

# WHO-AIMS

**WHO-AIMS REPORT ON**  
**MENTAL HEALTH SYSTEM**  
**in**  
**THE COMMONWEALTH OF**  
**DOMINICA**



**World Health  
Organization**



**MINISTRY OF HEALTH**  
**THE COMMONWEALTH OF DOMINICA**

**WHO-AIMS REPORT ON  
MENTAL HEALTH SYSTEM  
IN THE COMMONWEALTH OF DOMINICA**

*Report of the Assessment of the Mental Health System in  
The Commonwealth of Dominica  
Using the WHO-AIMS Instrument for Mental Health Systems (WHO-AIMS)*

The Commonwealth of Dominica

2009

The data was collected in 2009 based on data for 2007



**MINISTRY OF HEALTH  
THE COMMONWEALTH OF DOMINICA**

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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**

Dominica is the largest and most northern of the Windward Islands. It is called the “Nature Island of the Caribbean” for its unspoilt natural beauty. In 2007, the population was estimated at 71,286. Four percent of the population is comprised of indigenous Carib Indians who live the Carib Territory, a demarcated area in the northeast of the island.

The World Health Organization’s Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information and format the report on the mental health system in Dominica. 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. This assessment should provide momentum to initiatives to reform mental health services in Dominica.

There is no mental health policy or mental health plan. The Mental Health Act was legislated in 1987. In 2007, national expenditure on mental health was estimated at 3% of the total national health budget and this proportion is allocated to the Psychiatric Unit. An undetermined amount of additional resources contribute to the operation of the Unit but this is subsumed in the budget for the Princess Margaret Hospital. No data were available to estimate the extent of use of private mental health service providers and out-of-pocket spending on these services. One hundred percent of the population has free access to at least one psychotropic medication of each therapeutic category (anti-psychotics, anti-depressants, anxiolytics, mood stabilizers, and anti-epileptic drugs). These drugs are widely available in Dominica. Health regulations allow primary health care physicians and Family Nurse Practitioners to prescribe and/or continue use of psychotropic medicines. Family Nurses Practitioners are allowed to continue use of these medications.

The consultant psychiatrist is the defacto mental health authority. He provides advice to the government on matters related to mental health care. There is a Mental Health Review Board to handle applications by, and in respect of patients. No national or regional-level human right bodies exist in the country. The Psychiatric Unit never had an external review/inspection of human rights protection of patients and no mental health worker received training in this area.

The 40-bed Psychiatric Unit is located adjacent to the Princess Margaret Hospital, the island’s public secondary care institution. None of the beds in the Unit are reserved for children, adolescents, or forensic patients. In 2007, there were 374 admissions of which 30% were females, and 5% were aged 17 years and younger. Best estimates indicate that the majority of admissions were involuntary. Between 2-5% of admissions are restrained and/or secluded at least once in the Psychiatric Unit. On discharge, 61% of these admissions carried a diagnosis of schizophrenia or related disorders. On average, patient spent 14.7 days per discharge. The Unit has 16 long-stay patients each being institutionalized for 10 years or more.

The management and treatment of mental disorders is not fully integrated in the primary health care system. None of the primary health care centers had assessment and treatment protocols for key mental health conditions. The human resources for community mental health care reside in the Psychiatric Unit. Scheduled mental health clinics are held in primary health care facilities throughout the island, the Psychiatric Unit, the Prison, and at Ross University Medical School. No data was available to estimate the sex, age and diagnoses of persons seen in the 13 outpatient mental health clinics. There is no mental hospital, day treatment facility, community residential facility, or forensic facility.

In 2007, there were 47 human resources working in mental health—all but one (a psychiatrist) was assigned to the Psychiatric Unit. One of the 3 psychiatrists was a volunteer under a technical cooperation program between the governments of Dominica and Nigeria; returned to Nigeria in 2007. Currently, there are two psychiatrists in the country: one works in the public and private sectors and the other exclusively in the private sector at Ross University School of Medicine. None of the primary health care physicians, nurses, or non-doctor/non-nurse received at least two days of refresher training in the rational use of psychotropic drugs, psychosocial (non- biological) interventions, and child and adolescent psychiatry in the past five years.

