

# WHO-AIMS

**WHO-AIMS REPORT ON  
MENTAL HEALTH SYSTEM  
IN MONTSERRAT**



**World Health  
Organization**



**MINISTRY OF HEALTH  
MONTSERRAT**

**WHO-AIMS REPORT ON**  
**MENTAL HEALTH SYSTEM**  
**IN MONTSERRAT**

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

Montserrat  
2009

*The data was collected in 2009 based on data for 2007*



**MINISTRY OF HEALTH**  
**MONTSERRAT**

*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) Linda Dias  
diasl@gov.ms*

*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 project is coordinated by Shekhar Saxena.

## 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 Montserrat. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring change. This will enable Montserrat to finalize its mental health plan with clear baseline information and targets. It will be useful to assess gaps and monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care, and rehabilitation.

Montserrat has a Mental Treatment Act (2006) and a draft mental health plan (2002). There is no mental health policy nor is there a well functioning national health information system to inform the formulation of policy options. Although there is no explicit human rights policy, the Act provides a legal framework to address the critical issue of ill-treatment of insane persons in institutions. 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 has had an external human rights review. Financing is oriented towards community care and the mental health budget constituted around two percent of the total health expenditures. None of the mental health workers received training in human rights. There is no social insurance scheme and the entire population has free access to psychotropic drugs.

There is no mental hospital. Mental health services are community-based and this involves diagnosing, treating, and follow-up of patients with mental illness. Access to mental health care is even across the island. The St. John's health center is the main treatment facility. Forty-four persons were treated in an 11-month period in 2007, accounting for 667 outpatient contacts. Thirty-six percent of those seen were females. The overwhelming majority of mentally ill persons were diagnosed as having schizophrenia. Persons requiring hospitalization are admitted to the Glendon Hospital. Although there are no designated beds for psychiatric patients, the medical ward has a seclusion room (called a "strong room") for such admissions. There are no trained mental health professionals assigned to the Glendon Hospital. Quantitative data on admission status (voluntary or involuntary) and use of restraints are not recorded.

There are no forensic and other residential facilities. Inmates with mental illness are housed among the prison's population. Treatment and follow-up care are managed by the community mental health nurses.

Psychotropic medicines are available to address the symptoms of mental illness. These include antipsychotics, antidepressants, mood stabilizers, anxiolytics, and antiepileptics. Pharmacotherapy is the predominant treatment modality for the management of mental and behavioral disorders. The trusting relationship between the community mental health nurses and patients with chronic mental health conditions has a positive effect on compliance with treatment regimen. There is no risk-benefits assessment of the effects on long-term use of psychotropic medications.

Primary health care workers had at least two days of refresher training in essential skills of mental health care. The mental health nurses are not allowed to initiate a prescription for psychotropic drugs but are allowed to continue and/or adjust such prescriptions. Training in the application of psychosocial skills or behavioral interventions was non-existent. All primary health care centers are physician-based. None of the physicians in Montserrat has at least two days of refresher training in any aspect of mental health.

There were 9 persons working in mental health in Montserrat which includes an internist, not specialized in psychiatry, and the visiting consultant psychiatrist from Dominica. There was no social worker, psychologist, or occupational therapist. Two community mental health nurses at St. John's clinic form the nucleus of therapeutic and supportive care.

There are no consumer and family associations. There is an ad hoc Mental Health Committee that participated in the drafting of the Mental Health Treatment Act. The Mentally Challenged Housing Social Impact Assessment (2006) created the framework for policy guidelines and action with respect to housing for the mentally challenged. The Red Cross and communities/villages play an active role in the care and protection of mentally challenged persons although there are no formal collaborative arrangements.

Public education and awareness campaigns target the general population, adolescents, and professional groups linked to the health sector. The ad hoc Mental Health Committee serves as an advocacy group to address issues including stigma and discrimination against the mentally ill.

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 are no reports or briefings to inform the prevalence, types, and effects of mental illness in Montserrat. There is no research on mental health published in indexed journals.

The community-oriented approach to mental health includes a unique feature that addresses the nutritional and other needs of the mentally challenged patient. The Community Services Department enters into "good faith" agreements with supermarkets and cook shops in various communities where patients can collect groceries and receive daily meals. In some instances, patients did odd jobs in return for money, clothing, and other items. Twenty-one percent of all persons who receives welfare support are disabled due to mental disorders.

