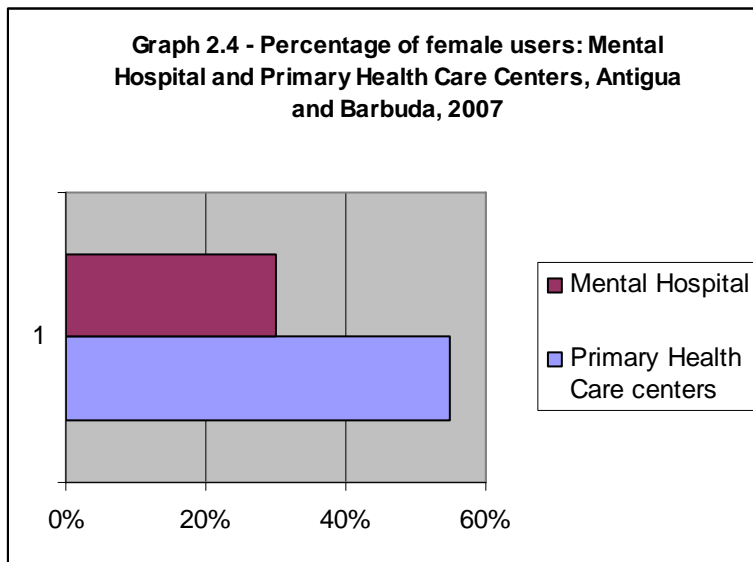
Graph 2.3



Summary for Graph 2.3

The elderly 60 years and older had a longer length of stay as compared to persons in other age groups. Of the 86 discharges in 2007, five percent (4) were 60 years and older.

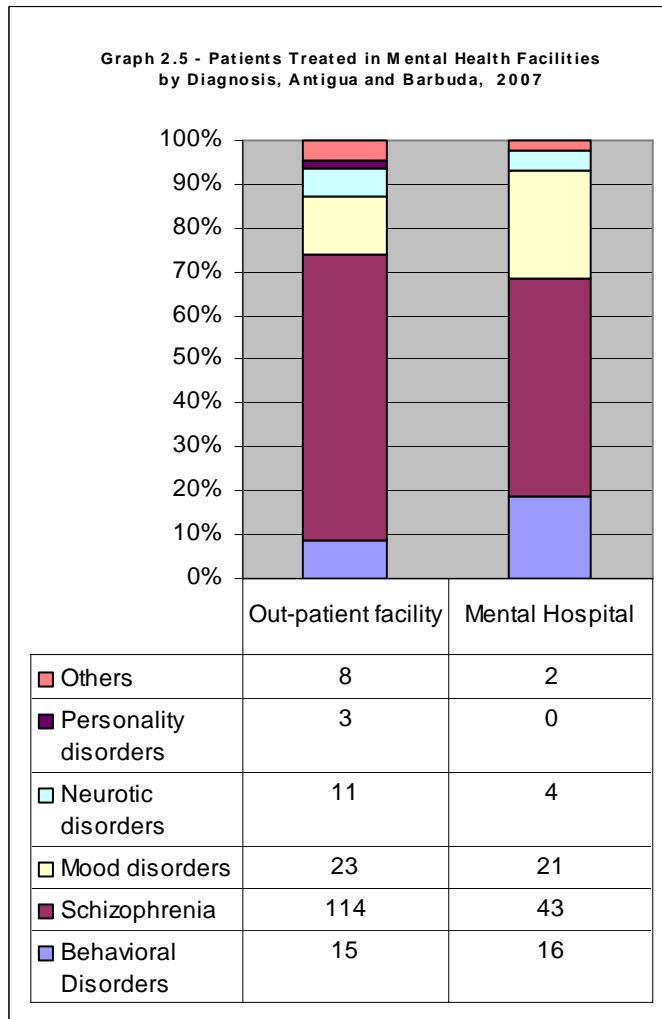
Graph 2.4



Summary for Graph 2.4

Thirty-percent (38) of the persons treated in the Mental Hospital were females and a corresponding 55% (96) were treated through the primary health care centers.