There are no user/consumer or family associations. No programs exist to provide employment for persons with mental disorders. No specific legislative and financial provisions are available to protect persons with mental disorders from discrimination in hiring processes and in allocation of housing. Similarly, no public provisions exist for persons with severe mental disorders to gain priority status in the acquisition of state housing and in subsidized housing schemes.

With regards to links with other public and private sectors, formal collaboration exists with the agency responsible for criminal justice. No such collaboration exists with health or other non-health sectors. No mental health professionals are assigned to either primary or secondary schools to recognize and treat mental health problems and there are no structured school-based activities to promote mental health and prevent mental disorders. No programs exist to provide employment for persons with mental disorders outside the mental health facility.

Regarding data collection, analysis and dissemination of mental health data, there is no mental health information system nor is there a repository where timely and comprehensive data is stored. Individual data items are available in the users' medical charts and in their health-passports. This institutional data is not compiled, analyzed or disseminated and no reports are generated. No national-level reports covering mental health data was available.

The priority next steps to reform the mental health services will include formulation of a mental health policy and plan; deeper integration of mental health into primary health; training of mental health workers; increase collaboration with key stakeholders; development of a mental health information system; and preparation of an article on mental health care in Dominica for publication in an indexed journal.

## **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 Dominica. Data was collected in August 2009 and is based on the year 2007.

Three days was assigned for the data collection phase. (July 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 Dominica.
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 Dominica.
5. The data was entered into the WHO-AIMS 2.2 Excel spreadsheet and discussed with the Non-Communicable Diseases and Mental Health Adviser, 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***

The reporting system for mental health does not permit a comprehensive, timely, reliable, and accurate data. Although client-centered data were available at the Psychiatric Unit, it was not compiled or analyzed. Consequently, considerable time was spent reviewing individual client records to extract date of admission, age, sex, diagnosis, and length of stay. For this report, the diagnoses were coded manually using the International Classification of Diseases, Tenth Revision (ICD-10). Time did not permit collection, compilation, and analysis of mental health data generated by the outpatient primary health care centers.

Taking these limitations into consideration and the expedience with which the data was required, the information reported herein best reflects the characteristics of the mental health system in Dominica.

## Introduction

Dominica is the largest and most northern of the Windward Islands. Its geographic coordinates are 15° 18 N, 61° 23 W. To the north-northwest of Dominica is Guadeloupe and to its southwest is Martinique. Dominica is 29 miles long, 16 miles wide, and covers an area of 289 square miles. Dominica is acclaimed as the “Nature Island of the Caribbean” boasting 365 rivers—one for each day of the year. In 2007, the population was estimated at 71,286. Although the official language is English, most of the population speaks a patois which is a blend of African and French linguistic structures.

Dominica has the largest population of indigenous people in the Eastern Caribbean. The Carib Indians (Kalinago) comprised approximately 4% of the total population. They occupy a 15.3 sq. km-demarcated area called the Carib Territory which is located on the northeast of the island. The Carib population is young with 70% being less than 30 years old and 40% less than 19 years old. The Carib’s main economic activity consists mainly of subsistence farming, craft production and boat building.

Dominica gained political independence from the United Kingdom in 1978. Dominica is a parliamentary democracy within the Commonwealth of Nations with a single-chamber parliament. The House of Assembly has 21 elected members and 9 appointed members. The parliament elects a president who is the head of state. It also appoints the Cabinet which is headed by the prime minister.

The Dominican economy is based primarily on agriculture with nearly one-third of the labor force employed in the agriculture sector. Dominica is self-sufficient in food production. With the decline in the banana industry, economic growth has gained momentum from gains in tourism, construction, offshore, and other services. Dominica’s currency is the Eastern Caribbean dollar (EC\$) which is pegged to the United States dollar at US\$1=EC\$2.70.

