

WHO-AIMS

WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
IN Belize



MINISTRY OF HEALTH
BELIZE

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MENTAL HEALTH SYSTEM
IN BELIZE

*A report of the assessment of the mental health system in Belize using the
World Health Organization - Assessment Instrument for
Mental Health Systems (WHO-AIMS).*

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Please refer to *WHO-AIMS* (WHO, 2005) for full information on the development of WHO-AIMS at the following website.

http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html

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The WHO-AIMS project is coordinated by Shekhar Saxena.

Executive Summary

This study was completed using the World Health Organization Assessment Instrument for Mental Health systems (WHO-AIMS). The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation. This will enable Belize to engage in evidenced-based mental health plan progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

This report was conducted in 2007 utilizing data for 2006.

Belize has a draft mental health policy, developed with all the relevant stakeholders, with technical and financial support from the Pan American Health Organization. There is a national plan of action which does not include specific lines of action or make provision for other stakeholders to contribute toward improving services. The current national plan must be tailored to delineate the actions required to achieve the stated objectives.

Based on this assessment, it was noted that 2% of the Ministry's budget is allocated to mental health, from which 26% is assigned to the mental hospital. However, the figure on mental hospital spending does not include medications which are procured through the central pharmacy. Additionally, no utilities are included as these are included in the total bill for central region. The goal is to increase expenditures on outpatient and primary health care services.

Mechanisms for human rights protection for persons with mental disorders are not systematized. Mental health facilities are not monitored. The responsibility of supervising mental health facilities should be one of the functions of the Ombudsman. The current legislation does not make legal provisions for protecting the basic human and civil rights of persons with mental disorders, supervision of treatment facilities and personnel, professional training and service structure. The legislation must also address the legal right to disability benefits from public funds for mental disorders that reduce a person's ability to function.

Belize for some years has been implementing a community mental health program. While there are minimal psychiatric infrastructures, there exists a network of psychiatric nurse practitioners and two psychiatrists that provides services countrywide. With limited mental health professionals, the country has trained and hired psychiatric nurse practitioners who provide services in the clinics, as well as outreach work in the communities, both rural and urban. The country has only one psychiatric hospital which is located outside the largest city. In 2006 there were limited community health facilities;

however, psychiatric nurses provided services directly to communities countrywide. Unfortunately, access to services by the rural population is limited; although services are provided to these areas via mobile clinics, the availability of transport always hinders this service. While no forensic facilities are available in the country, services are provided to patients who are incarcerated.

There are no outpatient or in-patient detoxification treatment facilities, and the three residential facilities offering substance abuse treatment are faith based and private limiting access to the general public. Similarly, no substance abuse policy detailing prevention and treatment activities exists. As a matter of priority, steps must be taken to prepare a substance abuse policy to be included as an addendum to the mental health policy.

No therapeutic drug policy is available in Belize, instead, there exists a national drug formulary and a committee organized by the Chief Pharmacist who with other health professionals review the list. While the drugs are free in the public clinics, stock-outs are frequent.

To strengthen primary health care even further, training of general practitioners in the public clinics and hospitals must be formalized and made mandatory. Currently, they participate in less than one day's training annually.

Critical barriers to the provision of mental health services include:

- An outdated mental health legislation for guiding provision of rights based treatment and the protection of human rights
- Lack of an approved policy which guides the development of mental health programmes and plan for better service delivery
- Lack of community infrastructure to ensure the provision of treatment in one's community
- The mental health programme is still not fully integrated into primary care which widens the treatment gap
- The lack of networking with other stakeholders such as NGOs, other ministries and private entities
- Lack of monitoring and evaluation of the mental health programme and proper surveillance systems
- Stigma continues to negatively affect the integration and patients fear to seek psychiatric care
- Lack of mixed mental health staff to provide better psychosocial rehabilitation and increase the patient's ability to function in society
- Belize is a young country with multiple psychosocial problems that start in early childhood, therefore there is demand for a center for the holistic treatment of children and adolescents
- Substance abuse problems continue to affect youth and the lack of drug policy and treatment facility hinders rehabilitation

Some of our achievements include:

- Training and hiring of new psychiatric nurses
- Consumer association established and functional in the capital city
- Revision of legislation which decriminalizes attempted suicide
- An acute psychiatric unit established within general hospital
- Training for mental health staff in human rights
- Revision of mental health legislation
- Development of a draft mental health policy

Introduction

Belize, the only English speaking country on the Central American mainland, has an approximate geographical area of 22,806 sq. km. Its total population is 301,300 and the sex ratio (men per hundred women) is 1.01 (CSO, 2006). Belize is a young population with 83.7% of its residents under the age of 44 years, of which 39.2% are under 15 years (CSO 2006). The World Fact Book places the literacy rate for the total population at 76.9; for males 76.7% and for females 77.1% (CSO, 2006). Rural dwellers make up 49.4% of the population. The official language is English with Kriol being the most widely spoken dialect. Other languages spoken include Spanish, Garifuna, Chinese, German and Mayan dialects. The main ethnic groups are Kriol, Mestizo, Garifuna, Chinese, German and Maya. Religious groups are mainly Roman Catholics, Anglicans, Methodist, Pentecostal, Seventh-Day Adventist, Mennonite, and Jehovah's Witnesses. The country is considered a lower middle income country based on World Bank 2004 criteria. Total expenditure on health of GDP is 5.3% (WHO, 2007). The proportion of the health budget to GDP is 2.7 and the total expenditure on health per capita (Intl \$, 2005): 377.

In 1996, the health sector reform project was initiated with the prime objective of improving the quality, efficiency and equity in the delivery of health services. Some key objectives have been met including improvements to the health information system and the reorganization of the health system into four regions to increase capacity utilization and thereby improve the quality of health care. Included in the health sector reform project are provisions for relocating and downsizing the mental hospital to the capital city. However, while there have been improvements to infrastructure and equipment for the health sectors at the primary and secondary levels, access to premium health care remains a concern.

The program is based on community mental health. However, mental health services continue to be centralized with two inpatient facilities (one mental institution, and an acute psychiatric unit) located in the two major cities. Twenty-six percent of the mental health budget is allocated to the mental hospital which is home to 34 elderly patients.

There are two psychiatric nurses assigned to the mental hospital. Psychiatric nurses are assigned to the public health clinics in each district and provide outpatient treatment. Stigma and discrimination continues to persist despite positive steps to integrate mental health at the community level.

There are 145 general hospital beds per 100,000 patients, as well as 70 general practitioners per 100,000. Fifteen percent (15%) of all hospital beds (389 countrywide) are in the private sector. In terms of primary care, there are 98 physician-based primary health care clinics in the country (11 in the public sector and 87 in the private), and 34 non-physician based primary health care clinics, all of which are in the public sector.