In order to put the above information into context, the situation in Montserrat is being compared to that which exists in six Eastern Caribbean countries. Montserrat is among: four countries without a mental health policy; three with at least a draft mental health plan; three without a mental health hospital. It is among four countries where the budgetary allocation to mental health is clearly defined. Montserrat is one of the two countries that, in the absence of a resident psychiatrist, depend on the services of a visiting consultant psychiatrist. Montserrat is the only country where informal

agreements exist with supermarkets and cook shops to meet the nutritional and other needs of those who are mentally challenged. In addition, it is the only island where the housing needs of patients are integrated into the process of rehabilitation.

Montserrat 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.

The national authorities in Montserrat are grateful for the assessment since it compiled current and 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) 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 Montserrat. Data was collected in 2009 and is based on the year 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 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 Anguilla), prior to the consultant's arrival in Montserrat.
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 Montserrat.
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 Montserrat, there were no fully developed organized processes and procedures to respond to the need for timely, reliable, and accurate health data. Specifically, there was no national health information and reporting system for mental health. 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 primarily managed the mental health delivery system, did not have a framework to inform them as to the type of indicators to collect to produce useful and reliable information. Poorly recorded and organized clinic records provided the salient information for this report. Up to 2007, there were no written national reports or consultant briefings. Even when the size of Montserrat is considered, there was inadequate trained human resource in mental health.

There is no mental hospital in Montserrat. 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 were scheduled in these clinics.

The data were not reported using rates since the country has a population (4,818) that is far 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 Montserrat.

## Introduction

Montserrat is an overseas territory of the United Kingdom. British control was established in 1632. Montserratians were granted full residency rights in the United Kingdom in 1998 and citizenship was granted in 2002.

Montserrat is located in the Leeward Islands Group in the Eastern Caribbean and has an area of 39.5 square miles (102 sq. km). The geographic coordinates of the island are 16.45°N, 62.12°W and it lies 27 miles southwest of Antigua and 40 miles northwest of Guadeloupe. The Soufriere Hills volcano became active in 1995 and remains active with occasional gas emissions, ash clouds and dome collapses. As a result of the volcanic activity, two-thirds of the country was declared unsafe and the inhabitants who remained in the island were forced to relocate to the north of the island. In addition to the loss of land space, there was a loss of population, arable land, use of air and sea ports, health infrastructure, and equipment as well as technical expertise.

By 1997, volcanic activity had intensified to an extent that the already-displaced population of the south were forced to move further north precipitating a severe housing shortage in the northern areas. The British and local governments responded by implementing an incentive program for depopulation which resulted in the mass exodus of some 70% of the island's people, mainly women and their school aged children. By the end of 1997, the total population had dwindled to 3,338. The relocation and emigration of thousands of Montserratians as a result of the volcanic crises left many persons without traditional community and family support systems. A number of persons were re-located to shelters, lived on the streets, or in dilapidated houses. A Mentally Challenged Housing Project was set up by the Government of Montserrat to provide appropriate housing solutions for an estimated 42 persons who were mentally challenged. In 2007, the country's resident population was estimated at 4,818 persons, comprising the remaining residents, migrant workers from other Caribbean territories, and a small percentage of returned residents.

The village of Brades currently serves at the *de facto* center of government. The currency, the Eastern Caribbean dollar, is pegged to the United States dollar at US\$1=EC\$2.70. Montserrat participates in the Caribbean Community (CARICOM) and the Organization of Eastern Caribbean States (OECS). The Department of Internal Development (DFID) has provided disbursements to Montserrat totaling some £250 million for both development assistance and budgetary support. Of this amount, £15.56 million was provided in the period 2006/07. Montserrat's fiscal performance has been characterized by significant fiscal deficits. In 2008, revenues hovered between EC\$34.0m and EC\$36.0m annually. The current expenditures grew steadily, except in 2004, when it rose sharply to just over EC\$90m. The expenditure for health and social welfare rose from EC\$10.72 in 2002 to EC\$15.57 in 2007.<sup>1</sup>

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<sup>1</sup>Ministry of Finance, Economic Development and Trade. Montserrat Sustainable Development Plan 2008-2010. December 2008.

