

WHO-AIMS

**WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
IN BRITISH VIRGIN ISLANDS**



**MINISTRY OF HEALTH
BRITISH VIRGIN ISLANDS**

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MENTAL HEALTH SYSTEM
IN THE BRITISH VIRGIN ISLANDS

Report of the Assessment on the Mental Health System in the British Virgin Islands using the WHO Assessment Instrument for Mental Health systems (WHO-AIMS)

British Virgin Islands
2009

The data was collected in 2009 based on data for 2007



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de la Salud**



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**MINISTRY OF HEALTH
BRITISH VIRGIN ISLANDS**

WHO, Country office, Barbados

Pan American Health Organization (PAHO), WHO Regional Office for the Americas (AMRO)

WHO Department of Mental Health and Substance Abuse (MSD)

For further information and feedback, please contact:

*1) Dr. June Samuels
Community Mental Health Center
jmsamuel@surfbvi.com*

*2) Dr. 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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Acknowledgment

The World Health Organization Assessment Instrument for Mental health (WHO-AIMS) was used to collect information and format the report on the mental health system in the British Virgin Islands.

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

A team from the Community Mental Health Center comprising June Samuels, Senior Psychiatrist, Virginia Rubaine, Director of Mental Health Services and Nickesha Nickie, Professional Cadet/intake clinician participated actively in the data collection phase. Ronald Georges, Acting CEO, BVI Health Services Authority and Tracia Smith, Health Information Officer, Ministry of Health also provided in-country support. The medical diagnoses were coded manually by Ingrid Malone, Medical Records Officer and Adelin Vanterpool, Executive Officer. Much gratitude and profound appreciation are awarded to these individuals for making this report possible. In-country logistics were coordinated by Katrina Smith, Country Program Officer (Anguilla). Shirley Alleyne, Non-Communicable Diseases and Mental Health Adviser, PAHO/ECC Office, provided support for the publication of this report.

The PAHO/ECC Office and the national authorities in the British Virgin Islands wish to thank the World Health Organization for its remarkable foresight to design this instrument to assess the mental health systems in its Member States.

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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 British Virgin Islands (BVI), an overseas dependent Territory of the United Kingdom, is located in the northeastern Caribbean Sea. It is comprised of 50 islands, cays, and rocks occupying a total land mass of 59.3 square miles. The four largest islands in the Territory are Tortola, Anegada, Virgin Gorda, and Jost Van Dyke. In 2007, the total population, comprising largely of immigrants, was estimated at 27,518.

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information and format the report on the mental health system in the Territory. The overall goal of this process is to provide a structured assessment of the mental health system and create the momentum for reform to reduce the burden of mental disorders.

The Territory does not have a mental health policy or plan. The disaster preparedness plan for mental health services was developed in 2000. The Mental Health Ordinance is dated 1986 and its revision is in progress. Approximately 3% of the national health budget is directed to mental health services which are delivered through the Community Mental Health Center. The cost of mental health care, that is delivered through the general hospital, is subsumed under that hospital's budgetary appropriation. One hundred percent of the population has free access to at least one psychotropic medication of each therapeutic category (anti-psychotic, anti-depressant, mood stabilizer, anxiolytic, and antiepileptic). Primary health care physicians are allowed to prescribe or continue the use of psychotropic medicines without restrictions. There is no human rights policy or human rights review body. None of the mental health facilities had an external review/inspection of human rights protection of patients and mental health workers were never trained in this area.

The Community Mental Health Center, the lead agency for the delivery of mental health services in the Territory, functions as the national mental health authority. The Center is responsible for the delivery of community-based mental health care which is delivered through the Center and three primary health care facilities. The Center is the repository for the records of all clients treated through community-based services. In 2007, 320 users accessed outpatient services; 56% were females; and 20% were aged 17 years and younger. The majority of users carried a primary diagnosis of schizophrenia and related disorders (30%) and mood (affective) disorders (27%). There are two secured rooms in the general hospital for persons with mental disorders. Non-disruptive patients are managed in the general medical wards. Seventy-nine persons were admitted with mental disorders in 2007; 41% were females and no users were under 15 years old. On admission, their diagnoses fell primarily into three groups: mental and behavioral disorders due to psychoactive drug use 32%; schizophrenia and related disorders (24%); had mood (affective) disorders (24%). Ethnic minorities, such as Hispanics, Hindus, and Muslims, under-utilize the public mental health services, opting for private care instead. No data were available on out-of-pocket spending for privately-accessed mental health care.

The Territory never had a mental hospital—the community care paradigm is the dominant approach to treatment. There is no forensic facility. There is one inpatient facility providing treatment for persons suffering from alcohol and substance abuse.

The majority of the cadre of mental health workers is assigned to the Center. The sole psychiatrist provides services to the Center, liaison services to the general hospital, and operates a private practice. Except for the psychiatrist, no other mental health worker had refresher training in the rational use of psychotropic drugs, psychosocial interventions, and child and adolescent mental health issues.

No consumer or family association exists. No legislative and financial provisions exist to assist specifically persons with mental disorders. Data was not available to indicate the number of persons receiving social welfare benefits solely because of mental disorders. No formal collaborative programs addressing the needs of people with mental disorders exist between the Center and other health or non-health departments/agencies. However, there is an effective, informal referral link between the Center and all schools. One private school has a part-time mental health professional. Primary and secondary schools have access to guidance counselors.

