Belize, Central America, the most sparsely populated country in Central America, has taken gigantic steps to improve the mental health of its citizens. This article profiles mental health in this country and explicates contextual factors circumscribing manifestations, treatment, and care of mental illness. An overview of mental health services is provided, with particular focus on the role of psychiatric nurse practitioners. Other innovative approaches in promoting mental health and providing care to the those who are mentally ill are highlighted. Current and future challenges for nursing care and mental health services are presented. Recommendations for future action are offered.

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ALTHOUGH MENTAL DISORDERS have not been a public health priority in any world setting, Belize, the most sparsely populated country in Central America, has taken gigantic steps to improve the mental health of its citizens. This article begins with an overview of mental health in Belize and contextualizes the manifestations, treatment, and care of mental illness. The core of the article focuses on psychiatric nurse practitioners (PNPs); their roles, education, and challenges in practice; and other innovative approaches for promoting mental health and providing care to people who are mentally ill. Recommendations for future action are incorporated in the conclusion.

SETTING

Although all ethnic groups are dispersed throughout the country, the major groups are generally concentrated in one of the six administrative districts of the country: Corozal, Orange Walk, Belize, Cayo, Stann Creek, and Toledo (Brenner, 1999). The Mestizos comprise 48.7% of the population; the Creoles, 24.9%; the Maya, 10%; and the Garifuna,
6.4%. Other ethnic groups include East Indians (3%); Mennonites (3.6%); and smaller groups, including Chinese, Middle Easterners, and North American Caucasians (About Belize, n.d.; Bonander, Kohn, Arana & Levev, 2000). In 2000, 52.3% of the country’s population resided in rural areas and 47.7% in urban areas, with approximately one fourth of the country’s population living in Belize City, the principal port, commercial center, and former capital of the country (About Belize, n.d.; Bonander et al., 2000).

Sixty percent of the country’s population is Roman Catholic; the Anglican Church and other Protestant Christian groups account for most of the remaining 40%. Although English is the official language, Spanish is the primary language for nearly 35% of the people. Approximately 40% of Belizeans are 14 years old and younger. Fifty-seven percent of the population are between the ages of 15 and 64, and 3.5% are 65 years and older. For the general population, life expectancy at birth is 68.3 (WHOSIS, 2006). In 2000, the basic literacy rate for Belizeans was 75% (Belize in Human Development Report, 2006).

SOCIOPOLITICAL CONTEXT OF MENTAL HEALTH AND ILLNESS IN BELIZE

Although the role of biological causes of mental illness is acknowledged, historic and contemporary factors are also critical etiological contributors and provide the contextual backdrop for viewing mental health and illness in Belize. Deeply entrenched structural problems of transformation, associated with the legacy of slavery and colonialism, have left an indelible yet understated mark on the Belizean culture as many have struggled for legitimacy in their own country (Kirmayer & Minas, 2000). Moreover, this oppressive past has locked major segments of the population in poverty for a considerable period (Kirmayer & Minas, 2000).

Currently, the small private enterprise economy of Belize is based primarily on agriculture and agro-based industry, with fishing, shrimp farming, forestry, and tourism having relative importance (Economy of Belize, 2006). In 2000, according to the Poverty Assessment Report (2002), 33% of Belizeans were poor during the previous year. The unemployment rate was 13.8% in 2003 (Economy of Belize, 2006). Changes in the international economy and difficulty in resolving macroeconomic problems associated with the liberalization of trade, service debt, and advances in technology have contributed to poverty in Belize (Poverty Assessment Report, 2006).

Natural disasters have also had a damaging effect on the country’s economic development throughout its history. Recovery from a series of devastating hurricanes has never been complete. Beyond the economic setbacks associated with the trauma of devastating storms, the short- and long-term psychological distress, associated with displacement; injuries; and loss of homes, businesses, other institutions, and familiar locations, is immeasurable (Caldas de Almedia, 2002).