In 2008, the crude birth rate was 17.3 births per 1,000 population and the crude death rate was estimated at 8.86 deaths per 1,000 population. Life expectancy at birth was 76.9 years for males and 81.5 for females. Total fertility rate was 1.8 children per woman.

The Ministry of Health and Community Services has the overall responsibility for the population's health. The health care delivery system is divided into primary and secondary care health services; tertiary care is referred overseas. The Chief Medical Officer has the day-to-day responsibility for organization and management of the mental health services. There are five primary health care centers. All health centers serve catchment areas and are easily accessible to their target population. The Glendon Hospital is the only hospital. The mental health service in Montserrat is essentially community-based. There is no mental hospital. There was no mental health outpatient facility, day treatment facility or community-based inpatient unit.

## **Domain 1: Policy and legislative framework**

### **Policy**

There is no mental health policy for Montserrat.

### **Plan**

The Pan American Health Organization/World Health Organization prepared a draft mental health plan for Montserrat in 2002. The plan defined the vision, goal, and purpose for mental health service delivery. It proposed five outputs: 1) strategies for prevention of mental health implemented; 2) management of persons with mental health disorders improved; 3) information systems for mental health established; 4) mental health legislation and policies updated and enactment facilitated; and 5) mental health plan coordinated, monitored, and evaluated. It also included a logical framework matrix for mental health; levels and sources of funding were not included. Up to 2007, the draft had not been approved nor any of the suggested milestones accomplished.

There is a one-page “Mental Health Preparedness Activity” information guideline that lists instructions for pre-hurricane, storm watch, hurricane, and post-hurricane activities.

### **Legislation**

The Mental Treatment Act and Related Legislation, revised edition, is dated 1 January 2006. It contains a consolidation of the Mental Treatment Act, Mental Treatment Institutions, and Poor and Persons of Unsound Mind Act. More specifically, the Act contains sections related to: Adjudication of Persons of Unsound Mind; Institutions; Licensed Houses; Interim Orders; Criminal Persons of Unsound Mind; Maintenance of Insane Persons; Offences in Reference to Insane Persons; and Treatment of Voluntary Patients in Mental Hospital. There were no references concerning the rights of mental health service consumers, family members, and other care givers or accreditation of professionals and facilities.

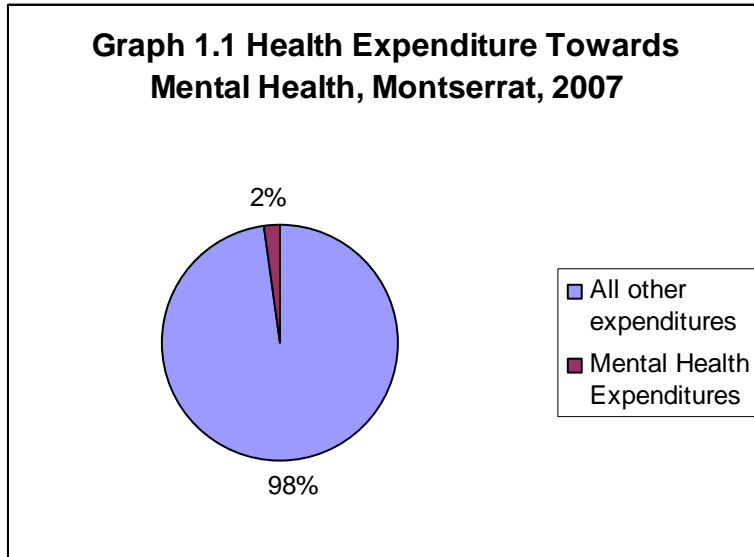
### **Human rights**

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 Montserrat. The Mental Treatment Act, under “Offences in Reference to Insane Persons,” contains two human-rights oriented sections that address ill-treatment of insane persons in the institutional context. In the case of insane persons in institutions, the law states that, upon summary conviction, there will be a fine not to exceed EC\$500 or imprisonment for six (6) months, or to both such fine and imprisonment for any person employed in an institution who strikes, ill-treats, or willfully neglects any insane person. If the ill-treatment occurs in a licensed house and there is summary conviction, the fine will be EC\$250 or

imprisonment for three (3) months. None of the community-based mental health treatment facilities ever had an external review/inspection of human rights protection of patients or had mental health staff been trained in this area.