Domain 1: Policy and Legislative Framework

Policy, plans, and legislation

In 2006, a draft mental health policy had been prepared that included proposals for developing community mental health services, increasing involvement of users and families, advocacy and promotion, human rights protection of patients, ensuring equity of access across different groups, and financing. This policy followed the guidelines recommended by WHO.

An essential medicines list that includes antipsychotics, anxiolytics, antidepressants, mood stabilizers and antiepileptic drugs was included in the National Drug Formulary and procured by the Ministry of Health. However, it must be noted that all these drugs are not consistently available.

The 2006 mental health plan primarily focused on downsizing the mental hospital and expanding community mental health services. The process of reducing admissions had commenced in response to recommendations from two assessments which focused on methods for downsizing the mental hospital and eventually closing it down. The plan also incorporated strategies for reforming the mental health services to provide more comprehensive and accessible care, developing a mental health component in primary health care, increasing human resources, employment of psychologists, psychiatric social workers, occupational therapists, train more psychiatric nurse practitioners increasing the involvement of families and consumer groups, promoting advocacy and promotion (in collaboration with the Mental Health Association), instituting a monitoring system and improving the quality of services.

The Mental Health Act of 1957 governs the provision of mental health services in Belize. It delineates those legally authorized to effect involuntary admissions and mandates the role of the police. Magistrates are empowered to involuntarily admit persons of “unsound mind” to the country’s mental institution. During the law revision of 2000, the primary change was the decriminalization of persons who attempted suicide. Between 2004 and 2005, an analysis of the mental health legislation was conducted with support of PAHO/WHO human rights advisor, and recommendations for improving the mental health legislation were developed.

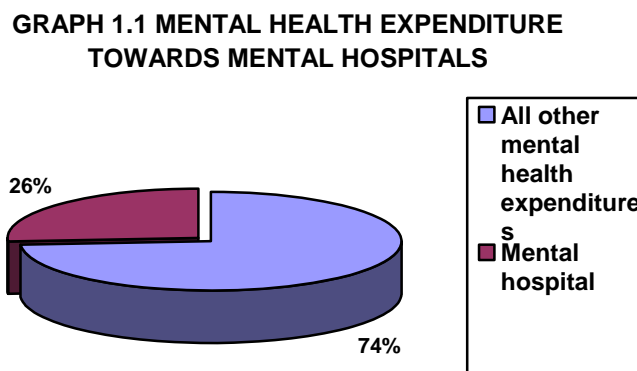
In Belize there exists a national human rights commission which is limited as it operates on a volunteer basis. A national or regional human rights review body to monitor human rights violations does not exist. Neither the mental hospital nor the community-based inpatient psychiatric unit have ever had an annual review of human rights protection of patients. However, in 2006, 100% of staff at both the mental hospital and the community-based inpatient psychiatric unit had at least one-day training on human rights protection of patients.

A disaster/emergency preparedness plan for mental health was revised in 2004 but it was specific to the Rockview psychiatric hospital and required updating. Recognizing the

need for a national mental health plan following a disaster, a workshop was conducted in 2005 to develop a plan for Stress Management in Disasters (SMID), which unfortunately was never implemented with key stakeholders.

It is estimated that approximately 2% of health care expenditures by the Ministry of Health are directed towards mental health. The manner in which mental health services were financed made it difficult to accurately assess the allocation of funds of all the expenditures spent on mental health, particularly in the Central Health Region, where the psychiatric hospital is located and 26% of the budget is allocated to the running of that hospital. It should be noted that the figure on mental hospital spending does not include medications, which are procured through the central pharmacy. Additionally, no utilities are included as these are included in the total bill for central region. The majority of the financial resources are allocated to the management and administrative cost of the mental health services in the country. It is projected that for the very first time, in 2008, the mental health unit will have its own cost centre.

Graph 1.1: Expenditures on mental hospitals as a proportion of total mental health care spending



Domain 2: Mental Health Services

Organization of mental health services

A national mental health authority which provides advice to the government on mental health policies and legislation does not exist. The chief psychiatrist acts as the technical advisor for mental health, makes recommendations to the Minister of Health for the improvement of mental health services, in addition provides clinical services and supervision to the psychiatric nurse practitioners. The multiplicity of roles has an impact on the effectiveness and efficiency of service delivery.

Mental health outpatient facilities

There are 8 outpatient mental health facilities available in the country with limited capacity for the provision of psychiatric care for children and adolescents. These facilities treated 4560 users per 100,000 population. While this number is extremely high, it includes patients who were provided pre and post test counselling for HIV/AIDS. Of all users treated in mental health outpatient facilities, 59% are female and 16% are children or adolescents. The users treated in outpatient facilities are primarily diagnosed with schizophrenia (29%) and mood disorders (20%). The average number of contacts per user is 1.16. One hundred percent of outpatient facilities provide follow-up care in the community. Additionally, 100% have mobile mental health teams but these are not consistent due to lack of transportation. In terms of available treatments, all or almost all (81-100%) of patients in outpatients facilities last year received one or more psychosocial interventions. Eighty-one to one hundred percent of outpatient facilities have at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility or at a near-by pharmacy all year long.

Day Treatment Facilities

As of 2006, there are no day treatment facilities in the country.

Community-based psychiatric inpatient units

There is only one community-based psychiatric inpatient unit available in the country with a total of 4 beds. None of these beds in the community-based inpatient units are reserved for solely children and adolescents. Forty-nine percent of admissions to community-based psychiatric inpatient units are female and 7% are children/adolescents. The diagnoses of admissions to community-based psychiatric inpatient were primarily from the following two diagnostic groups: schizophrenia, schizotypal and delusional disorders (31%) and mood disorders is (32%). An average patient spends 8.67 days in the unit. In community-based psychiatric inpatient units, 81-100% of patients received one or more psychosocial interventions in the last year. All of community-based psychiatric inpatient units had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

Community residential facilities

There are no community residential facilities in the country.

Mental hospitals

There is one psychiatric hospital which has 50 beds. This facility is organizationally integrated within the health services, with 100% of mental health outpatient facilities. None of the 50 beds in the mental hospital is reserved for children and adolescents. The number of beds was decreased by 55% over the last five years following two assessments that focused on methods for downsizing the mental hospital. The patients admitted to

mental hospitals belong primarily to the following two diagnostic groups, schizophrenia, schizotypal and delusional disorders (40%) and mood or affective disorders (29%).

On average patients spend 129 days in the mental hospital. Five percent of patients spend less than one year, 5% spend 1-4 years, 8% of patients spend 5-10 years, and 35% of patients spend more than 10 years in mental hospitals. The majority, 81-100%, of patients in mental hospitals received one or more psychosocial interventions in the last year. The mental hospital had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available. Data for the mental hospital were difficult to obtain since, in many cases, the admission or discharge dates were not documented. Notably, there are patients in the mental hospital who have been living there for over forty years and pre-date most of the staff.