In 2007, the crude birth rate was 12.7 births per 1,000 population and the crude death rate was 7.9 deaths per 1,000 population. Infant mortality rate was 22.3 deaths per 1,000 live births and the under-five mortality rate was 3.8 per 1,000 live births. Total life expectancy at birth was estimated at 75.77 years. There were 22 centenarians in 2007.

Dominica is a member of several international organizations and agencies, such as, Organization of Eastern Caribbean States (OECS), the Caribbean Community (CARICOM), the Organization of American States (OAS), the International Monetary Fund (IMF), and the Pan American Health/World Health Organization (PAHO/WHO).

The Ministry of Health has overall responsibility for the population’s health and wellbeing. There are two health regions which are divided into seven health districts with a total of 52 primary health care centers. All primary health care centers serve distinct catchment areas and are easily accessible to their target populations. The Princess Margaret Hospital is the only public secondary-care hospital. The Psychiatric Unit is adjacent to the hospital; it is the only institution providing inpatient and outpatient mental health services. Outpatient psychiatric care is delivered through scheduled mental health

clinics in 11 primary health care centers, the prison, and one private clinic at Ross University School of Medicine. This medical school grants a Doctor of Medicine degree and the majority of its students are from the United States.

## **Domain 1: Policy and Legislation**

### **Policy**

There is no mental health policy.

### **Plan**

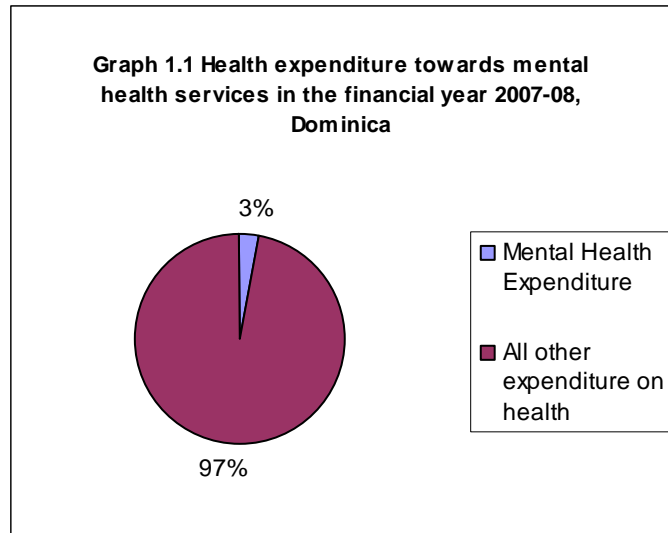
There is no mental health plan. There is no disaster/emergency plan for mental health.

### **Legislation**

The Mental Health Act 29 of 1987 is enshrined in the Laws of Dominica, Chapter 40:62. The Act provides for the care and treatment of persons who are mentally ill and related matters. The sections of the Act are: Part I, Preliminary; Part II, Admission to Psychiatric Hospital; Part III, Management of Property and Affairs of Patients; and Part IV, Miscellaneous. The Mental Health Regulations contain items pertaining to: notification of rights, search for and possessions of valuables, etc.; physical examination and records thereof; routine examinations; rights of voluntary patients/change of status; application of electro-convulsive therapy; application by nurse-in-charge of medication; seclusion as a method of treatment; when patients leave hospital without permission; access to visitors; power to withhold or return mail; and mail to attorney-at-law or the Mental Health Review Board. The Act does not contain procedures and standardized documentation for implementing the legislation.