**Financing of mental health services**

Two percent of the health care expenditures by the government health department was directed towards mental health. There was no social insurance scheme. The entire population had free access to essential psychotropic medicines.



## **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 Montserrat. 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 five primary health care centers. However, one center (St. John's) was the nucleus for comprehensive assessment, treatment and follow-up care. The other four centers assessed walk-in patients and provided the necessary treatment in consultation with the mental health nurses from the St. Johns center. Hereafter, the patients were referred to the St. Johns center for routine follow-up care including renewal of prescriptions. There was one mental health mobile clinic team consisting of the two trained mental health nurses from the St. John's health center. No social workers were assigned to the mental health delivery services. Where there was a need for psycho-social counseling, a social worker from the Community Services Department (CSD) provided part-time services.

There were no outpatient mental health facilities or services exclusively for children and adolescents. In 2007, forty-four (44) patients were treated at St. John's health center inclusive of one 12 year old male child. In an eleven-month period in 2007, the cumulative number of outpatient contacts was 667; data was not available for one month in that year. Of the users, 36% (16) were females; 84% (37) had schizophrenia and other related disorders; 11% (5) had mood affective disorders; and 5% (2) had other mental illnesses.

### **Day treatment facilities**

No exclusive day treatment facilities existed in Montserrat. However, the St. John's center also performs some functions of a day treatment facility.

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

No community-based inpatient unit existed in the country. Persons requiring hospitalization were assessed, admitted, and treated at the Glendon Hospital where there were no designated beds for psychiatric patients. These patients were housed in a "seclusion room" (known as a "strong room") located in a medical ward. There was no trained mental health staff assigned to the hospital. The data provided for "community-based inpatient unit" correspond to an analysis of the discharges from Glendon Hospital

in 2007. Five persons were admitted to the hospital; this included one female and one male patient, aged 12 years old. Four patients were in the age range 83-94 years of age. The total length of stay was seventeen (17) days, averaging 3.4 days per discharge. Four patients were classified in the category “other mental illness” and one (1) in the category of “neurotic, stress-related and somatoform disorders.” The hospital’s pharmacy had a least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines).

### **Community-based residential facilities**

There were no community-based residential facilities.

### **Mental Hospital**

There was no mental health hospital in Montserrat.

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

There were no forensic or other residential inpatient units in the country. Four inmates with mental illness were among the prison population in 2007. Their treatment and care were managed by the two mental health nurses who visited them, as needed.

No residential facilities existed exclusively for persons with mental retardation or substance abuse problems.

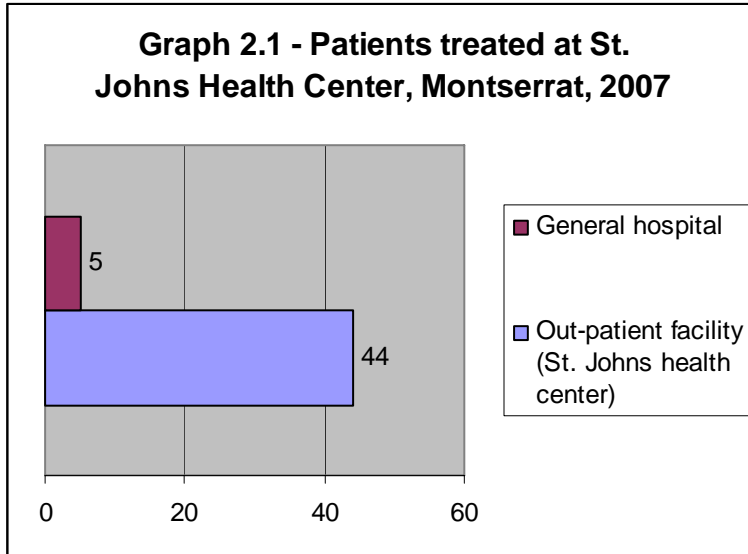
### **Human rights and equity**

Data were not recorded on admission status (voluntary or involuntary) or on use of restraint.