There is no formally-defined list of individual data items that ought to be collected by mental health facilities. Data is not routinely compiled, analyzed or disseminated to the Ministry of Health. No reports covering mental health data were published by the government.

Among the immediate priorities for the next steps are the development of policies and 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 the British Virgin Islands. Data was collected in 2009 and is based on the year 2007.

One week 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 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. A team of mental health professionals from the Community Mental Health Center (CMHC) attempted to complete most of the questionnaires prior to the arrival of the consultant.
3. Interviews were scheduled, through the PAHO/Country Program Officer (located in Anguilla), prior to the consultant's arrival in the British Virgin Islands.
4. The consultant met with the Chief Medical Officer, Ministry of Health to discuss contents of the WHO-AIMS as well as the procedures and requirements for its completion.
5. Since all the categories of health personnel mentioned under 1) above are available in the British Virgin Islands, the CHMC team of mental health professionals and the consultant reviewed each item in the questionnaires and made the necessary additions and corrections.

6. A chart-by-chart review was conducted to select the diagnoses and assign codes from the International Classification of Diseases, Tenth Revision (ICD-10) to the diagnoses for patients treated in the mental health outpatient setting.
7. 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.
8. The WHO-AIMS recommended format was used to prepare the draft report which was circulated to the national health authorities for comments and validation.
9. The final draft report was reviewed by the Regional Adviser for Mental Health, PAHO/WHO, Washington, D.C., prior to its submission to WHO-Geneva.

Limitations

There is no data management system to compile and analyze the wealth of mental health data that are available at the Community Mental Health Center, the institution responsible for community-based mental health services. There is no pre-defined minimum data set to guide the collection of mental health information. No annual reports were available and there was no information on mental health services in the Health Information Unit, Ministry of Health. The Center used the DSM-IV classification to code clients' diagnoses. Consequently, a chart-by-chart review was done to re-code these diagnoses based on the International Classification of Diseases, Tenth Revision (ICD-10).

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

Introduction

The British Virgin Islands (BVI) is an overseas dependent Territory of the United Kingdom. The islands are located in the Caribbean Sea, between 18° 20 N and 64° 30 W. The 50 islands, cays, and rocks occupy a total land mass of 59.3 square miles and these are spread over 1,330 square miles in the Caribbean Sea. The four largest islands in the Territory are Tortola, Anegada, Virgin Gorda, and Jost Van Dyke. The largest and most populated island is Roadtown, the capital, which is located in Tortola. The population was estimated at 27,518 in 2007. Immigrants accounted for over 60% of the population in 2006.

The Head of State is Queen Elizabeth II who is represented by the Governor. The BVI is self-governed by a democratically-elected Legislative Council. There is a unicameral House of Assembly that comprises 13 elected seats and one non-voting ex-officio member. The Executive Council is appointed by the governor from among the members of the House of Assembly. There are three District Officers with administrative functions for Virgin Gorda, Anegada, and Jost Van Dyke.

The BVI has one of the most stable and prosperous economies in the Caribbean. The economy depends heavily on locally-generated revenues with tourism providing almost 50% of the national income. In 2005, an estimated 820,000 tourists visited the islands. Substantial national income is derived from the incorporation fees charged to thousands of companies that incorporate in the island. The BVI uses the United States dollar as its national currency. BVI also receives small grants-in-aid from the British Government, mainly for security and foreign affairs.

Health services are delivered by the BVI Health Services Authority (BVIHSA), a semi-autonomous entity under the Ministry of Health and Social Development. The Ministry is responsible for all capital projects related to health as well as for the policies and legislation that govern the BVIHSA.

In 2007, the crude birth rate was estimated at 10.14 births per 1,000 population and the crude death rate, 3.78 deaths per 1,000 population. Total fertility rate was 1.3 children per woman and infant mortality rate was 16 deaths per 1,000 live births. Life expectancy for males was 75.9 years and 78.3 years for females.

BVI has one 44-bed public hospital, Peebles Hospital, and one 8-bed private hospital. Public sector primary health care is delivered through 10 health clinics and 2 health posts. Community mental health services are delivered through 4 clinics located in Tortola (Community Mental Health Center); Virgin Gorda (est. population 3,806); Anegada (est. population 297); and Jost Van Dyke (est. population 290). Catchment populations vary owing to the large numbers of tourists and boat/yacht dwellers who use the public mental health services.

The government's policy is to provide comprehensive health care, with special focus on women, children, the elderly, the mentally ill, indigent, and persons with physical disabilities.

Domain 1: Policy and Legislative Framework

Policy

The British Virgin Islands (the Territory) does not have a mental health policy.

Plan

There is no mental health plan. A disaster preparedness plan for mental health services was developed in 2000. It outlines the pre-disaster and post-disaster activities to be undertaken in the event of a disaster or emergency.