Drug trafficking further contributes to psychological costs, and its surveillance diverts resources from other more critical areas of concern. Belize, like other countries in the region, has been used as a conduit for the transit and storage of illicit drugs between Colombia, Mexico, and the United States. Because of the contiguous borders with Guatemala and Mexico, the variegated terrain, and an accessible coastline, Belize has considerable appeal for drug trafficking (Multilateral Evaluation Mechanism, 1999–2000). Although the number of Belizeans who are engaged in, or benefit economically from, drug trafficking is relatively small, this subterranean activity is detrimental to the community and fosters substance abuse and related criminal activity among local citizens (Counternarcotics and Law Enforcement Country Program: Belize, 2005).

As drug trafficking woes continue to fester, issues of migration also intensify. During the last few decades, the Belizean population has shifted from a predominately urban pattern to a more rural orientation (Haug, 2002). This redistribution has been associated with international population migration flows that have changed the ethnic composition of the country’s population and its spatial distribution. A mass exodus of Creoles, particularly to the United States, has occurred, including those who are most skilled (Bronfman, 1998; Payne, 1990). Simultaneously, the influx of immigrants and refugees from neighboring countries, such as Guatemala, Nicaragua, and El Salvador, has increased. Despite the rich cultural contributions recent immigrants have made, most of them have no capital, are poorly educated, and lack skills, contributing to the increase in unemployment,
underemployment, and poverty, especially in southwestern Belize (Poverty Assessment Report—Belize, 2002). Moreover, many of these immigrants are retreating to Belize after being engaged in territorial conflict or affected by guerrilla warfare in their home country. They bring physical injuries and psychological scars from violence, disruption of family and community, economic displacement, and posttraumatic stress syndrome that must be healed. Although Belize, as a signatory of the International Conference on Central American Refugees Agreement, consented to host neighboring countries, the country’s porous borders offer no barrier to undocumented residents. As a consequence, Belize has experienced an uncontrolled incursion of immigrants that has strained the country’s health, society, and other resources (Poverty Assessment Report—Belize, 2002). These population shifts have created an increased need to formulate culturally appropriate services and creative approaches to dispensing them throughout the country. Moreover, with the alterations in demographics, conflicts between and among established groups and recent arrivals have sharpened.

Belizean natives, who have migrated from the country primarily to improve their economic status, sometimes leave behind older parents or entire families. Adjusting to the absence of family members has created emotional distress for many. As cultures “clash,” dissonance in family functioning arises. Childrearing practices are strained, traditional family obligations are challenged, and age deference is altered (Ustun, 1999). Substance use, often a consequence of unemployment and a source of self-medication, frequently contributes to domestic violence. Survivors (and their children) of this abuse suffer emotionally, as well as physically. Diminished social support and the breakdown of kinship structures are key stressors for those who migrate, as well as the thousands of dependents who are left behind awaiting remittances relatives send from distant cities (Fabrega, 2001; Cayetano, 2004; Killion, 2002).

The confluence of these factors, superimposed upon other possible etiologies, configures mental disorders in Belize. Importantly, protective factors, such as the persevering spirit and solid religious base of the country, a strong work ethic, a vibrant sense of nationalism, and an altruistic worldview, permeate the Belizean culture and offset many of the precipitating influences. (McClaurin 1996; Sutherland, 1998; Killion 2002).

MENTAL ILLNESS IN BELIZE

In 2005, 12,318 patients were reported to have been evaluated and/or treated of mental disorders in the country of Belize (Psychiatric Nurse Practitioner Report, 2005). Table 1 provides a summary of the number of patients seen according to diagnosis by PNPs. Of that total, 26.8% were new patients, and 73.2% were old or returning patients. Slightly more than one fourth of all patients were seen for schizophrenia/psychotic disorder (26%) followed by mood disorders (19.5%) and “associated” conditions¹ (11.6%). Nationwide, 6.8% of individuals were seen for relational problems and 6.7% for anxiety disorders. Documented patient visits for problems related to abuse (1.2%) and substance-induced disorders (3.5%) were relatively small. The