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

In 2007-08 financial year, the national health expenditure totaled EC\$34.2 million of which EC\$1.1 million was directed towards the Psychiatric Unit, the sole provider of public mental health services. However, this figure is not an accurate reflection of the total government's expenditure on mental health services since numerous items involved in the operation of the Psychiatric Unit are subsumed under the Princess Margaret's Hospital's budget. These include: certain operational costs, psychotropic medications, and salaries for some categories of workers. It was impossible to delineate and estimate the dollar value for the shared services owing to the integrated structure of the budgetary allocations. Data were not available to estimate the extent of use of private mental health service providers and out-of-pocket spending on these services. No social insurance scheme existed in the country but the government provided free health services at the primary health care level. In practice, there is no cost for mental health services at the secondary care level. One hundred percent of the population had free access to essential psychotropic medications in the categories of anti-psychotics, anti-depressants, anxiolytics, mood stabilizers, and anti-epileptic drugs.



## **Human Rights**

There were no national or regional-level review bodies on human rights. The Psychiatric Unit never had an external review/inspection of human rights protection of users of mental health services. None of the human resources working in mental health had any exposure to training on the set of basic rights of mentally ill persons.

Part II, Section 13 of the Mental Health Act, refers to the constitution of a Mental Health Review Board for the purpose of dealing with applications by and in respect of patients. A person, acting on behalf of a patient detained either as a voluntary patient, medically recommended patient, or hospital order patient who believes that the detention is unreasonable may apply in writing to the Board for its review of the matter. The Act gives the Board 28 days from the receipt of the application to examine the case and provide a ruling. A person who is aggrieved by the decision of the Board may appeal against the decision to the High Court.

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

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

There was no mental health authority *per se* -- the government's consultant psychiatrist functioned as the main authority. He provided advice to the government on service planning and service management. Inpatient and community mental health care were delivered by the Psychiatric Unit's human resources.

### **Mental health outpatient facilities**

There were no outpatient facilities specifically for the delivery of mental health services. Primary health care centers are the first point of contact with the health services. The staff of the Psychiatric Unit conducted scheduled mental health clinics at primary health care centers island wide and the state prison. Ross University School of Medicine operated a

mental health clinic on the university's campus for its faculty and students. No data was accessed for that facility.

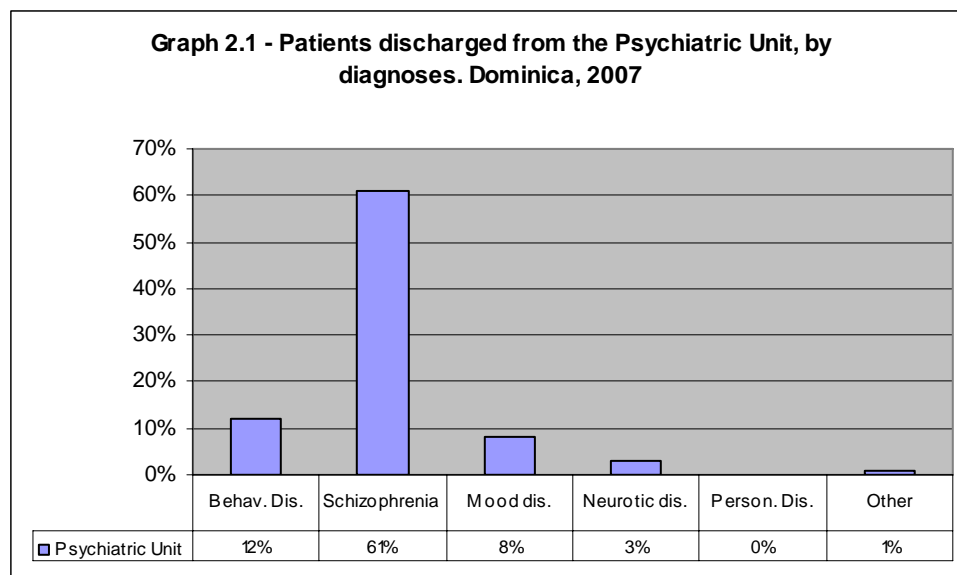
No data were available to estimate the number of users of mental health services through the outpatient mental health clinics in 2007. The Health Information Unit (Ministry of Health) estimated that 783 users were treated in outpatient mental health clinics for a total of 2,348 visits in 2006—this data was not disaggregated by sex, age, or diagnoses. 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 anti-epileptic medicines). Some (21-50%) of patients received one or more psychosocial interventions in the outpatient mental health clinics.