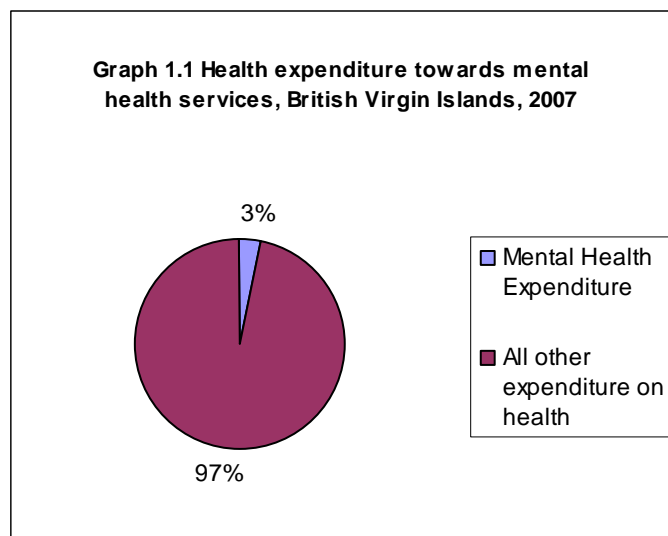
Legislation

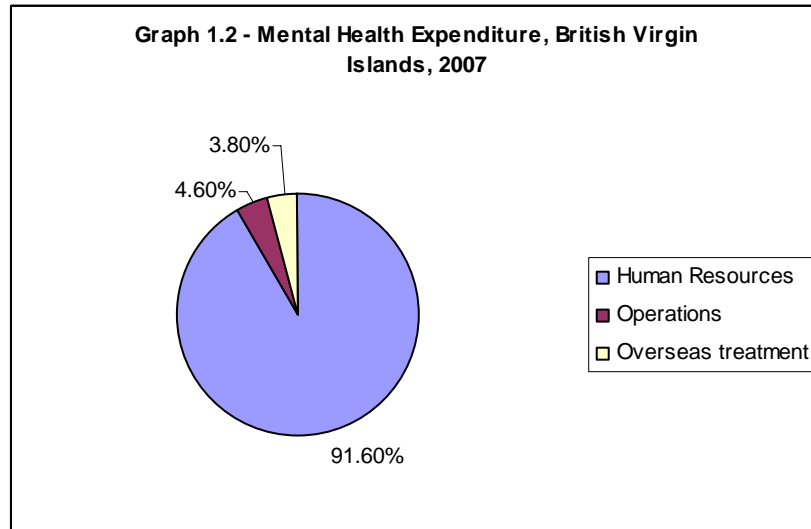
The Mental Health Act (referred to as the Mental Health Ordinance) is dated 1986. The sections of the Ordinance are: Part I, Preliminary; Part II, Application, Admissions and Enforcement; Part III, Management of Property and Affairs of Patients; Part IV, Miscellaneous; and Schedule, Mental Health Review Board. The Ordinance makes provision for bilateral agreements between the government of the Territory and any other country for the transfer of mentally disordered patients to a health institution in another country, if the required treatment is obtainable in that other country and not in the Territory. The Ordinance does not include: access to the least restrictive care; rights of mental health service consumers, family members, and other care givers; accreditation of professionals and facilities; law enforcement and other judicial system issues for people

with mental illness; and mechanisms to implement the provision of the mental health legislation. No standardized documentation (instruments or forms) is included in the Ordinance.

Financing of mental health services

Three percent of the national health expenditure was directed toward mental health services. This appropriation covers salaries and remuneration; operation of the Community Mental Health Center (CMHC); and costs associated with treatment overseas. The cost of institutional mental health care, which is delivered through the general hospital, is subsumed under that hospital's appropriation. However, the hospital's budget is not disaggregated to quantify the percentage of funds that is directed toward inpatient care for mentally disordered persons. No data were available to indicate the extent of use of private mental health service providers and out-of-pocket spending on these services. Patients suffering from mental disorders and all mental health problems of clinical concern are eligible for free care through the public health system. One hundred percent of the population had free access to essential psychotropic medicines in the categories of anti-psychotics, anti-depressants, anxiolytics, mood stabilizers, and anti-epileptic drugs.





Human Rights

There were no national-level or regional-level review bodies on human rights. Neither the inpatient or outpatient treatment facilities had an external review/inspection of human rights protection of patients. The Mental Health Ordinance of 1986, Section 16, sets up a Mental Health Review Board. The purpose of the Board is to deal with applications by, and in respect of patients. The composition of the Board is mentioned in Schedule (S.16 (2)) of the Ordinance. The referenced Board was never constituted. None of the human resources working in mental health had any exposure to training on the set of basic rights of rights for the protection of persons with mentally illness.

Domain 2: Mental Health Services

Organization of mental health services

The Community Mental Health Center functions as the national mental health authority and the lead agency providing mental health services in the Territory. The Center is staffed by a psychiatrist, psychologists, nurses, and other para-professionals. As the sole agency for mental health services, it provided advice to the government on mental health policy, legislation, service planning, and service management. No activities related to efficiency of treatment techniques, client satisfaction, and quality assessment were undertaken by the Center.

Mental health outpatient facilities

There are no mental health outpatient facilities *per se*. Mental health treatment was accessed through the Community Mental Health Center (located in Tortola) and scheduled mental health clinics in three primary health care centers located in Virgin Gorda, Anegada, and Jost van Dyke. Persons with mental disorders from the remaining inhabited islands and boaters/yachters accessed services at the clinic in close proximity to their location. In 2007, 320 users attended the mental health outpatient clinics. The average number of contacts per user was 12. Of all users treated in the mental health clinics, 56% were females; 20% were aged 17 years or younger. Thirty percent of users had a primary diagnosis of schizophrenia and related disorders and 27% had mood affective disorders. All outpatient mental health clinics had access to at least one psychotropic medicine of each therapeutic category (anti-psychotic, anti-depressant, mood stabilizer, anxiolytic, and antiepileptic). Some (21-50%) of users received one or more psychosocial interventions through the Center.