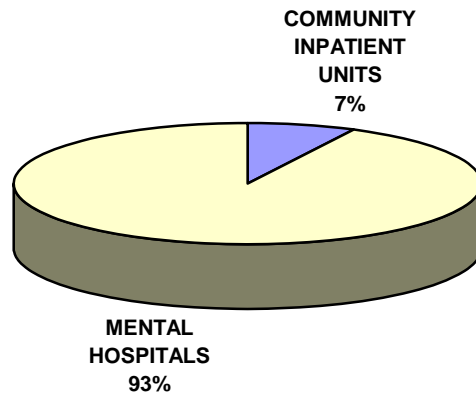
Forensic and other residential facilities

There are no forensic beds in the mental hospital, inpatient unit or in other residential facilities. Patients, who have committed a crime and have been incarcerated, are kept in the general prison and a psychiatric team visits the prison on a monthly bases.

Human rights and equity

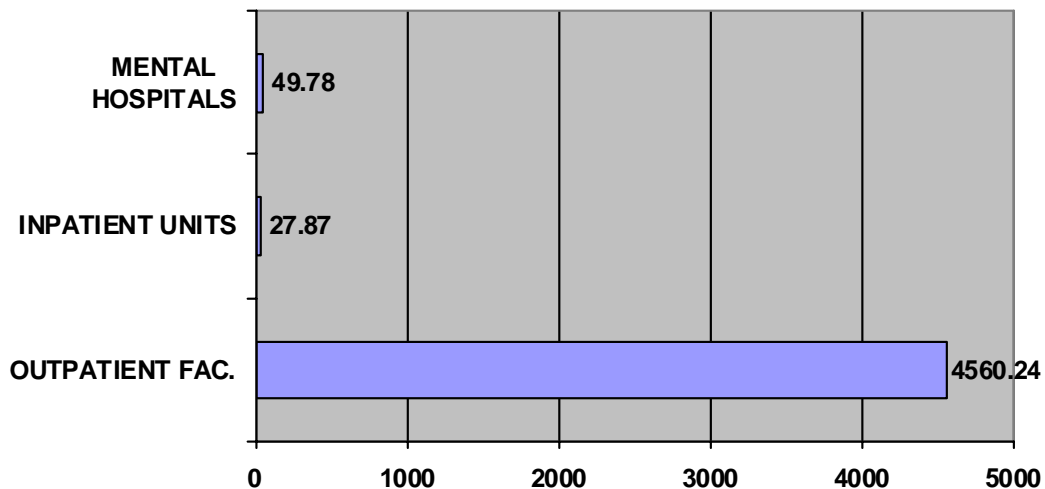
Fourteen percent of all admissions to community-based inpatient psychiatric units and 30% of all admissions to mental hospitals are involuntary. Approximately 11-20% of patients were restrained or secluded at least once within the last year in community-based psychiatric inpatient units, in comparison to 6-10 % of patients in mental hospitals. Controlling for population density, there are 2.79 times the number of psychiatry in or near the largest city in comparison to the rest of the country. Such a distribution of beds prevents access for rural users. Inequity and access to mental health services for minority users (e.g., linguistic, ethnic, religious minorities) is a major issue in the country.

GRAPH 2.1 - BEDS IN MENTAL HEALTH FACILITIES AND OTHER RESIDENTIAL FACILITIES



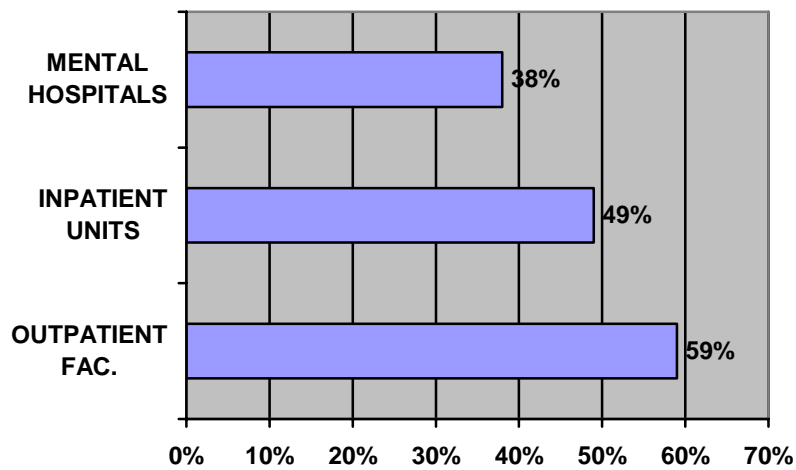
Ninety-three percent of beds are located in the mental health hospital, 7% in inpatient units. There are no beds in community residential facilities.

GRAPH 2.2 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES (rate per 100.000 population)



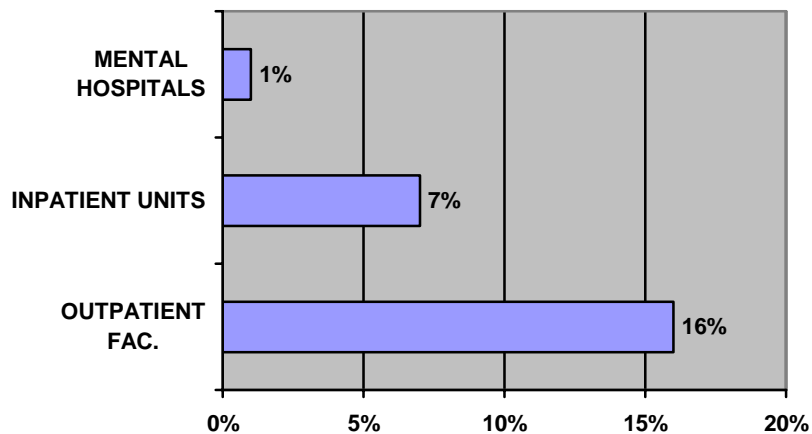
There are more patients treated in mental hospitals than there are in inpatient acute units, and outpatient facilities clearly have the largest amount of users...The outpatient figure includes patients who were provided pre and post test counselling for HIV/AIDS. Of all