### **Day treatment facilities**

There were no mental health day treatment facilities.

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

The Psychiatric Unit is a 40-bed inpatient facility and none of its beds were reserved for children, adolescents, or forensic patients. However, all categories of patients received emergency and acute mental health care within this facility despite their age or criminal records. Admissions were categorized and recorded as voluntary or involuntary which includes “medically-recommended” or “hospital order.” In 2007, there were 374 admissions of which 112 (30%) were females. Eighteen (5%) were aged 17 years and younger. For this report, discharge data was coded manually using the International Classification of Diseases, Tenth Revision (ICD-10). On discharge, 61% were diagnosed with schizophrenia and related disorders. On average, patients spent 14.7 days per discharge. The majority, 51-80% of patients received one or more psychosocial interventions in the Psychiatric Unit.



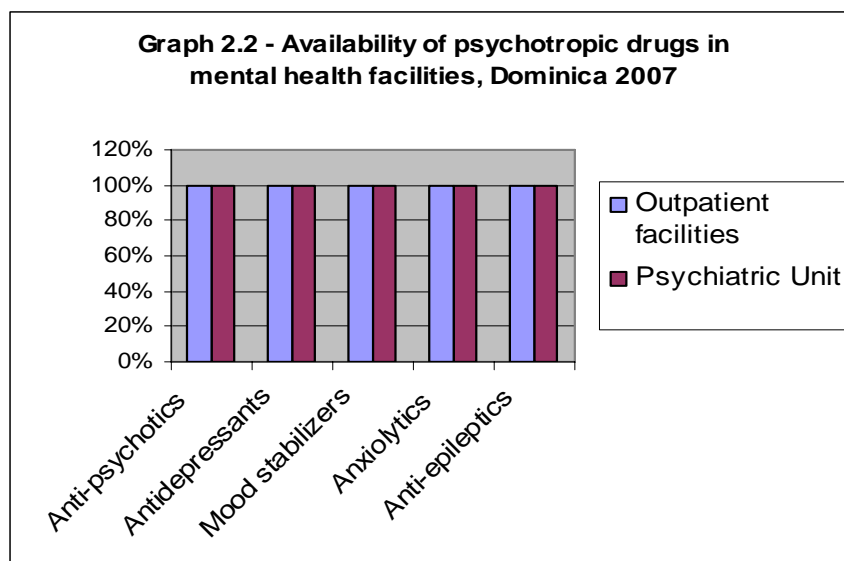
Summary for Graph 2.1

One hundred percent of patients managed at the Psychiatric Unit during the period reviewed had a clinical diagnosis on admission. Of the 374 discharges, 56 (15%) did not have a discharge diagnoses placed on their discharged certificate.

Discharged clients received a referral note to their health clinics. Furthermore, chronological events are recorded in a “health passport” which is a small book describing their medical illness, medications, and other pertinent events. Entries are made by the nurses, psychiatrist, medical officers, social worker, and pharmacist. The booklet is updated during clinic visits. For those clients who are incapable of protecting this passport, it is stored at the primary health care center or at the Psychiatric Unit depending on where follow-up treatment is accessed.

The Unit had an additional 16 long-stay patients all of whom were hospitalized for more than 10 years. All of these patients carried a diagnosis of schizophrenia and related disorders.

The Unit had at least one psychotropic medicine of each therapeutic category (anti-psychotic, anti-depressant, mood stabilizer, anxiolytic, and anti-epileptic drugs).



Summary for Graph 2.2

Psychotropic drugs are available in all facilities.

### **Community residential facilities**

There were no community residential facilities.