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>n</th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td>Psychotic disorder</td>
<td>3,206</td>
<td>26.0</td>
</tr>
<tr>
<td>Mood disorder</td>
<td>2,400</td>
<td>19.5</td>
</tr>
<tr>
<td>Associated conditions</td>
<td>1,460</td>
<td>11.6</td>
</tr>
<tr>
<td>Relational problems</td>
<td>838</td>
<td>6.8</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>825</td>
<td>6.7</td>
</tr>
<tr>
<td>Behavioral/Psychological/Physical</td>
<td>601</td>
<td>4.9</td>
</tr>
<tr>
<td>Substance-induced disorder</td>
<td>428</td>
<td>3.5</td>
</tr>
<tr>
<td>Childhood disorder</td>
<td>320</td>
<td>2.6</td>
</tr>
<tr>
<td>Problems related to abuse</td>
<td>142</td>
<td>1.2</td>
</tr>
<tr>
<td>Dementia/Delirium</td>
<td>85</td>
<td>.7</td>
</tr>
<tr>
<td>Other</td>
<td>2,013</td>
<td>16.4</td>
</tr>
<tr>
<td>Old patients seen</td>
<td>9,022</td>
<td></td>
</tr>
<tr>
<td>New patients seen</td>
<td>3,296</td>
<td></td>
</tr>
<tr>
<td>Total patients seen</td>
<td>12,318</td>
<td></td>
</tr>
</tbody>
</table>

NOTE. Source: Diagnoses by Districts, 2005. Associated conditions refer to other disorders associated with mental disorders: HIV, sexually transmitted infections (STI), epilepsy, hypertension, cerebrovascular accident, congenital malformation, abortion, intentional self-harm, and poisoning.

¹ Associated conditions refer to other disorders associated with mental disorders: HIV, STI, epilepsy, hypertension, cerebrovascular accident, congenital malformation, abortion, intentional self-harm, and poisoning.
number of children seen (2.6%) and older adults (0.7%) treated reflects the growing identification of mental conditions among the youngest and oldest members of the population.

Table 2 depicts the number of patients seen in the respective districts of the country (Psychiatric Nurse Practitioner Report, 2005). Significant variation exists in the types of reported mental disorders across districts. For example, a disproportionate number of patients with psychotic disorders were reportedly seen in Belize District.

Aside from the fact that Belize District has the largest population of all the districts, the higher number of patients with psychotic disorders is likely because Rockview Psychiatric Hospital is located in Belize District. Patients from Belize District, as well as from other districts, are referred, evaluated, and/or admitted to Rockview, the only psychiatric hospital in the country. This number also accounts for patient visits documented in the two mental health clinics and patients seen in the psychiatric clinic/rehabilitation center housed in...
Karl Heusner Memorial Hospital, the national referral tertiary acute care hospital, in Belize City. An interesting finding was that patients seen for problems related to abuse in Belize District are the lowest in the country, which may be attributed to the use of social services outside of the health care arena, use of the criminal justice system, or lack of reporting.

In comparison with other districts, Stann Creek, densely populated with Garifuna residents, and Toledo, with a concentration of Mayans (and the highest poverty rate in the country), have significantly fewer reported cases of individuals with mood disorders. Clinical signs may be masked, manifested differently than in other groups, or defined as other kinds of conditions in these particular ethnic groups. Familial and cultural factors may also play an important role in mitigating against mood disorders. Both districts are in the southernmost part of the country and may be more isolated from services. Moreover, use of indigenous healers may be more prevalent in this region. Lack of identification of mood disorders, however, may be a primary factor in cases not being seen and reported.

The aforementioned cases of mental disorders represent patients seen by PNPs only and do not include patients who are treated directly and solely by the psychiatrists in private practice. Importantly, a significant and inestimable number of those needing psychiatric care have not been evaluated or received treatment in a formal setting (Cayetano, 2004).