**GRAPH 2.3 - PERCENTAGES OF FEMALE USERS
TREATED IN MENTAL HEALTH FACILITIES**



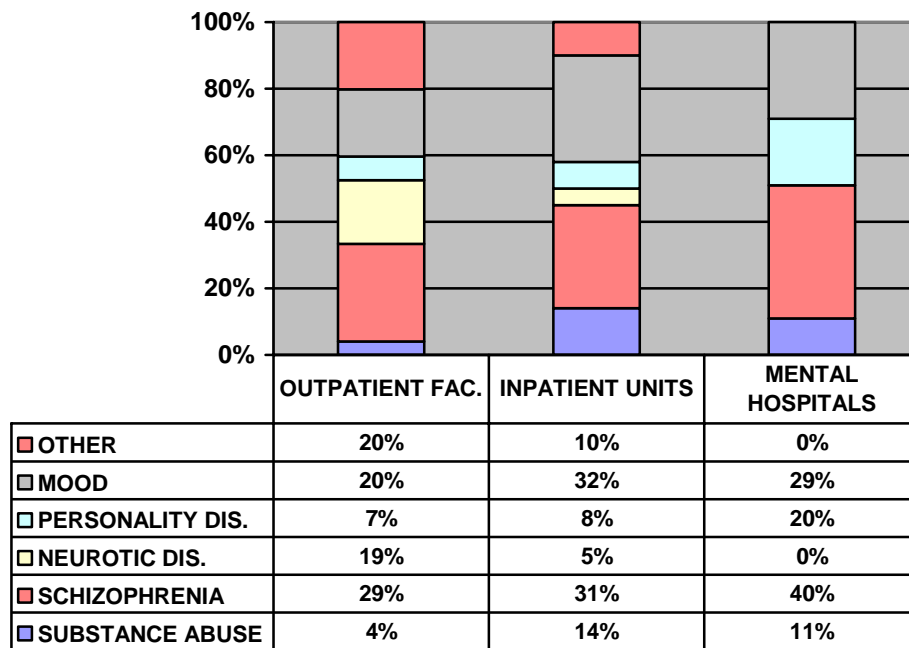
Female users comprise over 50% of the users of outpatient facilities, 49% of the inpatient population, and 38% of the mental hospital.

**GRAPH 2.4 - PERCENTAGES OF CHILDREN AND
ADOLESCENTS TREATED IN MENTAL HEALTH FACILITIES**



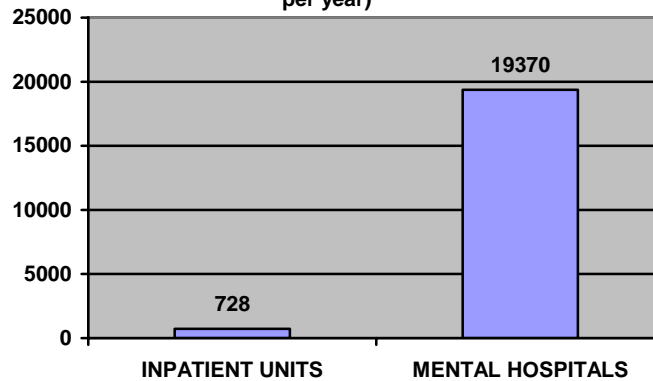
Overall, the number of children and adolescents treated in mental health facilities is very small. The percentage of these users varies substantially between outpatient and other facilities.

GRAPH 2.5 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS

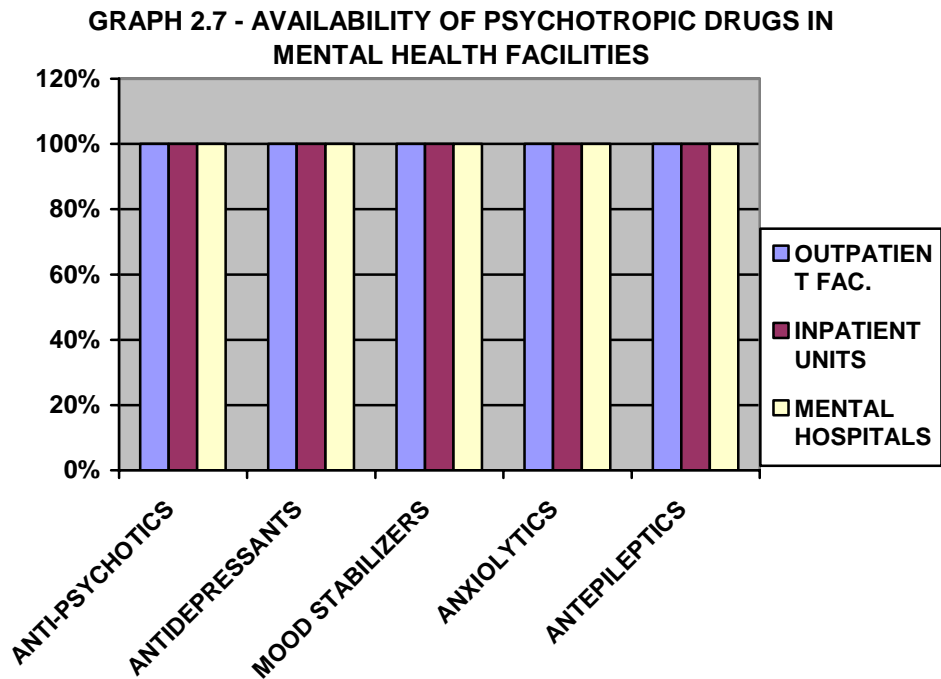


The distribution of diagnoses varies across facilities: in outpatients facilities, inpatient units and in mental hospitals, mood disorders and schizophrenia are most prevalent.

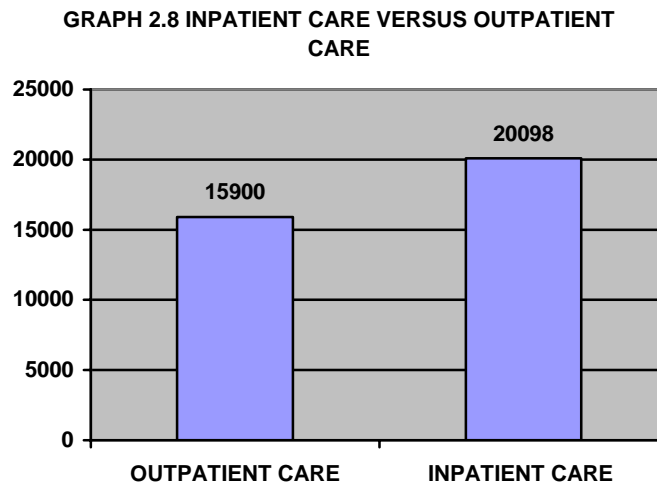
GRAPH 2.6 - CUMULATIVE NUMBER OF DAYS PATIENTS SPENT IN INPATIENT FACILITIES (days per year)



Graph 2.6 describes the cumulative number of days patients spent in the facility. The length of stay in the mental health hospital is 96% higher than the inpatient facility.



Psychotropic drugs are free and the medications are included in the National Drug Formulary and therefore procured by the Ministry of Health. However, stock-outs are frequent.



