PSYCHIATRY. LAM Selina

Elective write up

1. Describe the prevalence of psychiatric conditions in Barbados. How do they differ from the United Kingdom (UK)?

In the Caribbean, there have not been any rigorous population prevalence or incidence studies. It is suggested the age-corrected incidence rate for schizophrenia per 10,000 was 2.92 in Barbados. These rates are lower than the incidence rates reported for white British people, and significantly lower that the 6- to 18-fold higher risk ratio incidence reported for African Caribbeans living in Britain. There are relatively low incidence figures reported for affective disorders, anxiety states, suicide and attempted suicide in Barbados (1).

Cochrane and Bal, in a study of England and Wales with data from the Mental Health Enquiry, reported a prevalence rate of 30.7 per 1 000 for African Caribbeans and 8.7 for the native white population (2).

Mahy reported a suicide rate in 1989 of 2.3 per 100 000 in Barbados. Mahy concluded that the rates of attempted suicide in the English-speaking Caribbean are generally lower than those in the developed world (3). It has been reported in the United Kingdom that depression has a community prevalence of 10% and is associated with physical morbidity and mortality. One study in Jamaica found that 52% of women and 40% of men were often depressed in the previous month (4) while a community sample in Trinidad & Tobago reported a prevalence of 14% (5). High rates of depression have also been reported for adolescents (25%) and these were significantly associated with violence in the home and substance use (6).

A review of preliminary work published on Caribbean populations suggests that there is a significantly lower incidence of affective psychoses and suicide in the Caribbean than among African Caribbean people or whites living in the UK (7).

In conclusion rates of psychiatric conditions are generally lower than in the general UK population and African Caribbeans living in Britain, but due to the small population and migration of people from Barbados to other parts of the world, this will distort the interpretation of prevalence rates, therefore caution is urged.

2. Describe the pattern of psychiatric services in Barbados. How do they differ from the United Kingdom (UK)?

The psychiatric hospital in Barbados is located in Black Rock, St. Michael and is called Psychiatric Hospital. The site was an old plantation house that was purchased by the Ministry of Health in 1891 and admitted its first patients in 1893. The hospital provides 24 hour care, 7 days a week with nursing care available for both in and out patients. It has approximately 640 beds. It also provides counselling and therapy sessions, Child Guidance Clinic to help children suffering with a variety of mental disorders and Occupational Therapy Unit, to help patients with their life skills and function. There is also vocational skill programs develop concentration and cognitive skills through activities such as building furniture. There is a Forensic Unit with medium and high security units (8). Most of the patients in the Psychiatric Hospital are considered 'long stay' meaning patients who suffer from chronic psychiatric conditions and would not be discharged in the foreseeable future.

There are two other psychiatric services; they are a 12 bed unit in Queen Elizabeth Hospital (the main general hospital near Bridgetown) (9) with outpatient clinic held once a week and Community

Services, which helps patients move back in to the community. This is combined with aDistrict Nursing Service allows the psychiatric service to keep an eye on out patients and ensure they are settling back in to the community. Social Serviceswork closely with psychiatric team which acts to prevent crises within the family and places children who are considered at risk in their home environment (8).

In comparison to the Mental Health Services of the United Kingdom (UK), the UK has in essence the same range of services but is based less on institutionalisation and more on care within the primary care setting. The number of mental hospitals has reduced and avoids possible detrimental effects of long term hospitalisation and focuses on patients being reintegrated into the community. This however has lead to increased number of readmissions with multiple short term stays for specific patients requiring inpatient treatment (10).

- 3. The short/long term effects on health caused by a natural disaster e.g. Hurricane Tomas
- 4. Develop clinical skills needed in medical and psychiatric care of patients and reflect on these experiences.

My experience of psychiatric care in Barbados has increased my understanding of West Indian culture through colloquial terms such as 'cheese on bread' as an expression of surprise or 'licks' culturally accepted form of discipline in school (only done by principle) or at home that is slowly changing. Obviously this is only a glimpse in my short time here.

It has also increased my appreciation of the role psychiatric team has on the impact of the patients life, acting a not only a psychiatrist but a counsellor as well. There was no psychologist at Queen Elizabeth Hospital so the psychiatric team act as a role of support for patients who are finding it difficult to adjust in the community. For example a pregnant patient diagnosed previously with postnatal depression, and currently finding themselves tired all the time who found it difficult to cope at home with three younger children, medical causes were ruled out and advice was given to change the dynamics at home in terms of help and support. Another example was a patient who came into the admissions unit in the Psychiatric hospital seeking support on adjusting to life without their previous partner as they had a history with depression, appearing tearful and distraught with no suicidal ideation. Observing this made me realise that the patients would find it extremely difficult to cope without the advice of the psychiatric team.

A patient with known Bipolar disorder presented to the Psychiatric hospital with a manic episode and refused to shower instead decided to bathe in their own urine. I appreciated the patience and skill needed to deal with a patient in this state to obtain a history, especially with symptoms of pressure of speech, excitability and some grandiose delusions. I will try to put this into my own future practice with patients.

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