AN OVERVIEW OF MENTAL HEALTH SERVICES IN BELIZE

In advocating for a comprehensive mental health program in Belize, Dr. Claudina Cayetano (2004), chief psychiatrist and technical advisor to the Ministry of Health, has urged policy makers and public officials to “…be honest enough to face up to mental illness, informed enough to recognize it for what it is, and open enough to enlist the help of family and community members in its treatment.” Increasingly, this challenge is being embraced, and progressive efforts are underway to promote mental health and prevent mental illness. A unique, decentralized delivery system of high-quality psychiatric services is emerging.

Currently, mental health services are offered in all the district hospitals in the country and at the polyclinics in Belize City. Patients are also seen in the Karl Huesner Memorial Hospital in Belize City. Further, in each of the medical districts of the country, psychiatric clinics are regularly held. Specific guidelines are followed to assure optimal care to individuals with mental and physical conditions in primary care settings (Community mental health service policy and procedure manual for mental health nurse practitioners/psychiatric nurse practitioners/mental health officers, 2000). The country has one inpatient facility, Rockview Psychiatric Hospital, located on the outskirts of Belize City, which houses those who are severely, often chronically, mentally ill. (A new facility, in the country’s capital, has been constructed, and residents will be moved to this new location in the near future). In addition, a four-bed psychiatric unit opened within the general hospital in Belmopan, the country’s capital, in 2001. This network of inpatient and outpatient facilities is provided by the psychiatrists, PNPs, practical nurses, nurses’ aides, occupational therapists, social worker’s aide, and clerical personnel. Referrals and consultations are augmented by the use of the Internet, which is available in every mental health clinic. Outpatient mental health services are provided in two community-based psychiatric clinics in Belize City. Telepsychiatric services are also on the horizon. An informal parallel system of care is maintained through traditional healers, although the extent of their engagement is not known. International organizations such as the Pan American Health Organization (PAHO) provide technical support to the mental health program. Community activist groups, including the Mental Health Association and the Belmopan Mental Health Consumer Association, diligently and aggressively augment the roles of clinicians by educating the public, sponsoring fund raisers, lobbying for critical issues related to mental health, and providing social support to individuals and families affected by mental illness. For example, the Belmopan Mental Health Consumer’s Association lobbied and gained approval for new psychotropics (Risperidone, Sertraline, Olanzapine, and Biperiden) which make a significant difference in treatment options and outcomes.

Less than two decades ago, Belize, like other low- and middle-income countries, focused primarily on life-threatening physical disorders (Desjarlais, Eisenberg, Good, & Kleinman, 1995). Care for
people who are mentally ill was largely fashioned after the asylum mode of the colonialism era. The early 1990s proved to be a turning point in the development and offering of mental health services in Belize, however. During this period, two Belizean-born psychiatrists independently arrived in Belize to practice. Each served different regions of the country and had distinct clinical and administrative roles. Although their expertise and services were highly valued and continue to meet a critical need, it was impossible for them to provide care to all in need of help. Concurrent with the psychiatrists’ arrival, the PNP program was being launched to address the rising visibility of mental illness, improve coverage of services, and reduce the demands on inpatient care (Bonander et al., 2000).

Psychiatric Nurse Practitioners

In 1991, the first training program for PNPs was established under the auspices of the PAHO/World Health Organization and the Bliss School of Nursing in Belize City, Belize, in collaboration with Memorial University in Newfoundland, Canada, with support from the Canadian International Development Agency (Sen, Laryea, Glen, Kozma, & Palacio, 1996). Highly skilled, well-respected registered nurses were recruited from each district to participate in the program.

In 2004, a second cohort of PNPs nurses was prepared. The requirements of this, and the former program, mandated that enrollees be graduates of an accredited school of nursing, have a minimum of 3 years of experience in nursing, and have completed a 6-month community psychiatric nursing course (or its equivalent; Profile of the mental health nurse practitioner/psychiatric nurse practitioner, 2000). The curriculum includes courses focused on theories of personality, communication and counseling, mental health assessment, variation in human needs, psychiatric nursing, psychopathology and treatment, group dynamics and counseling, and issues in rehabilitation, accompanied by clinical practicums in the community and mental health and primary care facilities. After nurses complete the course, registration with the nursing council is required before they can practice in the area of mental health (Profile of the mental health nurse practitioner/psychiatric nurse practitioner, 2000).