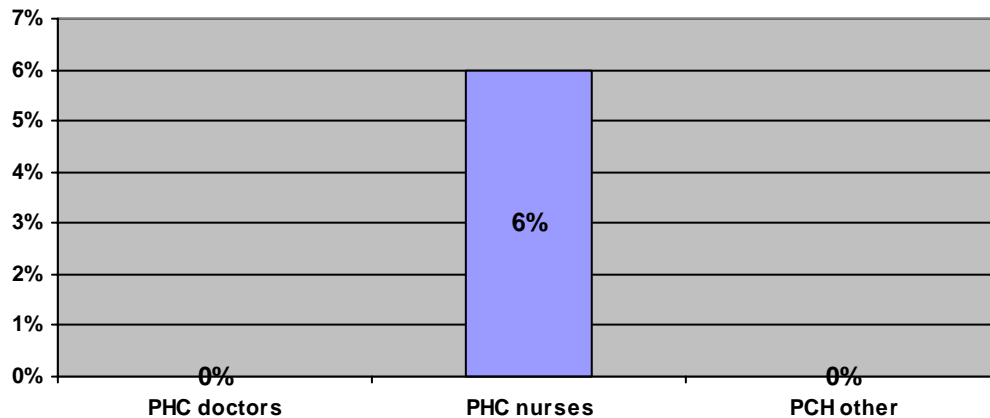
The ratio between outpatient contacts and days spent in the two inpatient facilities (the mental hospital and the inpatient unit) is an indicator of how much emphasis has been placed on inpatient care, specifically on the mental hospital: in this country the ratio is .79. This means that there is less than one outpatient contact per day spent in inpatient care.

Domain 3: Mental health in primary health care

Mental health training for primary care providers

There is no medical school in Belize. . There are 5 off shore medical schools that offer only 5 scholarships to Belizean students. Four percent of the undergraduate training hours for nurses is devoted to mental health. In terms of refresher training, there are a few primary health care doctors who received less than two days refresher training in mental health. 6% of nurses participated in refresher training. The majority of doctors choose not to attend mental health training sessions.

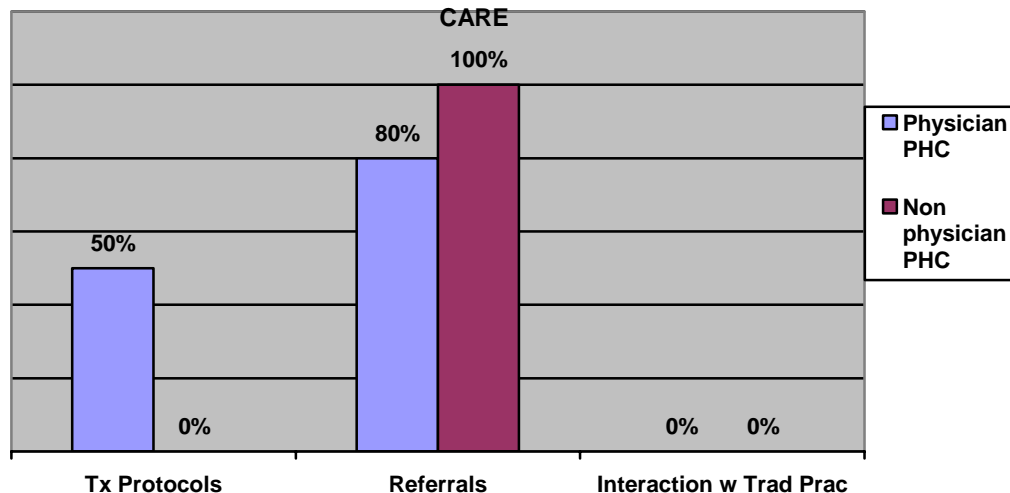
GRAPH 3.1 - % OF PRIMARY CARE PROFESSIONALS WITH AT LEAST 2 DAYS OF REFRESHER TRAINING IN MENTAL HEALTH IN THE LAST YEAR



Mental health in primary health care

Both physician-based primary health care (PHC) and non-physician based PHC clinics are present in the country. In terms of physician-based primary health care clinics, 50 % have assessment and treatment protocols available for key mental health conditions, but there are none available in the non-physician-based primary health care clinics. The majority (51-80 %) of physician-based primary health care clinics make on average at least one referral monthly to a mental health professional. All or nearly all, (81-100 %) of non-physician based primary health care clinics make a referral to a higher level of care. As for professional interaction between primary health care staff and other care providers, the majority, (51-80%) of primary care doctors have interacted with a mental health professional at least once in the last year. None of the physician-based PHC facilities, non-physician-based PHC clinics nor mental health facilities have had any interaction with a complimentary/ alternative/traditional practitioner.

GRAPH 3.2 - COMPARISON OF PHYSICIAN BASED PRIMARY HEALTH CARE WITH NON-PHYSICIAN BASED PRIMARY HEALTH CARE



Prescribing medications in primary health care facilities

Primary health care doctors and psychiatric nurse practitioners are permitted to prescribe psychotropic medications. Regular nurses and non-doctors are not permitted to prescribe medications in any circumstance. As for availability of psychotropic medicines, 81-100% of physician-based PHC clinics have at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic), yet none of the non-physician-based PHC clinics carry these medications.

Domain 4: Human resources

Number of human resources in mental health care

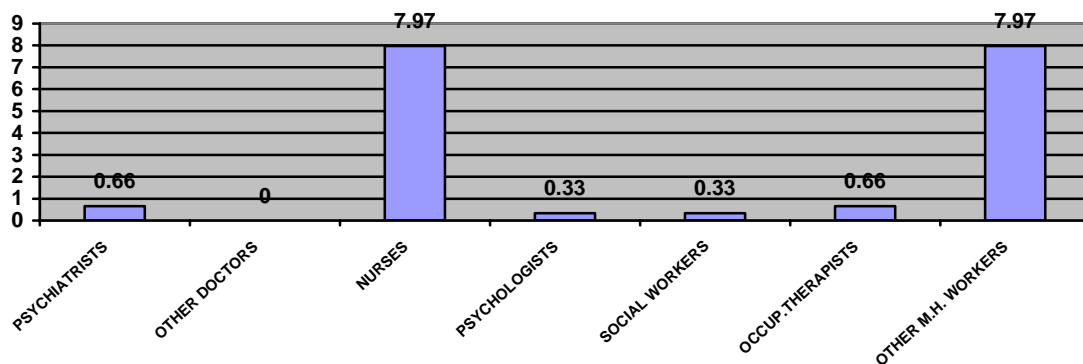
The total number of human resources working in mental health facilities or private practice per 100,000 is 18. The breakdown according to profession is as follows: 0.6 psychiatrists, 7.9 nurses, 0.3 psychologists, 0.3 social workers, 0.6 occupational therapists, and 7.9 other health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, and medical assistants, professional and paraprofessional psychosocial counselors). Both the psychiatrists work for both government administered mental facilities and private practice. With the exception of one psychologist who has a private practice, all social workers, nurses and occupational therapists work only for government administered mental health facilities. None of these professionals work with NGOs, for profit mental health facilities or private practice.