The Center's psychiatric services include child and adolescent psychological evaluations as well as a Crisis Intervention team. Its psychological services include direct and indirect intervention (psychometric assessments and psychotherapy), consultation, and community outreach and awareness. The nursing staff of the Center is responsible for crisis intervention, health teaching, counseling, referrals, intake screening, medication administration, and institutional visits to the sister islands, prison, and nursing homes. The Center's occupational therapy services provide patients with the skills required to achieve independence, meaning, and satisfaction in all aspects of their lives.

Day treatment facilities

There were no mental health day treatment facilities.

Community-based psychiatric inpatient unit

No community-based psychiatric inpatient unit existed in the country. Patients with mental disorders were admitted to the 44-bed Peebles Hospital. This general hospital has two secured rooms (one bed in each room) in the medical wards for mentally disordered patients who were considered to be "high risk." Non-disruptive patients are admitted to the medical wards. The Senior Psychiatrist provided consultation-liaison services to the general hospital. There were 79 admissions in 2007; 41% were females. There were no users in the age-group less than 15 years; 7.5% of users were in the age group 15-24 years. The diagnoses on discharge from the general hospital were primarily from three diagnostic groups: mental and behavioral disorders due to psychoactive drug use (32%); schizophrenia and related disorders (24%); and mood (affective) disorders (24%). On

average, patients spent 15.4 days per discharge. Some (21-50%) of the patients with mental disorders received one or more psychosocial interventions in the referenced year. The hospital stocked at least one psychotropic medicine of each therapeutic category (anti-psychotic, anti-depressant, mood stabilizer, anxiolytic, and antiepileptic).

Mental Hospital

There was no mental hospital in the Territory.

Forensic or other residential facilities

There was no forensic facility. The staff from the Community Mental Health Center managed the forensic patients in the prison complex or in the general hospital. In 2007, 2-5% of the forensic clients carried a diagnosis of psychosis and less than 2% had a diagnosis of mental retardation. One inmate with mental disorder is incarcerated at “Her Majesty’s Pleasure.”

The population at the Adina Donovan Home, a geriatric facility, included residents with dementia and other mental disorders; these patients share the same living arrangements with other patients in the Home. The Center’s staff treated these patients in the Home or in the Center’s clinic, as warranted. However, no data were readily available on the number of persons in the Home who were treated solely for dementia or other mental disorders.

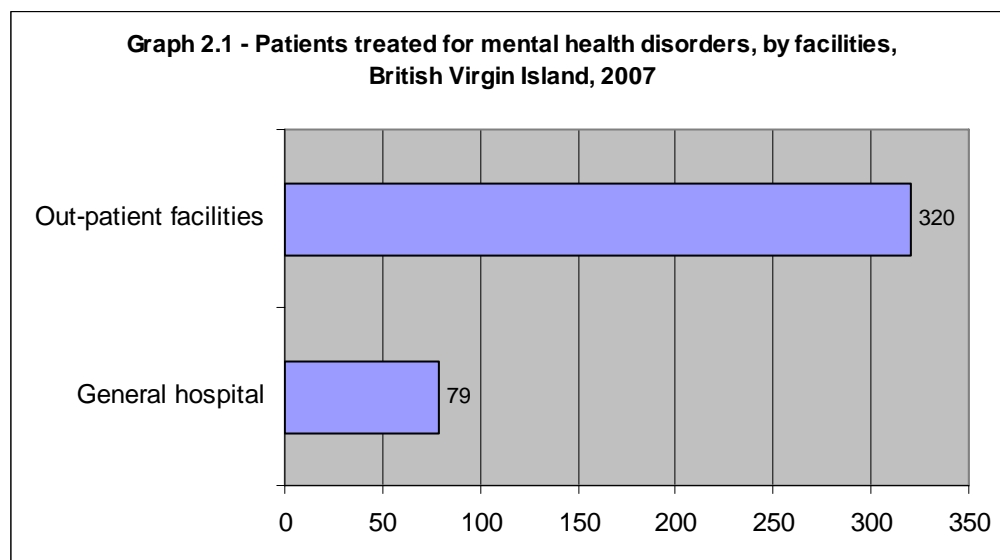
The Sandy Lane Centre is an outpatient drug/transitional housing facility. Its purpose is to provide treatment and other related services to persons suffering from alcohol and other drug addictions; lend support to their families; and provide public education on drug addiction and treatment. The transitional housing component of the Centre assists residents to find gainful employment while providing a means for gradual re-socialization. Clients with addiction problems are allowed up to 18 months in residence, whereas dually diagnosed clients (those diagnosed with mental illnesses and addiction problems) are allowed up to 2 years in this 24-bed facility. No mental health-related statistics was available for 2007. Data for 2008 showed that their clientele included 3

females and 6 males with a diagnosis of schizophrenia; and 1 female with bi-polar disorder.