Although nurses worldwide have been engaged in the delivery of psychiatric care, Belize is one of few countries to endow PNPs with extended clinical responsibilities in mental health (Mental health advanced practice nursing in the Caribbean, 2000). Belize, Guyana, and Jamaica are the only countries in the region that have nurses with advanced training in mental health. (Belize has PNPs; Guyana and Jamaica have mental health officers;) (Profile of the mental health practitioner/psychiatric nurse practitioner, 2000). Close supervision and frequent consultations are maintained with the two psychiatrists in the country who review the most difficult cases. The role of the PNP in Belize, however, has evolved to allow for considerable clinical autonomy, including independent assessment of patients, the initiation of selected treatments, the prescription of psychotropic medications and psychotherapy, and the consultation with local health and social agencies (Bonander et al., 2000, Killion, 2002; Laryea, Sen, Glen, Kozma, & Palacro, 1999).

A typical day for the PNP in an inpatient setting may involve attending ward rounds with the hospital’s medical officer or with the psychiatrist on his or her visiting day. Other responsibilities include assessing and reassessing the client while suggesting treatment options, administering and/or prescribing medication, assessing for side effects and efficacy of the medication, admitting and discharging patients, working with staff to arrange activities for clients who are functional, leading psychotherapy sessions, and communicating with the families of clients.

In the community, PNPs maintain caseloads in clinics and travel to rural areas to provide care, extending the availability of professional psychiatric services. Beyond clinic visits, home visits are regularly made. A single mother of five with a diagnosis of schizophrenia was able to maintain a part-time job and care for her children because of the assistance she received from her PNP. Through home visits, the PNP was able to monitor the woman’s medications, advise her on financial planning for home management, provide nutritional education and assistance, and counsel her regarding child-rearing matters.

Frequently, law enforcement officers call upon PNPs to interview and consult on persons held in lockups to assess their psychiatric condition. Food and the opportunity to bathe are provided to
individuals who may or may not be mentally ill yet are destitute because of a temporary or permanent situation. PNPs teach about mental health in the schools and serve as consultants for teachers and school administrators. Schools, within each district, also seek the expertise and services of PNPs for children who are maladaptive, have behavior problems, or are mentally challenged. Further, PNPs serve as liaisons between indigenous healers, patients, and the formal health care system.

According to one PNP, “We carry a little bit of mental health wherever we go.” The PNPs provide outreach in the community by way of the radio and television and promote mental health through churches and other community groups. Annually, the PNPs implement a series of activities and events which culminate on World Mental Health Day. PNPs are actively involved with other advocates of mental health in promoting mental health and attempting to eliminate the stigma associated with mental illness. These activities are supported by the PAHO. Further, PNPs act as health educators and consultants in the community.

Keeping their skills updated is a critical part of the PNPs’ role. Dr. Claudina Cayetano organizes an annual workshop sponsored by the Ministry of Health for the PNPs to meet as a group to problem solve, share information, and support one another. They enroll in continuing education classes and workshops to keep abreast of new therapeutic approaches. In fact, Belize is the only country in the region where there has been a systematic evaluation of the PNP model (Laryea et al., 1999).