Regarding the workplace, there are only two psychiatrists serving the entire country. One psychiatrist based at the mental hospital provides services to the outpatient clinics in the north and central zones of the country. The other psychiatrist is based in the community-

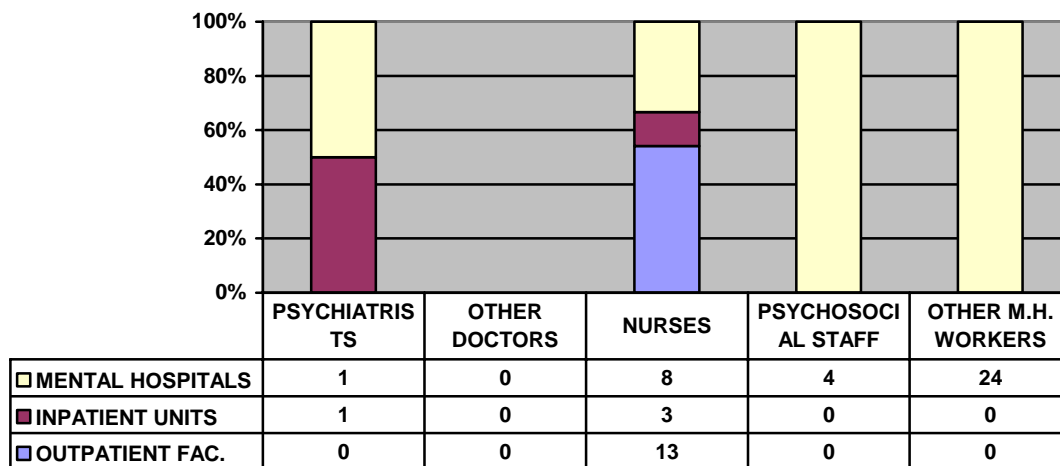
based psychiatric inpatient unit and provides outpatient services to the western and southern zones of the country. There are no medical doctors not specialized in mental health working in any of the facilities. As far as nurses, 13 work in outpatient facilities, 3 in community-based psychiatric inpatient units and 8 in mental hospitals. There are no psychologists, social workers or occupational therapists working in outpatient facilities. In terms of staffing in mental health facilities, there are 0.13 psychiatrists per bed assigned to the community-based psychiatric inpatient unit, and 0.02 psychiatrists per bed assigned to the mental hospital. As for nurses, there are 0.75 nurses per bed in the community-based psychiatric inpatient unit and 0.16 per bed in the mental hospital. Finally, with regards to other mental health care staff (i.e. psychologists, social workers, occupational therapists, other health professionals or mental health workers), none of these professionals work in the community-based psychiatric inpatient unit, and 0.50 per bed work in the mental hospital.

The distribution of human resources between urban and rural areas is unfair: controlling for population density the number of psychiatrists in or near the largest city is 1.51 times the number in the entire country. The one of two psychiatrists and twelve of twenty-four nurses work in or near the largest city. Mental health services are highly centralized in Belize City and the capital city, Belmopan. Rural users are forced to leave their communities to receive treatment in either of these two locations.

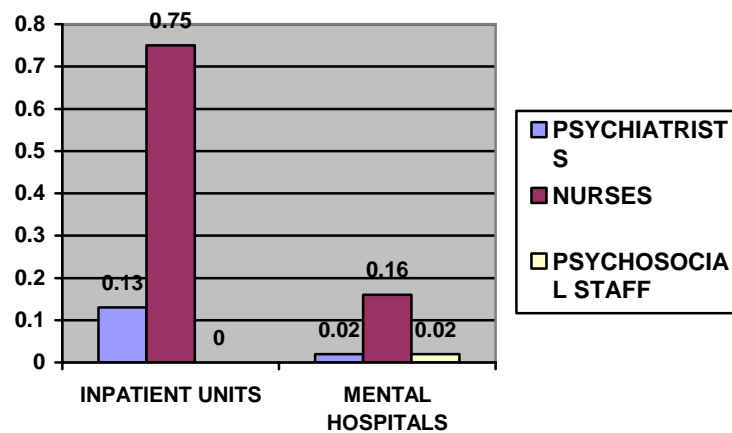
GRAPH 4.1 - HUMAN RESOURCES IN MENTAL HEALTH
(rate per 100.000 population)



GRAPH 4.2 - STAFF WORKING IN MENTAL HEALTH FACILITIES
(percentage in the graph, number in the table)



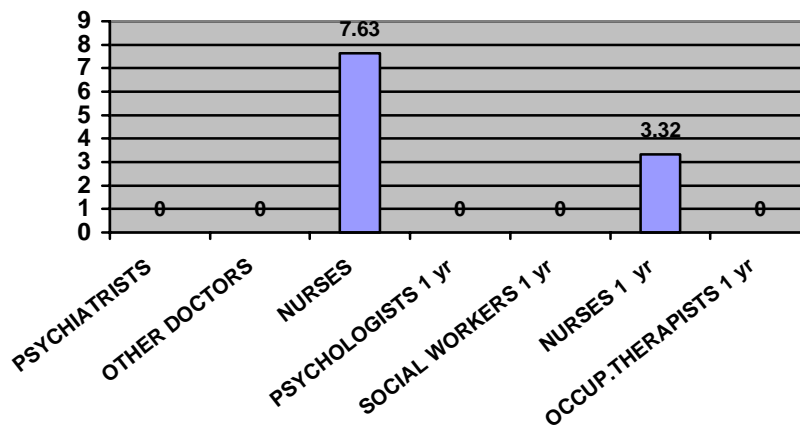
GRAPH 4.3 - RATIO OF HUMAN RESOURCES/BED



Training professionals in mental health

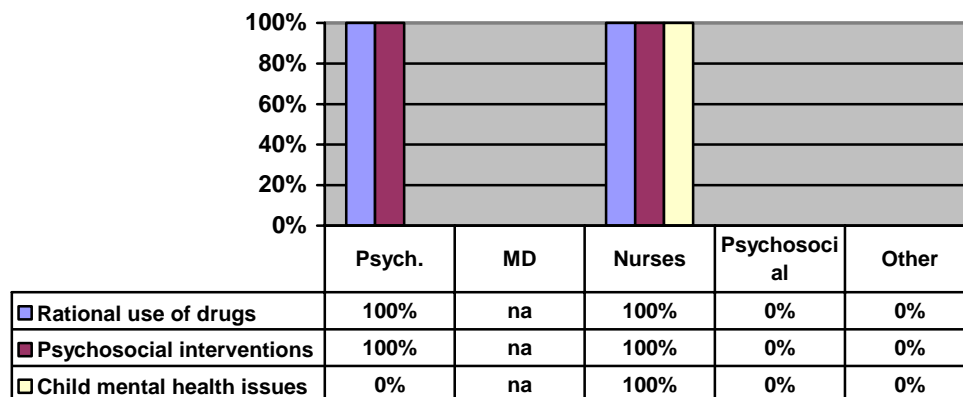
Training for psychiatric nurse practitioners is provided locally. Thirteen psychiatric nurse practitioners graduated last year from the national university. None of the nurses migrated to other countries within five years of completing their training.