### **Mental Hospital**

There is no mental hospital.

### **Forensic and other residential facilities**

There were no forensic inpatient units and no beds designated for forensic patients in the Psychiatric Unit. Forensic clients are integrated into the general population in the Unit. Six residential facilities provided care to the elderly population. Data was only available for the Grotto Home for the Homeless. In 2007, this facility had 40 residential clients and of these, 15 (6 females and 9 males) had mental disorders in the category of schizophrenia and related disorders.

### **Human rights and equity**

The patients' admission status was recorded in the clients chart but not compiled. This indicator was not tabulated during the data collection process but best estimates indicate that the majority of admissions were involuntary. Approximately 2-5% of patients were restrained and/ or secluded at least once in the Psychiatric Unit. One hundred percent of the psychiatric beds are located in the capital city. Persons residing in rural communities are over-represented in their use of the outpatient community mental health services. Inequity of access to mental health services based on language, ethnicity, or religion is not an issue in Dominica.

## **Domain 3: Mental Health in Primary Health Care**

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

The majority of junior physicians (A number of the physicians) in the public sector were trained in Cuba. Their six-year medical training program included a six-week clinical rotation in psychiatry. Physicians who were trained at the University of the West Indies estimated that 1% of their training was devoted to psychiatry. An estimated 3% of the registered nurses training program was devoted to mental health concepts and clinical practice.

### **Mental health care in primary health care**

The human resources at the Psychiatric Unit are responsible for community mental health services. Thirteen outpatient mental health clinics are offered in various facilities: 7 clinics are held in the primary health care centers in rural communities; 4 clinics are held at the Psychiatric Unit to serve distinct catchment populations in the city of Roseau; 1 clinic is held in the prison; and one private clinic at Ross University School of Medicine. All primary health care centers are managed by a physician (district medical officer).

None of the public physician-based primary health care clinics had assessment and treatment protocols for key mental health conditions. All or almost all, (81-100%), of full-time primary health care doctors made on average at least one referral per month to a mental health professional. Similarly, all or almost all (81-100%) of primary health care doctors interacted with a mental health professional at least monthly. None of the physician-based primary health care centers interacted with a

complementary/alternative/traditional practitioner at least once in the referenced year. The Psychiatric Unit had limited interaction with the latter category of practitioners.

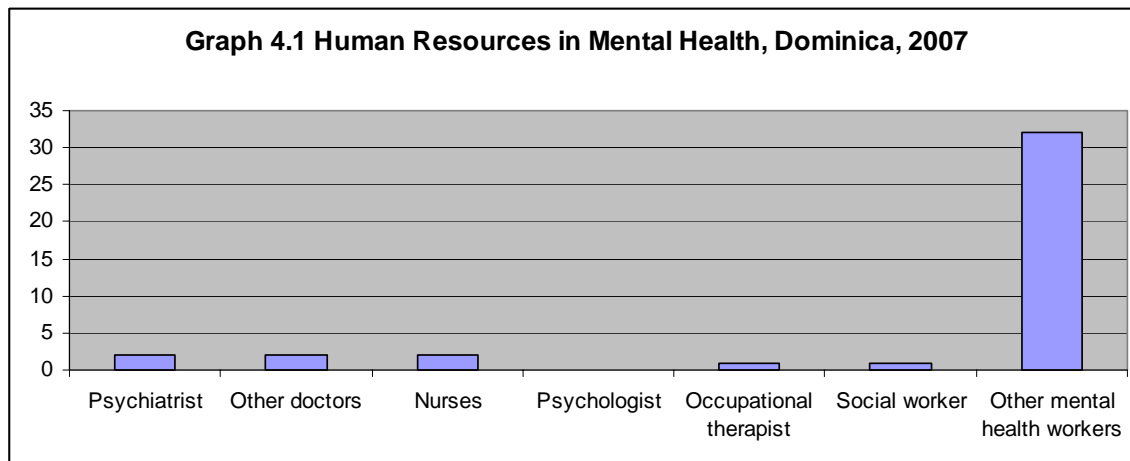
### **Prescription in primary health care**

Health regulations authorize primary health care physicians to prescribe and/or continue prescription of psychotropic medicines. Primary health care nurses cannot initiate prescriptions for psychotropic medicines but they are allowed to continue such prescriptions. Non-doctor/non-nurse primary health care workers are not allowed to prescribe or continue prescriptions for psychotropic medicines.