Human rights and equity

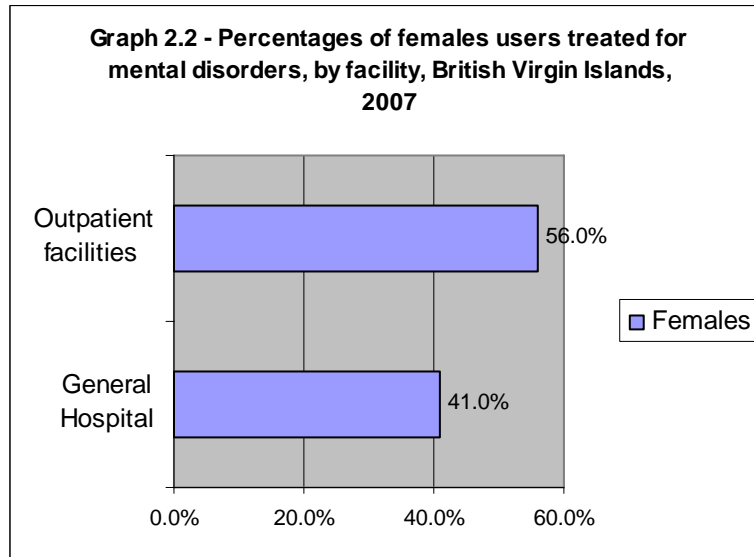
Data are not collected to indicate the proportion of involuntary admissions to the general hospital or the percentage of patients who were secluded and/or physically restrained. The migrant population from Spanish-speaking countries continued to increase but there was no specific strategy to facilitate their access to mental health services in their native language. Ethnic and religious minority groups such as Hispanics, Hindus, and Muslims accessed care primarily through private services. Similarly, these minority groups accounted for a substantially smaller proportion of admissions for mental disorders in the general hospital.

Summary charts



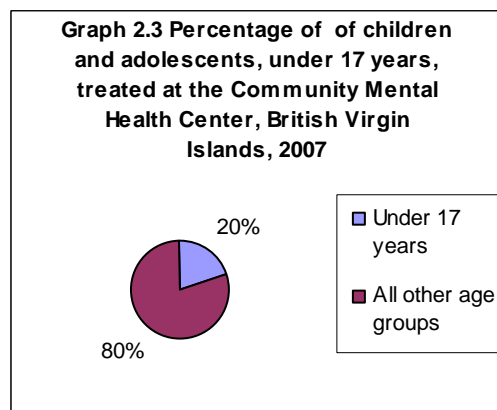
Summary for Graph 2.1

The paradigm shift from hospitalization to community care is evident in the BVI.



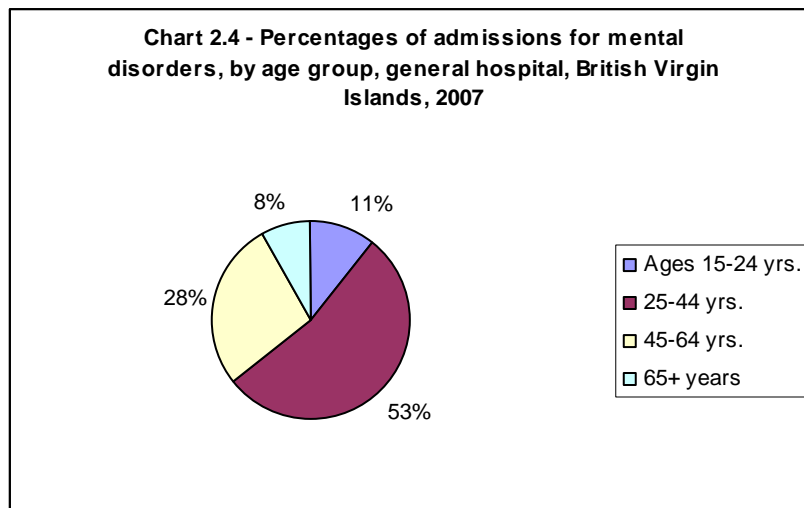
Summary for Graph 2.2

The gender distribution in the outpatient facility showed a higher percentage of females using the outpatient services. Conversely, fewer females were hospitalized at the general hospital.