### **Summary charts**

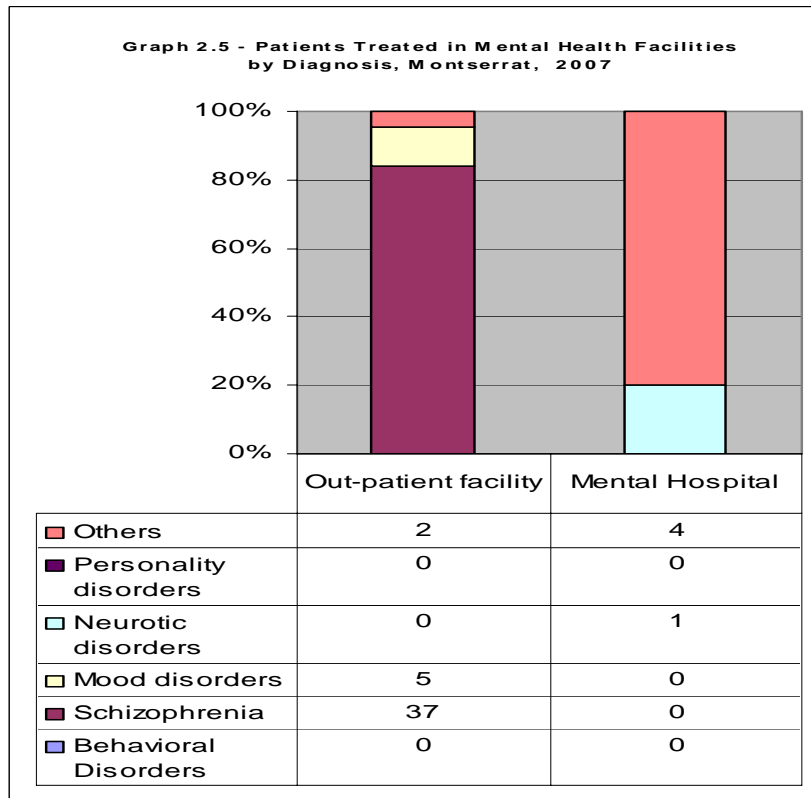
Summary for Graph 2.1

The majority of persons with mental illness was treated at the St. Johns health center (outpatient facility) where the two trained mental health nurses were stationed.



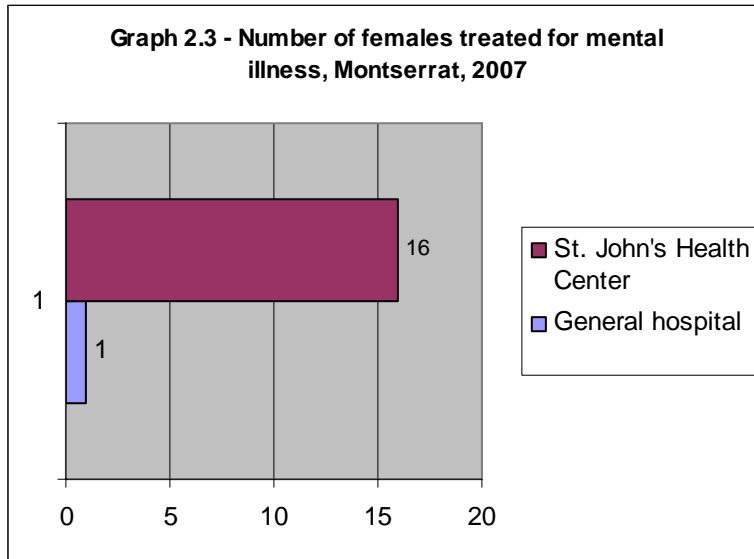
**Summary for Graph 2.2**

The majority (84%) of persons seen at St. John’s health center were diagnosed as schizophrenia and related disorders for which fluphenazine was the most frequently prescribed drug. Four of the five persons admitted to Glendon Hospital and “Other” psychiatric illness, such as senile dementia.