## **Domain 4: Human Resources**

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

In 2007, 46 persons worked in public mental health facilities and private practice. There were two psychiatrists: 1 worked only in a private capacity – Ross University; and 1 in the public health care system and privately. The 2 medical doctors (not specialized in psychiatry), 8 nurses, 1 social worker, and 1 occupational therapist (a volunteer from Japan) were responsible for providing care in the Psychiatric Unit as well as in the outpatient mental health clinics. No data was accessed with respect to the number and category of staff in the mental health clinic at the Ross University School of Medicine.



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

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 the rational use of psychotropic drugs, psychosocial (non-biological) interventions, and child and adolescent mental health issues. The two medical doctors (not specialized in psychiatry), who were assigned to the Psychiatric Unit graduated from medical school in 2005. The psychiatrist who worked solely in the public sector was a volunteer under a technical cooperation



agreement with the government of Nigeria; he returned to Nigeria in 2007. No psychiatrists migrated to other countries within five years of the completion of training.

### **Consumer and family associations**

There were no user/consumer or family associations.

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

### **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. In the last five years, the Ministry of Health was primarily responsible for promoting these campaigns. Annually, the Ministry dedicates a week to public education and awareness campaigns that target primarily the general population. These activities are held in celebration of World Mental Health Day which is celebrated on October 10<sup>th</sup> each year.

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

No legislative or financial provisions were in place concerning: a) 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) priority in state housing and in subsidized housing schemes for people with severe mental disorders; and discrimination in allocation of housing for people with mental disorders. The social welfare scheme provided benefits to 3,100 persons because of mental and physical disorders. However, the proportion of persons who received welfare benefits solely because of disability due to a mental disorder could not be estimated since this information was not recorded.

### **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 other formal collaboration existed with any health or non-health sector. None of the primary or secondary schools had either a part-time or full-time mental health counselor. However, the 79 primary and secondary schools had access to 5 Guidance Counselors (with Masters' degrees) and 1 Counselor (with a Bachelor's degree). There were no school-based activities to promote mental health and to prevent mental disorders. No police officers, judges or lawyers participated in educational activities on mental health in the last five years. An estimated 6-10% of prisoners were diagnosed with a psychotic disorder and none with mental retardation. The single prison hosted a monthly clinic providing mental health care to at least twelve persons in prison while at least one prisoner per month had emergency 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**

Although there was a formally-defined list of individual data items that ought to be collected by mental health facilities, the Psychiatric Unit only collected and compiled data on numbers of beds and inpatient admissions. Admission and discharges dates were recorded in the patients' charts as well as their admission status (voluntary or involuntary) but the information was not compiled. There was no information on the number of patients who were physically restrained and/or secluded.

The mental health outpatient clinics routinely collected data on the number of users treated and their diagnoses. However, 2007 data was not compiled, and analyzed.

No report covering mental health data was available from, or published by the government. Although not in the last five years, Kohn, Sharma, Camilleri, and Levav conducted research on "Attitudes towards mental illness in the Commonwealth of Dominica;" the results were published in the *Revista Panamericana de Salud Publica* in March 2000.

## NEXT STEPS IN STRENGTHENING THE MENTAL HEALTH SYSTEM

The WHO-AIMS assessment has given momentum to mental health reform in Dominica. The weaknesses of the mental health system will be discussed and addressed as a matter of priority. The activities outlined in Table 1 constitute the next steps in the reform process.