GRAPH 4.4 - PROFESSIONALS GRADUATED IN MENTAL HEALTH (rate per 100.000 population)



The following graph shows the percentage of mental health professional with at least two days of refresher training in the rational use of drugs, psychosocial interventions, and child/adolescent mental health issues.

GRAPH 4.5 - PERCENTAGE OF MENTAL HEALTH STAFF WITH TWO DAYS OF REFRESHER TRAINING IN THE PAST YEAR



Consumer and family association

There are 15 users/consumers who are members of the Belmopan Consumer Group. While there were other groups trying to become established, no other groups existed in 2006. There were no family associations, and interested family members became active members of the existing consumer group. The government has never provided economic support to consumer associations. The Consumer Group has been actively involved in the formulation of the mental health policy in the last two years. The various mental health facilities actively interact with consumers. In addition to Consumer Group, there is one other NGO in the country (Haven House, shelter for battered women), which is involved in individual assistance activities such as counselling, temporary housing and a support group for survivors of domestic violence.

Domain 5: Public education and links with other sectors

There is no coordinating body to oversee public education and awareness campaigns on mental health and mental disorders. However, the psychiatrist who acts in the capacity of technical assistant to the Minister of Health makes recommendations for the improvement of mental health services. The Ministry of Health, the Mental Health Association and the Pan American Health Organization have promoted public education and awareness campaigns in the last five years. These campaigns have targeted the following groups: the general population, children, adolescents, women and trauma survivors. In addition, there have been public education and awareness campaigns targeting professional groups including teachers, health care providers and social services staff.

At the present time, there is no legislative or financial support for users. Specifically, there are: (1) no provisions concerning a legal obligation for employers to hire a certain percentage of employees who are disabled, and (2) no provisions concerning protection from discrimination (dismissal, lower wages) solely as the result of a mental disorder. Furthermore, there is no legislative or financial support for and no protection from discrimination in housing.

There are no formal collaborations with any of the departments/agencies responsible for child and adolescent health, education, welfare, and criminal justice. In terms of support for child and adolescent health, 9 % of primary and secondary schools have either a part-time or full-time mental health professional. 51 – 80 % of primary and secondary schools have school-based activities to promote mental health and prevent mental disorders.

Regarding mental health in the criminal justice system, the percentage of prisoners with psychosis is less than 2 % while the corresponding percentage for mental retardation is also less than 2 %. Regarding mental health activities in the criminal justice system, the sole prison has at least one prisoner per month in treatment contact with a mental health professional.

As for training, some police officers (between 21–50%) and a few magistrates and lawyers (between 1–20%) have participated in educational activities on mental health in the last five years. In terms of financial support for users, none (0%) of mental health facilities have access to programs outside the mental health facility that provide outside employment for users with severe mental disorders. Finally, 42 of the 102 social welfare beneficiaries countrywide (41%) have a mental disability.

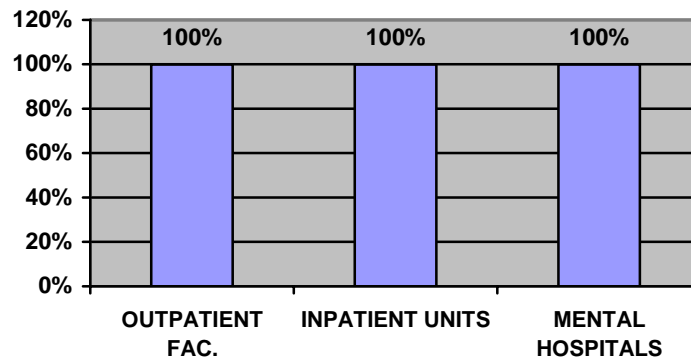
Domain 6: Monitoring and research

There exists a formally defined list of individual data items to be collected by all mental health facilities. This list includes the number of beds, admissions, involuntary admissions and patient diagnoses. As shown in table 6.1, the extent of data collection is consistent among mental health facilities. The government health department received data from the mental hospital, the community based psychiatric inpatient unit and mental health outpatient facilities. Based on the data collected, annual reports were published and disseminated. In terms of research, 13% of all health publications in the country were on mental health. The research focused on epidemiological studies in community samples and non-epidemiological clinical/questionnaires assessments of mental disorders.

TABLE 6.1 - PERCENTAGE OF MENTAL HEALTH FACILITIES COLLECTING AND COMPILING DATA BY TYPE OF INFORMATION

	MENTAL HOSPITALS	INPATIENT UNITS	OUTPATIENT FAC.
N° of beds	100 %	100 %	N/A
N° inpatient admissions/users treated in outpatient fac.	100 %	100 %	100 %
N° of days spent/user contacts in outpatient facilities.	0 %	100 %	100 %
N° of involuntary admissions	100 %	100 %	N/A
N° of users restrained	0 %	100 %	N/A
Diagnoses	100 %	100 %	100 %

**GRAPH 6.1 - PERCENTAGES OF MENTAL HEALTH
FACILITIES TRANSMITTING DATA TO HEALTH
DEPARTMENT**



Conclusion

There are no mechanisms in place to protect the rights of psychiatric patients. No national or regional level review bodies on human rights, with the authority to ensure the rights of mental patients exist. The Mental Health Act of 1957 is in urgent need of revision but must first be preceded by the Cabinet's acceptance of the completed draft policy. The current legislation does little to protect the rights of citizens resulting in 30% of all admissions to the mental hospital and 14% at the community inpatient unit being involuntary. Treatment for chronic mental patients is very centralized with 55% of psychiatric beds located in Belize City, and the only other inpatient unit located in the capital city, thereby severely restricting access to rural users.

The network of mental health facilities is incomplete with only one mental hospital located in Belize City, one community inpatient unit and no forensic units. There are only 54 beds available for inpatient psychiatric care countrywide. Unfortunately, there are plans to move the mental hospital to the capital city which will ensure that psychiatric care continues to be centralized and deny equity of access to mental health services. Twenty-three of the available beds are filled by elderly patients who are institutionalized and have been living at the hospital in excess of twenty years. Eight more of the available beds are occupied with patients who have been there over a year but less than ten years. 62% of beds at the mental hospital are taken up by elderly, institutionalized patients with chronic mental conditions that could have been treated locally in community facilities, if these had been available. Approximately 26% of mental health resources are spent on the mental hospital. Of the 54 personnel working in mental health, 34 are assigned to the mental hospital; in other words, a whopping 63% of personnel are allocated to caring for 31 chronic patients. 62% of patients admitted to the hospital are men, 30% of which with warrants which seems to indicate that men are perceived as more dangerous, a clear indication that more training is necessary for magistrates and police. 40% of the patients in the mental hospital are treated for schizophrenia, a treatable illness which can be

controlled with medication, in a community setting. Personality disorders are conditions that start in childhood but which are very treatable in community settings, yet 20% of patients in the mental hospital are treated for this set of disorders. Mental health personnel receive annual training, however, primary care staff receive less than 8 hours of training annually. This indicates a clear need for training of primary health care staff, the community and family members. Additionally, it is an accepted practice for most Belizeans to first seek help from the local herbalist or spiritualist, yet, there is no interaction between mental health facilities or personnel and alternative/traditional practitioners. In fact, some of the resources spent on the mental hospital would be best diverted to prevention training of primary health care personnel and alternative/traditional practitioners who are the gate keepers of many rural communities.