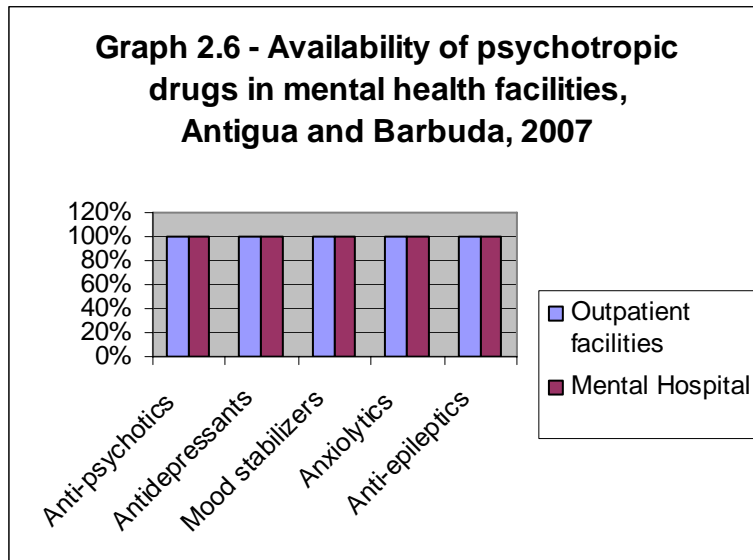
Graph 2.5



**Summary for Graph 2.5**

The data in this graph reflect the *number of discharges* from the Mental Hospital in 2007. When the number of mentally ill persons who were treated in the primary health care setting is combined with discharges from the Mental Hospital in 2007, the majority carried a diagnosis of schizophrenia and related disorders (157 patients or 60%); followed by mood (affective) disorders (44 or 17%); 12% (32) had mental and behavioral disorders; 6% (15) had neurotic, stress-related, and somatoform disorders; 1% (3) had disorder of adult personality and behavior; and 4% (10) other mental illnesses.

Graph 2.6



Summary for Graph 2.6

At least one medication from each class of psychotropic drugs was available in the Mental Hospital and the outpatient facilities. The purchase of drugs is centralized through the Regional Organization of Eastern Caribbean States Pharmaceutical Services (OECS/PPS).

### Domain 3: Mental Health and Primary Health Care

#### Training in mental health care for primary care staff

The majority of the primary health care physicians in Antigua and Barbuda were educated in countries such as Cuba, the United States, and the United Kingdom. Data were not available with respect to the number of hours devoted to mental health in their respective training programs. None of the primary health care physicians had at least two days of refresher training in any aspect of psychiatry/mental health. Three percent of the training hours for registered nurses was devoted to mental health. None of the primary health care nurses had at least two days of refresher training in psychiatry/mental health. Similarly, 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 primary health care setting was the first point of contact and treatment new clients with acute mental illness as well as those requiring follow-up and supportive care. All primary health care centers 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 centers and interaction occurred 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 Mental Hospital interacted with a complimentary/alternative/traditional practitioner.

### **Prescription in primary health care**

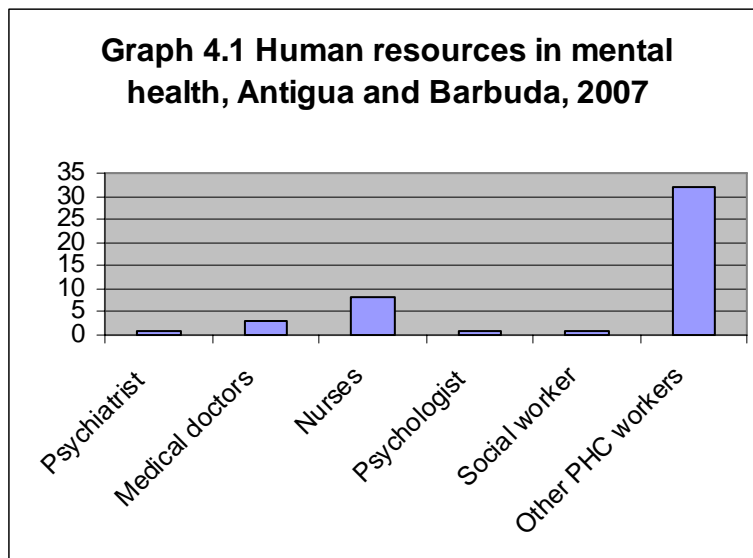
Health regulations authorize primary health care physicians to prescribe and continue prescription of psychotropic medications without restrictions. However, the regulations do not extend this privilege to primary health care nurses or non-doctor/non-nurse primary health care workers. All seven primary health care centers that delivered mental health services, the prison, and the Mental Hospital had access to at least one psychotropic medication of each therapeutic category (antipsychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic).

## **Domain 4: Human Resources**

### **Number of human resources in mental health care**

The available human resources in mental health consisted of 46 persons serving both Antigua and Barbuda. There were: 1 psychiatrist; 3 medical doctors (not specialized in psychiatry); 8 mental health nurses; 1 psychologist, 1 social worker, and 32 primary health care workers. Two of the eight mental health nurses were assigned to the community mental health program. The social worker is the Director of the Child and Family Guidance Center. The psychiatrist is the Medical Superintendent at the Mental Hospital, the consulting psychiatrist for the Child and Family Guidance Center, the consulting psychiatrist for the Holberton Hospital, and a private practitioner.