**Table 1: Proposed next steps to strengthen the mental health services in Dominica, 2009**

DOMAINS	PROPOSED NEXT STEPS
Legislation and Policy	<ul style="list-style-type: none"> <li>• Formulation of a mental health policy</li> <li>• Formulation of a mental health plan and a mental health disaster/emergency plan.</li> <li>• Review the Mental Health Act</li> <li>• Include standardized forms of documentation in the Mental Health Act.</li> </ul>
Mental health services	<ul style="list-style-type: none"> <li>• Integrate mental health into primary health care</li> <li>• Appoint a national coordinator of mental health services to operate within central administration of Ministry of Health</li> <li>• Development of infrastructure for mental health services; rehab facility, day hospital facility</li> </ul>
Mental health in primary health care	<ul style="list-style-type: none"> <li>• Reassign the chronic stable mentally ill clients to the DMOs clinics</li> <li>• Provide regular specialist support for newly diagnosed and noncompliant clients</li> <li>• Provide training for DMOs and district health teams in recognizing and managing chronic mental illnesses.</li> <li>• Source technical assistance to conduct training: a) Physicians: Use of the ICD-10 or DSM 4R framework for recording diagnoses; at least two days of refresher training in psychiatry/mental health for primary care physicians and nurses. 2) Ward Clerks: Morbidity coding using the ICD-10 or DSM 4R Classification</li> </ul>
Human Resources	<ul style="list-style-type: none"> <li>• Request technical cooperation to provide at least a two-day training on human rights protection of persons with mental disorders.</li> <li>• Secure sources of funding/fellowships to develop specialized nursing, medical, social, occupational and psychological skills in mental health</li> <li>• Assign a part-time medical records officer for the Psychiatric Unit</li> </ul>
Public Education and links with other sectors	<ul style="list-style-type: none"> <li>• Increase the mental health system's link with other key stakeholders such as politicians, families, and consumers.</li> <li>• Forge linkages with agencies responsible for domestic violence, HIV/AIDS, drug and alcohol abuse, and child welfare services.</li> <li>• Develop formal collaboration with the Ministry of Education and the Disability Association.</li> </ul>
Monitoring and Research	<ul style="list-style-type: none"> <li>• Development of an integrated mental health information system.</li> <li>• Review work-load in the Health Information Unit to ensure that data from the medical records for mental health patients are collated and analyzed.</li> <li>• Assign a part-time medical records officer for the Psychiatric Unit</li> <li>• Use the formally-defined list of mental health indicators for data collection at the Unit and in the outpatient mental health clinics</li> <li>• Prepare an article for publication on mental health services in Dominica</li> </ul>

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

The Ministry of Health and the Environment is responsible for the care, treatment and protection of persons with mental disorders. The core budgetary appropriation for mental health care, estimated at around 3% of the total health budget, is allocated to the Psychiatric Unit, the sole inpatient psychiatric institution. The Unit is also responsible for the delivery of community mental health services. Mental health services are not fully integrated with primary health care.

In 2007, the majority of persons treated for mental disorders in the Psychiatric Unit carried a diagnosis of schizophrenia and related disorders. Morbidity data from the clinics was not accessed in order to describe fully the characteristics of users in the community mental health setting. One hundred percent of the population had free access to essential psychotropic medications in the categories of anti-psychotics, anti-depressants, anxiolytics, mood stabilizers, and anti-epileptic drugs. Primary health care physicians are allowed to initiate and continue prescriptions for psychotropic medicines; nurses are allowed to continue prescriptions for these drugs.

There is no mental health policy or plan. The Mental Health Act was legislated in 1987. Issues concerning human rights protection for persons with mental disorders, human resources development, data management, links with other sectors, and stakeholder/community involvement do not receive merited attention.

The WHO-AIMS assessment gives momentum to mental health reform in Dominica and the government has identified a number of priority activities to strengthen its mental health services.