There are 13 psychiatric nurses assigned throughout the country to provide outpatient care. 15900 consumers accessed services which are available in all districts and the capital city. The ratio between outpatient contacts and days spent in the inpatient facilities was .79, a clear indicator of the emphasis that is placed on inpatient care, specifically, the mental hospital. It is also a clear indication of the work necessary to mitigate the huge stigma and discrimination associated with mental issues. Essential psychotropic medicines are available in all physician-based facilities and primary care physicians, who do not avail themselves for refresher training, access and prescribe these medications. To their credit, however, the majority of physician-based, primary health care clinics make at least one referral monthly to a mental health professional. There are fledgling consumer associations throughout the country but only the Belmopan group is truly functional. To date there are no family associations.

The mental health sector has no formal links with other relevant sectors such as education, criminal justice, health or social security. There is no legislative or financial support for consumers (persons who access mental health services). Specifically, there is no legal provision for obligating employers to hire a certain percentage of persons with disabilities and no legal provisions for protection against discrimination due to their illness. Finally, there is no legislative protection against discrimination in housing. This must be addressed, post haste, once the policy has been approved.

Only 16% of patients seen in all sectors were children; a clear indicator that the mental health needs of children need to be addressed. In fact, there has never been a child psychiatrist/psychologist available to provide for the mental health needs of children. Additionally, there are no formal collaborative interactions with child and adolescent health, education, child welfare or criminal justice agencies. The result is that a number of children with childhood mental disorders are being treated criminally and placed in detention facilities like the youth hostel, the youth facility in the prison or who become perpetrators of crimes in the localities. Once again, resources being wasted on the mental hospital would be better served in prevention programmes for 50% of the population.

The mental health information system has been updated to coincide with the ICD 10 and should function since it is well organized to collect all pertinent data, however any system is only as good as the users. The information at the hospital was invariably

inaccurate; specifically, data concerning admission and discharge dates and the use of restraints were noticeably missing from the documentation.

More female users access outpatient services suggesting that women access help earlier while more males, who are seen as more menacing and dangerous, are placed into the mental hospital. Additionally, men tend to access treatment much later than women who access outpatient care in much greater numbers.

The data indicate that the government approach to mental health in Belize is a 1900 custodial paradigm. There is clear supporting evidence that more persons can be successfully treated in their communities in small, inexpensive community inpatient units and outpatient facilities, and can potentially return to being successful, productive citizens.

Follow-up actions

It is of most importance that the mental health policy will be approved by the Cabinet. Subsequent to the passage of the policy, it is imperative that the Mental Health Act will be updated and rights-based legislation will be enacted. The Mental Health Program needs to organize formal collaborations with departments responsible for housing, child and adolescent health, education, welfare and criminal justice. NGOs and consumer groups must continue to vigorously advocate for the decentralization of mental health programmes.

Stigma and discrimination against those with mental illness is pervasive. For this reason there is an urgent need to develop a multi-sectoral response to address the needs of people with mental disorders. Government departments and organization that could be involved in this response could include: The Ombudsman, Chief Magistrate, Director of Human Services, Community Rehabilitation Department, Youth For the Future, National Council on Aging, Human Rights Commission, Human Rights Department, University of Belize, Social Work Programme, University of Belize, Superintendent of Prisons, Director, Women's Department, Consumer Associations, Mental Health Association, the various media houses, UNICEF, UNFPA, SPEAR, CARE, National Drug and Alcohol Abuse Council, National Council on Education, President, Physicians and Dental Association, President, Nursing Association, CEO, Ministry of Education, Commissioner of Police, Director, Health and Family Life Education, Belize City Council.

RECOMMENDED ACTIVITIES

Activities	Type	Implementer	Target Date
Present Mental Health Policy to Cabinet for approval	Short Term	Psychiatric Dept	June 2009
Integrate appropriate stakeholders into national plan	Short Term	Psychiatric Dept	March 2009
Establishment of Mental Health Department at the Ministry of Health	Short Term	DHS	May 2009
Development of Strategies to implement the Mental Health Policy	Medium Term	Psychiatric dept	August 2009
Update the Mental Health legislation	Medium Term	Psychiatric dept	September 2009
Institutionalize a minimum of at least 2 psychiatric beds in each district and regional hospitals	Medium Term	DHS/Tech advisor	June 2010
Advocate for a small forensic unit for criminally insane at Kolbe Foundation, prison facility	Medium Term	Psychiatric Dept	June 2010
Relocate elderly from the Mental Health Institution to appropriate facilities for the elderly	Medium Term	Human Services	June 2010
Reprogrammed and allocate financial resources to support the hiring of a child psychiatrist /psychologist, psychiatric social workers and Occupational Therapists	Medium Term	MOH	Sep 2010
Development appropriate community facilities: homeless shelters, day hospitals, club houses	Medium term	Psychiatric Dept, human development	April 2010
Collaborate with the National Drug Council to develop a substance abuse policy for inclusion as addendum into the Mental Health Policy	Short Term	NDAAC/MHA/Psych Dept	December 2009
Collaborate with the Belize Medical and Dental Association to ensure a minimum of 2 days annual training in mental health for General Practitioners	Short Term	DHS/CEO	May 2009
Development of a therapeutic drug policy	Short Term	Technical Advisor/ DHS/ CEO	May 2011

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The WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Belize including the mental health policy and legislative framework, mental health facilities, human resources, links with other sectors, and monitoring and research. The goal of collecting this information was to enable policy makers to develop information-based mental health plans with clear base-line information and targets.

A mental health policy drafted in 2007, but it is currently awaiting authorization.. The latest version of the national mental health plan is from 2006 and contains a variety of components including the plan to downsize mental hospitals. The most recent legislation dates from 1957. Although there is a national human rights commission which operates on a volunteer basis, there is no national human rights review body.

Facilities for mental health include 8 outpatient facilities, one community-based psychiatric inpatient unit, and one mental hospital; 93% of psychiatric beds are located in the mental hospital.

The total number of human resources working in mental health facilities or private practice per 100,000 is 18. The breakdown according to profession is as follows: 0.6 psychiatrists, 7.9 nurses, 0.3 psychologists, 0.3 social workers, 0.6 occupational therapists, and 7.9 other health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, and medical assistants, professional and paraprofessional psychosocial counselors). Human resources are unequally concentrated in the largest city compared to rural areas.

The first step to improving mental health in Belize includes the authorization and implementation of the draft mental health policy.