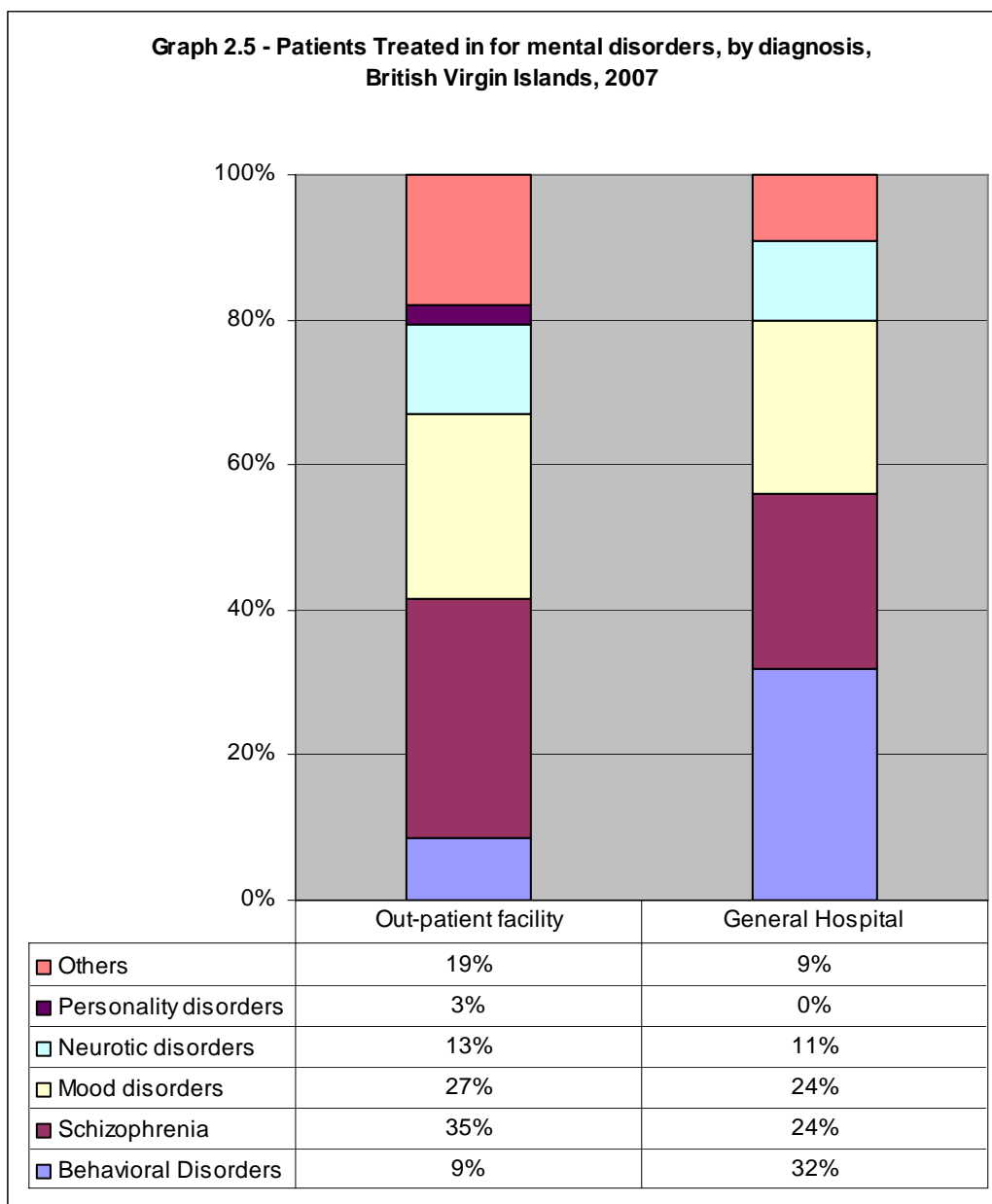
Summary Graph 2.3

The wide range of rehabilitative services offered at the Community Mental Health Center for the under-17 year age group (psychotherapy, group education, and family counseling) increased the probability of this age group accessing services through the Center as opposed to the general hospital.



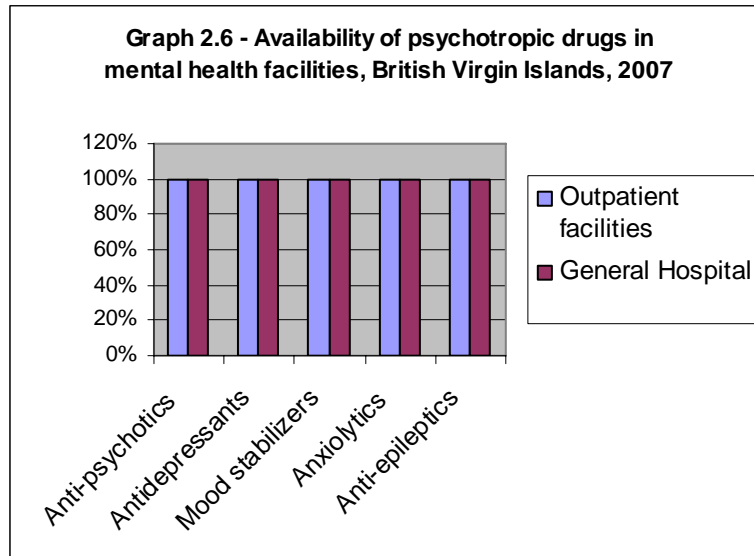
Summary for Graph 2.4

An analysis of data by age groups showed that there were no admissions in the under-15 year age group. Among all other age groups, the number of persons aged 25-44 years that were hospitalized for mental disorders was almost five times greater than those in the age group 15-24 years.



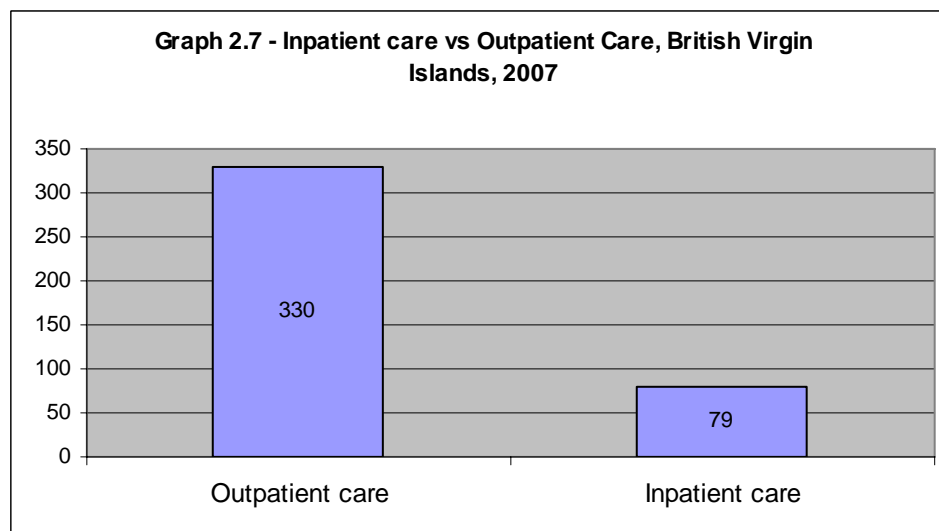
Summary for Graph 2.5

Mental and behavioral disorders due to use of psychoactive substance use was the leading cause of admission to the general hospital followed by both mood (affective) and neurotic disorders. As for the outpatient facilities, schizophrenia and related disorders, followed by mood (affective) disorders, were the most frequent diagnoses of the majority of users.