Challenges Ahead

Despite these valoric efforts, a number of challenges persist. PNPs administer approximately 90% of the mental health care in the country (Ministry of Health, 2005). The quality of care is jeopardized, however, as the nursing profession grapples with the nursing shortage. Emigration from Belize has been a major consequence as nurses seek better working conditions and respond to the aggressive recruitment tactics of countries such as the United States, the United Kingdom, and Canada as they attempt to assuage the shortage of nurses in their own countries. Within the Caribbean Basin, country-to-country migration has been encouraged, however, to deal with the supply of nurses in the region. Initiatives developed by the collective efforts of regional nursing organizations are replacing “Brain Drain” with “Gain Brain” (Yan, 2006). Attrition of nurses in Belize has declined within the last few years because of some of these efforts, but improvements in the numbers and working conditions are still sorely needed (Salmon, Yan, Hewitt, & Guisinger, 2008). Increasing the overall number of nurses in Belize is likely to expand the pool of nurses who are available to complete specialized training in mental health.

The migration of nurses to Belize from other neighboring countries coexists with emigration of nurses as refugees and lay immigrants also arrive. These oscillating migratory patterns render a “mixed blessing” for Belize. The foreign nurses may help to alleviate the nursing shortage in Belize, and immigrant residents may find respite and revitalization in a new country. Conflict often occurs as cultures collide, however. Misunderstandings play out between native and immigrant nurse, and immigrant patient and native nurse (or immigrant nurse and native patient) in the clinical arena. Advances made in improving mental health are often missed, delayed, or reversed because of lack of sensitivity and understanding of cultural differences and needs.

Formalizing mental health as an integral component of the health care system is still in progress. Although the range of services provided is expanding, the Belizean government spends less than 3% of its health budget on mental health and mental illness (Mental Health Atlas, 2005). The country has mental health legislation, based on the British model, dating back to 1965, which is currently being reviewed and updated to ensure that it adheres to international human rights standards (Belize National Mental Health Policy Draft, 2008). Multiple stakeholders are involved in this process. The latest addition to the legislation was enacted in 1998 after the Mental Health Association lobbied vigorously for decriminalizing suicide, as well as ensuring that survivors of suicide attempts received professional help rather than face criminal charges (Bonander, Kohn, Arana, & Levav, 2000). A written document exists that gives policy directions to be adopted by the country to become the official mental health policy; however, no mental health policy has yet been implemented (Mental Health Atlas, 2005). Belize has a national drug demand reduction strategy, however, and a national therapeutic drug policy/essential list of drugs is available (MEM, 1999–2000). Further, the issue of whether or not to completely decentralize
and/or deinstitutionalize mental health services has now been resolved as the Mental Health Policy is in its final stages of formulation (Belize National Mental Health Policy draft, 2008).

Lastly, Belize continues to struggle with the elimination of the stigma that plagues people who are mentally ill and their families. Educational programs geared for school-aged children and sessions taking place in churches and other community organizations hold promise for making a significant impact. Use of the media has also been effective, although much more work is needed to change attitudes and behavior toward people who are mentally ill.

CONCLUSION

Globally, mental disorders exceed both HIV and cancer in terms of the numbers affected (Ustun, 1999). Individuals with mental disorders experience significant disabilities, including limitations of physical, personal, and social functioning. Moreover, their quality of life is diminished, and relationships with their families and communities are distorted and damaged. The serious and pervasive social stigma associated with mental disorders adds further insult. Although efficacious methods of managing mental disorders exist, they are not applied sufficiently nor are they accessible to all who are in need.

The commitment of Belize to promote mental health and improve mental health services is exemplary and serves as a model for other countries. Strides taken by Belize are consistent with the public mental health priorities set forth by the World Health Organization which include providing treatment in primary care settings; making psychotropic medications available; giving care in the community; educating the public; involving communities, families, and consumers; establishing national policies and legislation; developing human resources; linking with other sectors; monitoring community health; and supporting more research (World Health Report, 2001). Other developing nations can embrace these goals as much as their individual circumstances can allow, bearing in mind that the ingenuity and steadfastness of Belize demonstrate the magnitude of what can be done with limited means and visionary stamina. Clearly, the call for continued planning, evaluating, and acquiring more resources is warranted for Belize and other nations.

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Community Mental Health Service Policy and procedure manual for mental health nurse practitioners/psychiatric nurse practitioners/ and mental health officers. Belmopan: Ministry of Health; (2000) (pp. 30-32).