Graph 4.1



### **Training professionals in mental health**

One mental health nurse graduated in 2007. Only the psychiatrist had at least two days of refresher training on the rational use of psychotropic drugs and on child and adolescent mental health issues. No mental health professional had at least two days of refresher training on psychosocial (non-biological) interventions in the year of assessment. No psychiatrist emigrated from the island within 5 years of completion of training.

### **Consumer and family associations**

There were no user/consumer or family associations. There is a National Association of Mental Health with membership that included community mental health nurses, nursing assistants, a representative from the Gender Affairs Division, and other persons from the local community. The Association advocated for the rights of mentally ill and devised strategies to bring about changes for the benefit of such persons. The Association did not receive economic support from the government for mental health initiatives.

## **Domain 5: Public Education and Links with other Sectors**

### **Public education and awareness campaigns on mental health**

The government and the National Association of Mental Health promoted public education and awareness campaigns on mental health and mental disorders. Similar campaigns were also conducted by other entities, such as: professional associations, international and non-governmental agencies, private trusts and foundations. These targeted a diverse audience that included the general population, teachers, health care providers, children, adolescents, women, trauma survivors, and other vulnerable or minority groups.

### **Legislative and financial provisions for persons with mental disorders**

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.

### **Links with other sectors**

Formal collaborative programs existed between the agency responsible for mental health and the primary health care network, HIV/AIDS programs, child protective services, and the social welfare department. No mental health professionals were assigned to either primary or secondary schools; students had access to school-based guidance counselors.

There were no educational activities on mental health for police officers, judges or lawyers in the last five years. Of the 171 inmates in the prison in 2007, 12 males (7%) were diagnosed with psychosis and in active treatment. Less than 2% of the prison's population had a diagnosis of mental retardation. The single prison had at least one prisoner per month in treatment contact with a mental health professional inside the prison. Information was not available on the number of persons who received welfare benefits solely because they had a mental disorder.

## **Domain 6: Monitoring and Research**

There was no formally-defined list of individual items/indicators that were to be collected by the mental health facilities. Quantitative data was available only through a chart-by-chart review at the Mental Hospital. For this report, all diagnoses were coded manually using the International Classification of Diseases, Tenth Revision (ICD-10). The hospital produced its last mental health annual report in 2005. It included indicators such as the number of admissions, discharges, and deaths for that year. The community mental health nurses routinely collected data with regards to number of users treated, number of user contacts, gender, and diagnosis. However, these facilities did not compile the data and generate reports in 2007.

No data on the mental health activities were sent to the Health Information Unit, Ministry of Health. No report covering mental health was published by the government. No mental health professional was involved in mental health research or was mental health research conducted in the last five years. In 1997, an evaluation report on "Mental Health Services: Antigua and Barbuda" was prepared by a consultant for the Pan American Health Organization/World Health Organization.

## **NEXT STEPS IN STRENGTHENING THE MENTAL HEALTH SERVICES**

The activities listed in Table 1 are the immediate priorities to be pursued by the Government of Antigua and Barbuda. These activities, which may require external technical assistance, will provide momentum for a comprehensive reform of the mental health system.

**Table 1:** Immediate next steps to strengthen the mental health services in Antigua and Barbuda

<b>DOMAINS</b>	<b>PROPOSED NEXT STEPS</b>
Legislation and Policy	Formulation of a mental health policy Formulation of a mental health plan Updating the mental health legislation
Human Resources	Training of mental health professionals Recruitment of social workers and occupational therapists
Monitoring and Research	Development of an integrated mental health information system

The World Health Organization Assessment Instrument for Mental Health (WHO-AIMS) was used to collect information on the mental health system in Antigua and Barbuda. The process highlights the strengths and weaknesses of the mental health delivery system. The assessment provides momentum for pursuing specific reform strategies to improve the mental health system in Antigua and Barbuda.

Mental health services are provided at the sole mental hospital, the general hospital, primary health care clinics, the prison, two residential facilities, and the Child and Family Guidance Center. There is one psychiatrist for a rate of 1.16 psychiatrists per 100,000 population. Four percent of the national health budget is directed towards mental health services. Psychotropic medicines are available and the Medical Benefits Scheme guarantees that all persons suffering from a mental illness are entitled to medication free of charge. The majority of mentally ill persons carried a diagnosis of schizophrenia and related disorders.

No human rights review body exists and mental health workers are not oriented in the set of basic human rights of the mentally ill. The majority of mental health workers did not have any refresher training in key aspects of psychiatry/mental health. There is no mental health information system and no research on mental health is published in indexed journals.

Priority activities, such as, updating the mental health legislation, formulation of mental health policy and plans, and capacity building, regained importance and a renewed call for action. The assessment underscores the need for political will, ministerial dialogue, stakeholder involvement and broad-based support from national, regional, and global levels for improving and monitoring mental health service delivery in Antigua and Barbuda.