Summary Graph for 2.6

At least one psychotropic medicine, of each therapeutic category, was widely available in the British Virgin Islands.



Summary Graph for 2.7

The number of clients treated in the outpatient setting includes those seen and Sandy Lane outpatient drug rehabilitation center.

Domain 3: Mental Health in Primary Health Care

Training in mental health care for primary health care staff

Physicians who were trained at the University of the West Indies indicated that 1% of their training was devoted to psychiatry. Similar information was not available for the physicians who were trained in countries such as Nigeria and the Philippines. Five percent of the nurses' training was devoted to mental health concepts and clinical practice. Neither of the primary health care physicians nor nurses received at least two days refresher training in any topics related to psychiatry/mental health.

Mental health in primary health care

Mental health services are offered through 4 primary health care centers and none of them had assessment and treatment protocols for key mental health conditions. There were no non-physician-based primary health care centers. Some, (21-50%), of primary health care physicians made on average at least one referral per month to a mental health professional. A few, (1-20%) of primary health care physicians interacted with a mental health professional at least monthly in 2007. None of the physician-based primary health care centers or the Community Mental Center had interaction with a complementary/alternative/traditional practitioner.

Prescription in primary health care

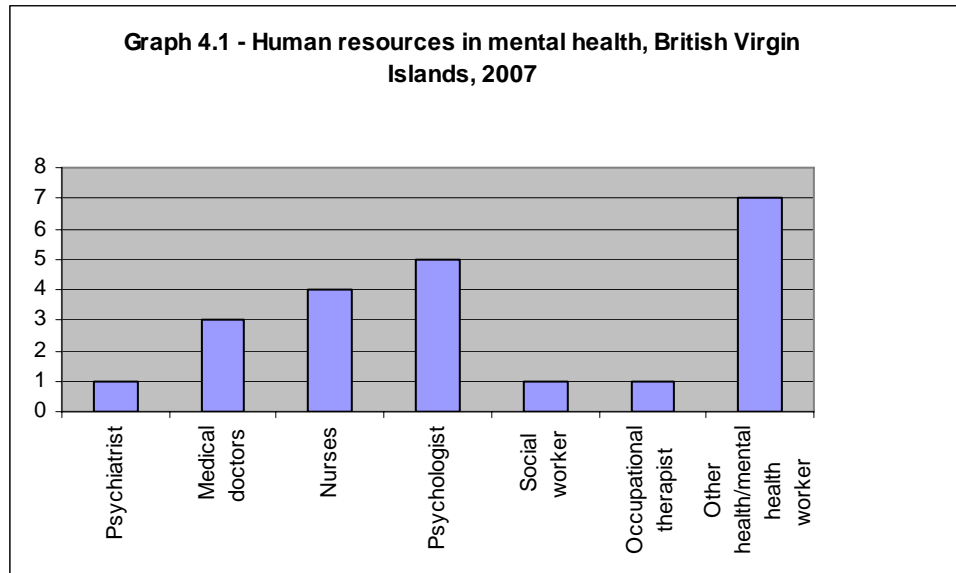
Health regulations authorize primary health care doctors to prescribe and/or continue prescriptions for psychotropic medicines without restriction. Psychotropic drugs of each

therapeutic category (anti-psychotic, anti-depressant, mood stabilizer, anxiolytic, and anti-epileptic) were available in almost all (81-100%) sites where mental health clinics are scheduled.

Domain 4: Human Resources

Number of resources in mental health care

A total of 22 mental health professionals provided mental health care through the community-based mental health program, the general hospital, and private practice—the majority being assigned to the Community Mental Health Center. The breakdown according to profession was as follows: psychiatrist – 1; other medical doctors, not specialized in psychiatry – 3; nurses – 4; psychologists – 5; social worker – 1; occupational therapist – 1; and other health or mental health workers – 7. The sole senior psychiatrist provided services at the Community Mental Health Center, the general hospital, and in private practice. Three nurses, 2 psychologists, the social worker, and the occupational therapist were all assigned to the Center. One mental health nurse and two mental health workers were assigned to the general hospital. The three physicians, not specialized psychiatry, were assigned to the general hospital; care and treatment of persons admitted for mental disorders were done in consultation with the sole senior psychiatrist.



Training professionals in mental health

Of all mental health workers, only the senior psychiatrist had refresher training in the rational use of psychotropic drugs, psychosocial (non-biological) interventions, and child and adolescent mental health issues. No psychiatrist emigrated from the country within five years of completion of training.