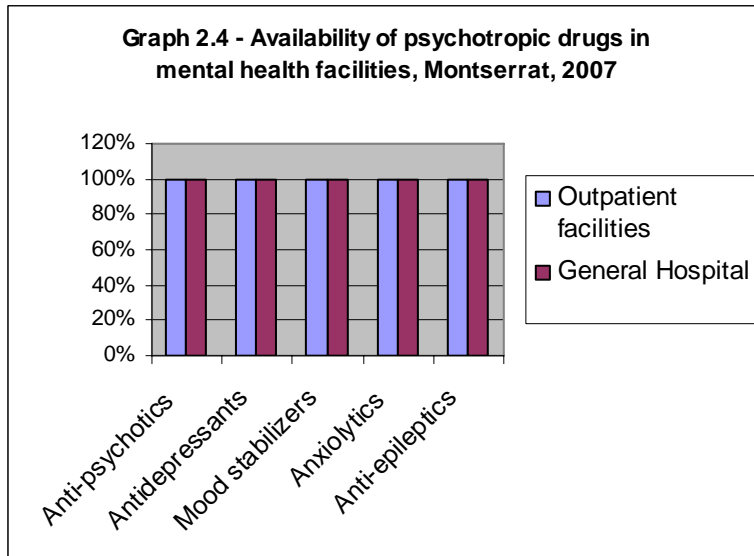
**Summary for Graph 2.3**

Of the 44 persons who were treated at St. Johns health center, 16 were females; only one (1) female was hospitalized in 2007.



**Summary for Graph 2.4**

At least one medication from each class of psychotropic drug was available through the five primary health care centers and the general hospital. Drugs were procured through the Regional Organization of Eastern Caribbean States Pharmaceutical Procurement Services (OECS/PPS) which allows drugs to be purchased at competitive prices.



## **Domain 3: Mental health and primary health care**

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

The cadre of physicians (4) was 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 these physicians had at least two days of refresher training in any aspect of mental health.

Approximately 6% of the training hours for registered nurses was devoted to mental health. Six (86%) of the seven primary health care nurses had at least two days of 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 overwhelming majority of persons accessed essential mental health care and follow-up in the primary health care setting. All primary health care clinics are physician-based. There was no protocol for treating mental illness at the hospital or in the primary health care centers. In 2003, a PAHO consultant prepared a document on “Protocols for mental health services in Montserrat.” The objective of this document was “to guide health providers in delivering a more efficient and effective community-based mental health service to the people of Montserrat; and to encourage a multidisciplinary approach to mental health while respecting the human rights of the individual.”<sup>2</sup> In 2007, a draft protocol for mental health services was prepared by another consultant. It includes: points of contact for emergency and non-emergency services; instructions for patients admitted to the hospital; the basic composition of a mental health team; and an organogram.

Referrals were made from the physician-based primary health care centers and there was interaction between the primary health care physicians and a mental health professional; however, these did not occur on a monthly basis. None of the primary health care centers or the Glendon Hospital reported an interaction with a complimentary/alternative/traditional practitioner.

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

Primary health care doctors are allowed to prescribe psychotropic medicines without restrictions. The mental health nurses are not allowed to initiate a prescription for psychotropic medicines; however, they are allowed to continue and/or adjust such prescriptions. Non-doctor/non-nurse primary health care workers are not authorized to prescribe and/or to continue medications. The majority of the primary health care centers and the hospital’s pharmacy had access to at least one psychotropic medication of each

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<sup>2</sup> Office of the Caribbean Program Coordination, PAHO/WHO. Protocols for Mental Health Services in Montserrat. Bridgetown, Barbados; May 2003.

