Development psychiatry in Belize

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Belize, in Central America, has a population of just under 200,000. It is remarkable in the region for functioning as a democracy, with a long history of tolerance towards minorities. This has led to its considerable ethnic mix. Formerly a British colony, Belize became independent in 1981.

In attempting to provide mental health services Belizeans have been frustrated by a number of factors: a fragile economy has often restricted the money available to the health services; a hurricane swept through the country's mental hospital in 1961, necessitating its relocation in an inaccessible inland site; moreover, there has been a chronic shortage of Belizeans who have qualified as psychiatric nurses and psychiatrists.

The last point has meant that Belize has had to rely heavily on expatriates to help develop psychiatric services. In 1990, we left the UK with Voluntary Service Overseas to work in Belize. JONB is a community psychiatric nurse. KONB is a post-membership psychiatrist. Both of us have a special interest in teaching psychiatry. This paper describes our work in Belize between 1990 and 1992.

Existing services in Belize

The main centres of psychiatric activity upon our arrival were Rockview Hospital, the only mental hospital; Belize City Clinic, the major out-patient clinic; district clinics throughout the country; and Belize Prison.

The hospital was staffed by 18 untrained attendants, three mental health aides and five general nurses who held the equivalent of a state enrolled nurse (SEN) qualification. Two SENs and three mental health aides staffed Belize City Clinic. The clinic staff also performed the weekly visit to Belize Prison and the monthly out-patient clinics in the outlying districts. Between these monthly visits there were no psychiatric services available to the districts. No specialist service existed for children, for those with learning disabilities or the elderly mentally ill. Upon arrival we became the only psychiatrist and psychiatric nurse in the country.

Limitations in the provision of mental health care

The major limitations in mental health care delivery were the lack of trained personnel and the severe shortage of transportation for home visits and outlying clinics. The mental health team had one vehicle with which to conduct all of its outreach work. During the rainy season, roads to the South became impassable so that the Southern clinics might not take place for up to three months at a time.

The structure of Rockview Hospital was extremely poor, with no running water at first, and later only an erratic supply. The ward environment was spartan. Other challenges included the rather unwieldy mental health legislation, dating back to the 1840s, and the restricted supply of medications. In particular, the only depot anti-psychotic was underordered to the extent of 200%. This meant that at any one time, two thirds of those requiring depot injections did not receive them. Lithium carbonate was often unobtainable for weeks at a time.

Strengths of the Belize mental health services

The greatest strength of the services lay in the motivation to learn among the mental health team members. In spite of the low status afforded their work by the rest of their community, the majority of staff members were committed to providing care of the highest quality to their patients.

The philosophy of psychiatric care in Belize also had a great deal to commend it. Rockview Hospital is unusual in the Central American/Caribbean region in that it is an open hospital. Only a six-bedded area of the male ward may be locked and is used for severely disturbed patients. Psychiatric clinics function as primary referral centres, with the overwhelming majority of patients referred by themselves or a family member. If mentally ill people will not come to the clinic, then the team will try to visit them. A tenuous routine of street visits to the homeless mentally ill had been established, although it was curtailed by lack of transport. A National Mental Health Day has been held annually for several years to raise the profile of mental health issues throughout the country.

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Development of services between 1990 and 1992

Training of personnel

This was the greatest single component of JONB's work, taking place at several levels in the health service. Only six attendants had previously received any instruction in psychiatry. JONB went on to train a further 12 attendants in intensive full-time courses and a further six were chosen to attend an advanced course. In both courses there was an emphasis upon the principles of rehabilitation, as until then the long-stay patients had been consigned to their fate, suffering greatly from institutionalisation.

We helped to train Belize's first ever psychiatric nurse practitioners. Before our departure, the first six psychiatric nurse practitioners had graduated from Belize School of Nursing. JONB also taught psychiatric nursing to the final year general nursing students and set up a course in mental health for social workers in Belize City.

Belize City Clinic

A number of sub-speciality sessions were designated each month in the Belize City Clinic to cover the areas of child and adolescent psychiatry and psychotherapy. JONB established a weekly clinic for the elderly mentally ill at a voluntary clinic which already dealt exclusively with the elderly of Belize City. Links were forged with the local school for the learning disabled. Specific depot injection clinics were set up and record-keeping improved. Figures thus obtained would eventually be used in quantifying for the Ministry of Health the amount of depot medication needed and improving the supply.

During our first year in Belize, clinic attendances rose dramatically. The proportion of new patients who fell within the broad category of psychotic illness decreased steadily relative to those with other complaints. At first the clinic attenders were almost all suffering with serious, long-term mental illnesses but with time people presented with affective disorders, neurotic disorders and eventually even psychosexual problems.

District clinics

Perhaps the biggest change occurred in this sphere, largely due to the newly-trained psychiatric nurse practitioners. There is now a mental health professional based permanently in each of the Northern, Southern and Western areas. This has led to the establishment of a psychiatric liaison service in the regional hospitals and opened up new channels of communication between psychiatric services and the local community.

Interior of the male ward, Rockview Hospital, Belize. Seated, left to right, mental health aide (L. Domingo), psychiatrist (K. O'Neill-Byrne) and nurse (S. Giuisseppi)

Medications

Close liaison with the Ministry of Health led to an increase in the amount of depot medication ordered every month. Approximately 80% of the country's needs were being met by 1992, as compared with 33% in 1990. Permission was obtained to prescribe lithium on a named patient basis for the six patients nationwide with the most brittle affective disorders.

Overview

Our time in Belize coincided with an increased drive on the part of the Ministry of Health to train mental health workers at all levels. While it is tempting for expatriates in developing countries to become active solely in the clinical area, this does little to encourage development and may foster dependence. As JONB was replaced by a psychiatric nurse practitioner whom he had helped to train and KONB by a post-membership Belizean psychiatrist, the hope must now be that Belize will continue to move toward self-sufficiency in mental health. The increases in clinic attendances from 1990 to 1992 have continued with the posting of psychiatric nurse practitioners in the outlying districts. With its present emphasis upon community rather than hospital psychiatry and its moves to decentralise the services, Belize may in time provide an appropriate model of mental health care throughout Central America.

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