Consumer and family associations

No user/consumer associations existed in the country. The Family Support Network (FNS) provided services free of charge to victims of domestic violence, their children, and those struggling to control abusive behaviors. FNS referred children who witnessed violence in the home to the psychologist at the Community Mental Health Center. In 2007, all of the clients who were victims of domestic violence were women. An estimated 65% of domestic violence cases had children residing in the abusive household.

Domain 5: Public Education and Links to 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. The Ministry of Health promoted public education and awareness campaigns on mental health and mental disorders in the last five years. These initiatives targeted the general population, children, adolescents, health care providers, teachers, and social services staff.

Legislative and financial provisions for people with mental disorders

In 2007, 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. An estimated 265 persons received social welfare benefits in 2007, inclusive of persons with mental disorders. However, data was not available to indicate the number of persons receiving these benefits solely because of mental disorders.

Links with other sectors

There were no formal collaborative programs that specifically addressed the needs of people with mental health issues between the department/agency responsible for mental health and the department responsible for HIV/AIDS, reproductive health, child and

adolescent health, and substance abuse. Similarly, no formal collaboration existed with non-health sectors such as child protection services, criminal justice, housing, or social welfare. However, there was an effective, informal referral link between the Center and all schools. The BVI Services, an entity operating under the social development arm of the Ministry of Health, provided daily occupational-type rehabilitative services for adults with special needs. The Services equips its clients with life/social skills to secure and maintain gainful employment through the following activities: arts and crafts; academic enrichment; exercise; and job placement. In 2007, 6 clients with mental disorders participated in the Services' activities. No non-health sector was formally involved in the improvement of mental health services in the country.

There were 23 primary and secondary schools; one private school had a consultant mental health professional on call to manage crises situations. None of the remaining 22 schools had either a part- or full-time mental health professional. All schools had access to guidance counselors. A few (1-20%) of primary and secondary schools had school-based activities to promote mental health and prevent mental disorders. No police officers, judges or lawyers participated in educational activities on mental health in the last five years. Of all inmates in the single prison, between 2-5% were diagnosed with psychosis and less than 2% with mental retardation. At least one prisoner per month was in treatment contact with a mental health professional within the prison or in the community.

Domain 6: Monitoring and Research

There was no formally-defined list of individual data items that ought to be collected by all mental health facilities. The Community Mental Health Center is the repository for the records of all users of public sector mental health services. Clients' records are up-to-date and include well-documented psychosocial assessments. The Center collected and compiled data on number of users treated and number of user contacts; it recorded but did not compile data on users' diagnoses. Clients' diagnoses were coded using the DSM-IV classification. The International Classification of Diseases, Tenth Revision (ICD-10) was introduced to the Center's staff and used to code the clinical diagnoses.

As for the general hospital, it routinely collected and compiled data on numbers of beds, inpatient admissions, days spent in hospital, and diagnoses. It did not collect data on number of involuntary inpatient admission or patients who were physically restrained or secluded. None of the mental health facilities transmitted data to the Ministry of Health or any other government entity. No reports covering mental health data were published by the government of the Territory. No research activity was conducted in 2007 and there were no mental health publications on the Territory in the last five years.

NEXT STEPS IN STRENGTHENING THE MENTAL HEALTH SYSTEM

This opportune assessment of the mental health services in the Territory provided an objective and comprehensive framework for evaluating and improving mental health services with priority focus on mental health policy, plans, data management, and training. The next steps in the reform process will consider the following:

- Development of a mental health policy and plan.
- Development of an efficient paper-based mental health information system to transmit data to the Health Information Unit (Ministry of Health) as an immediate first step to the routine collection and dissemination of national data on mental health services.
- At the level of the general hospital, collect and compile data on: number of involuntary admissions and number of persons restrained and secluded. At the level of the center/clinics, compile data diagnoses of users treated, by age groups; and assign ICD-10 codes.
- Requesting technical assistance to host at least a two-day training for mental health workers on human rights protection for persons with mental disorders.
- Requesting support for Spanish language courses for mental health workers.
- Development (or sourcing) an assessment and treatment protocol for key mental health conditions for use in physician-based primary health care clinics.
- Exploring the possibility of forging partnerships with external colleges and universities to secure the services of senior-level students to undergo internships in the Territory with an aim of filling human resource gaps.

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

There is no mental health policy or plan. The Mental Health Ordinance is dated 1986. There is no mental hospital—community-based care is the dominant paradigm. There is one psychiatrist in the Territory. Management of persons with mental disorders is the responsibility of the Community Mental Health Center, an outpatient facility that is located in the Tortola, the largest island in the Territory. Care and treatment are delivered through the Center and three primary health care clinics. Prisoners were treated in the prison complex or in the general hospital. The Center has a well-developed psychological service component. The general hospital provides inpatient care to mentally disordered persons. The majority of discharges from the general hospital was for mental and behavioral disorders due to use of psychoactive substance use whereas the majority of persons treated in the community outpatient clinics were diagnosed with schizophrenia and related disorders.

Three percent of the national health budget is appropriated for mental health care. Psychotropic medicines are available free of charge and only physicians are allowed to prescribe or continue their use without restriction. No data is available on out-of-pocket expenses for privately-accessed mental health care.

There is no mental health information system and no reports or publications on mental health services in the Territory. There are limited activities to forge links with other sectors, disseminate data on mental health, and promote mental wellness across all sectors.

The next steps in the process to reform the mental health service will focus on the development of policies, plans, data management, and training.