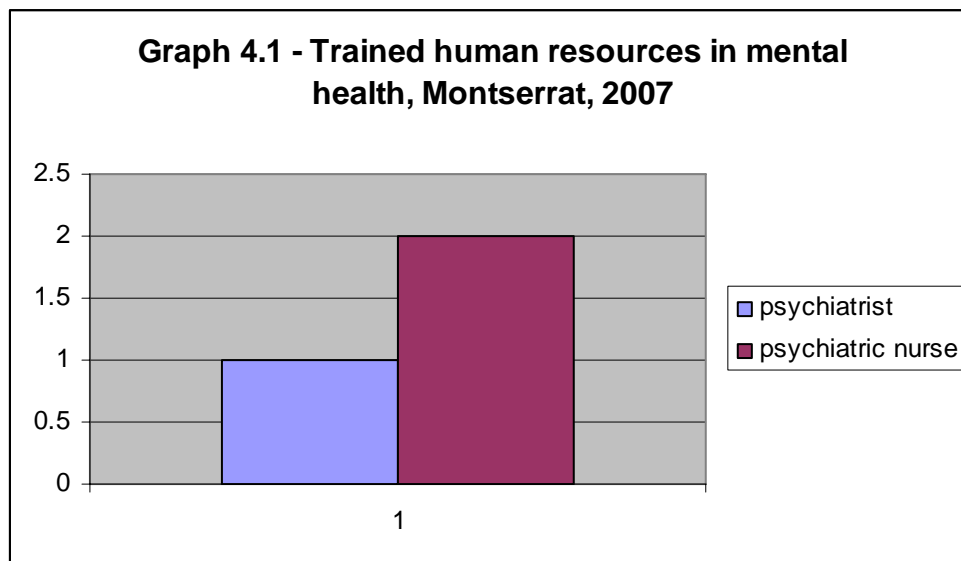
therapeutic category (that is, antipsychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic).

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## Domain 4: Human resources

### Number of human resources in mental health care

There were 9 persons working in mental health in Montserrat: 1 visiting psychiatrist (from Dominica); 1 internist, not specialized in psychiatry (who visits all primary health care clinics); and 7 primary health care nurses. There were no mental health aides, social workers, psychologists, or occupational therapists in the mental health team. There was no psychiatrist in private practice in the island. Four doctors (surgeon, anesthetist, pediatrician, and general medical doctor) were assigned to the general hospital and 26 nurses—none are mental health professionals.



### Training professionals in mental health

There were no training programs at the national level to train physicians, psychiatric nurses, mental health aides, social workers, or occupational therapists. The cadre of nurses in the public sector was either trained in Montserrat or in other CARICOM countries. Most of the physicians working in the island were trained outside of the CARICOM region, such as in Africa and India. 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 five years of completion of overseas training.

### **Consumer and family associations**

There were no user/consumer or family associations. The Mental Health Committee was actively involved in the drafting of the Mental Treatment Act.

## **Domain 5: Public education and link with other sectors**

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

Although there were no coordinating bodies *per se* to oversee public and education and awareness campaigns on mental health or mental disorders, the ad hoc Mental Health Committee served as an advocacy group for mental health issues. Its members represent a wide range of professional agencies. From time-to-time, the government also convened activities to promote public education and awareness. These activities targeted the general population, adolescents, and professional groups linked to the health sector.

### **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 mental disorder; c) financial provision concerning priority in housing and in subsidized housing schemes for people with mental disorders; and d) protection and discrimination in allocation of housing for people with severe mental disorders.

Notably, since the volcanic crisis, housing is considered as a component of rehabilitation for the mentally challenged. In 2006, a Mentally Challenged Housing Social Impact Assessment was conducted to formulate a policy for housing for the mentally challenged which would, in turn, inform the Mental Health Policy and Mental Health Act.

### **Links with other sectors**

Formal collaborative programs existed with the department/agency responsible for primary health care/community health, child protection, education, housing, employment, and welfare. The Red Cross and communities/villages played an active role in the care, protection, and feeding of mental challenged persons even though there were no formal collaborative programs. There were no mental health professionals assigned to either the primary or secondary schools. However, there was a guidance counselor that served both levels of schooling. Greater than 15% of prisoners were diagnosed with some form of psychosis and none had mental retardation. The single prison had at least one prisoner per month in treatment with a mental health professional. Concerning training, no police officer, judge or lawyer participated in educational activities on mental health in the last five years.

The CSD provided a monthly check in the amount of EC\$600 to mentally challenged persons to cover food and related bills. For persons who could not manage these funds responsibly, “good faith” informal arrangements were made with supermarkets and cook shops in communities where the patients were well-known. Through these arrangements, they collected groceries from designated supermarkets or daily meals from cook shops.

The CSD monitored periodically the use of the funds and the clients complained when their expectations were not met. Recognizing that the funds from the CSD were not sufficient to meet the clients' needs, the Red Cross and other NGO's gave supplementary assistance, as needed. In some cases, the clients did odd jobs at the supermarket and cook shops to supplement the welfare funds.

The CSD provided welfare support to three hundred and twenty-one persons in 2007. Of these, seventy-one (22%) received assistance only because they were disabled due to mental disorders.

### **Next Steps in Strengthening the Mental Health System – Montserrat**

The initial step in addressing the weaknesses in the mental health system will commence with a national consultation to discuss the WHO-AIMS report. Other phases will include discussions/actions on the development of policies and plans; legislation review; human rights for the criminally insane; management of children and adolescents with mental illnesses; and on issues concerning abuse of mentally challenged adults, children and adolescents. The activities in the table below will guide the reformation process.

Table 1: Next Steps to reform and strengthen the mental health services in Montserrat

<b>DOMAINS</b>	<b>PROPOSED NEXT STEPS</b>
Legislation and Policy	<ul style="list-style-type: none"> <li>• Formulate a mental health plan</li> <li>• Formulate of a mental health disaster/emergency plan</li> <li>• Review the Legislation</li> </ul>
Mental Health Services	<ul style="list-style-type: none"> <li>• Improve the day care facilities to the mentally ill</li> </ul>
Mental health in primary health care	<ul style="list-style-type: none"> <li>• Improve the specialist services for the newly diagnosed and chronic patients</li> <li>• Improve the delivery of rehabilitation services to substance and alcohol abusers</li> <li>• Establish a life skills program for persons with mental illness. The primary objective is to generate employment and apprenticeships among this population.</li> <li>• Formulate and strengthen the plan of action for improving the community mental health program</li> </ul>
Human Resources	<ul style="list-style-type: none"> <li>• Access fellowship funds to develop specialized skills in</li> <li>• Provide training for nurses in the Mental Health Unit to update their skills in first level diagnostic assessments</li> <li>• Conduct refresher training for physicians and nurses in the use of the ICD-10 coding for mental health and DSM 4R</li> </ul>

	Classification
Public Education and links with other sectors	Establish linkages with: <ul style="list-style-type: none"> <li>• Health Promotion Unit</li> <li>• Schools through PTA (parent teachers association)</li> <li>• Service clubs</li> <li>• Youth and church organizations</li> </ul>
Monitoring and Evaluation	<ul style="list-style-type: none"> <li>• Establish a manual information system with the view of further development into a computerized integrated mental health information system</li> <li>• Implement the Minimum Data Sets in collaboration with the Health Information Unit</li> </ul>

The primary goals of the Montserrat Mental Health Program are to prevent mental illness and to enhance the mental health of individuals, families and communities. A systematic review, update and operationalization of the draft mental health plan (2002) and the development of a mental health policy will provide the impetus for the formulation of a comprehensive work plan.

Concomitant with the plan, Montserrat will ensure the routine collection of mental health data, establish a culture of research driven policy-making decisions and provide information for an integrated national data base.

The management of persons with mental health disorders will be coupled with the requisite training and strengthening competencies. Training in the application of psychosocial skills, behavioral interventions and risk-benefits assessment of the effects on long-term use of psychotropic medications must be addressed through a myriad of ways.

Due to the dearth of skilled professionals in Montserrat, a multidisciplinary approach is the only viable solution that can assist in increasing the mental health system's links with other key sectors and provide optimum uninterrupted care for the mentally ill.

The World Health Organization Assessment Instrument for Mental Health (WHO-AIMS) was used to collect information and structure the report on the mental health system in Montserrat. The overarching goals of this exercise are to provide a structured assessment of the mental health system, encourage improvements, and provide a baseline for monitoring change.

Care and treatment of mentally disordered persons are not guided by a modern legislative framework, mental health policy, or mental health plan. No single institution is dedicated solely to the care and treatment of persons with mental illness and there is no resident psychiatrist. Service delivery is community-based. No mental health information system exists. Two percent of the national health budget is directed towards mental health services. Psychotropic medicines are widely available. The housing and nutritional needs of mentally challenged individuals are included in the rehabilitation process.

There is a need to finalize the mental health legislation, policy, and strategic plan. The goal of the proposed mental health plan is to enhance the mental health of individuals, families, and communities through improved services, health promotion, advocacy, training, and stakeholder involvement.