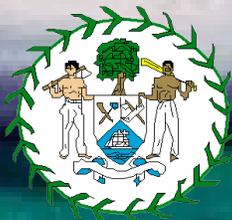


BELIZE NATIONAL MENTAL HEALTH POLICY

MINISTRY OF HEALTH
MENTAL HEALTH PROGRAM
April 2008



**Pan American
Health
Organization**

Regional Office of the
World Health Organization

TABLE OF CONTENTS

	1
SECTION I	3
COUNTRY PROFILE	3
EPIDEMIOLOGY	4
SECTION 2	6
SITUATIONAL ANALYSIS	6
MENTAL HEALTH REFORM IN BELIZE	6
THE NATIONAL MENTAL HEALTH PROGRAM	7
<i>Non-Governmental Organizations</i>	13
<i>International Organizations</i>	13
SECTION 3	14
NATIONAL MENTAL HEALTH POLICY	14
1.0 INTRODUCTION	14
2.0 VISION	14
3.0 MISSION	14
5.0 VALUES AND PRINCIPLES	15
5.1 HUMAN RIGHTS	15
5.2 ACCESSIBILITY AND EQUITY	16
5.3 INTEGRATION OF MENTAL HEALTH SERVICES	16
5.4 DECENTRALIZATION AND COMMUNITY CARE	16
5.5 PREVENTION	16
5.6 INTER-SECTORAL COLLABORATION	17
6.0 PRINCIPAL AREAS AND STRATEGIES FOR ACTION	17
6.1 COORDINATION	17
6.2 LEGISLATION	17
6.3 FINANCING	18
6.4 PROVISION AND ORGANIZATION OF SERVICES	18
6.4.5 Forensic Psychiatry	19
8.0 INTERSECTORAL COLLABORATION	20
9.0 ADVOCACY	21
10.0 RESEARCH AND EVALUATION OF POLICIES AND SERVICES	21
11.0 INFORMATION SYSTEMS	21
12.0 QUALITY IMPROVEMENT	21
13.0 PROMOTION AND PREVENTION	22
ANNEX 1: DEFINITIONS	22

Introduction

The Ministry of Health has since the 1990s taken steps towards strengthening the national mental health program. Over the years, the program has been transformed from one based on institutional care, to improved services and programs based on community based care. The overall objectives of the mental health program are to provide standards of psychiatric treatment and services that ensure the highest quality of care to the Belizean populace. This is achieved through the development and improvement of programs and user-friendly psychiatric services that are accessible, efficient, and cost effective and contribute to reducing the incidence of mental illnesses.

In an effort to reform mental health, and with a comprehensive understanding of the importance of having a mental health policy which takes into account the human rights of persons with mental disorders, the Ministry of Health took up the challenge of developing the mental health policy.

Since 2005 under the leadership of Dr. Cayetano, Psychiatrist, a national committee comprised of psychiatric nurses, members of the Mental Health Association, key stakeholders, with technical support from PAHO/WHO country and regional offices, worked tirelessly on revising and updating the mental health policy. It is anticipated that this policy will help to guide the advancement of mental health programs and services which promote and protect the human rights of people with mental health disorders. This is especially important since people with mental health disorders are often times exposed to a wide range of human rights violations. Unfortunately many of these violations occur in psychiatric institutions as a result of inadequate care and treatment, and, above all, inhumane living conditions.

This policy document prepared, in line with WHO's framework, form the basis for the evolution of the mental health program, facilitate the development of an annual plan of action for the delivery of mental health services, and address the urgent need to improve mental health care in Belize. Over the next five years, the annual action plan will focus on service development and outline strategies and timeframes for achieving the targets set by this policy.

Section I

Country Profile

Belize is a diverse, English speaking country located in the northern hemisphere in Central America. Belize lies in the outer tropics or subtropical geographic belt and is 274 km long and 109 km wide. The total land area is 22,700 km² with a population density of approximately 13 inhabitants per square kilometre. The country is flat and swampy on the coast, with low mountains in the interior. A former British colony, the country is considered to be a link between the Caribbean and Central America

The 2007 mid year population estimate was 291,800 inhabitants (147,400 males and 144,400 females). The demographic profile is of a young population: 40.9% is 14 years and under with 51.9% 19 years and over. Statistical Institute of Belize (SIB), formally Central Statistical Office (CSO). Belize has an open economy based primarily on agriculture and services (tourism). One of the main attractions for foreign investment is the stability of the currency.

The Belize dollar (BZ\$) has been pegged to the United States dollar (US\$) since 1976 at an exchange rate of US\$1.00 to BZ\$2.00.

According to the 2000 census, Mestizos comprise the major group constituting approximately 48.7% of the population, with Creoles estimated at 24.9%. Other ethnic groups are the indigenous people (Mopan, Yucatec and Ketchi) (10%), Garifuna (6.1%), East Indian (3.0%), Mennonites (3.6%), and other smaller groups (3.3%), including Caucasian/White and Chinese. Roman Catholicism is the major religion. (CSO, 2001). While English is the Official Language, Spanish is widely spoken and is now considered the first language of many, especially Mestizos.

According to the National Health Information System, the GDP per capita income for 2003 was BZ\$7,208 or US\$3,604 of which 2.4% is spent on health. The National Human Development Report 2002 states that private expenditure on health was approximately 0.5% in 1998. The literacy rate is noted as 76.5 - 76.1 for males and 76.9 for females (Statistical Institute of Belize, formerly Central Statistical Office, 2000). Life expectancy is 73.5 for females and 66.7 for males (2000).

According to the WHO Comparative Risk Assessment of 2002, which categorises countries on the basis of high, medium or low levels of adult and infant mortality, Belize is in Region B, which means low child and low adult mortality. However, child and maternal mortality rates are still of some concern. Similar to the Caribbean countries, there is a transition from communicable disease to non-communicable disease. Diabetes, hypertension, cancers and road traffic injuries are the leading cause of death and disability in the country. Communicable diseases such as HIV, dengue, malaria are some of the emerging and re-emerging health issues are priority public health concern. Social determinants of health, such as poverty, gender, geographic and socio-economic results in health inequities, a situation the country is trying to address.

Epidemiology

There is a paucity of epidemiological data on mental illnesses in Belize in internationally accessible literature. McClusky (1999) conducted an ethnographic study on domestic violence against rural Belizean women of Mayan origin. An *Anthropological and Epidemiological Overview of Mental Health* in Belize was conducted in 1993, by various persons: Jason Bonander and Robert Khon from Brown University, Belito Arana from Belize, and Itzhak Levav from PAHO. The article presented a preliminary overview of the mental health needs and resources in Belize using historic, demographic, epidemiologic, and ethnographic methods to survey both the needs and societal resources available to the ethnically heterogeneous population of the country.

A recent survey on alcohol use in Belize, GENACIS (Gender, Alcohol and Culture) revealed that the proportion of drinkers of alcohol in Belize is quite high, particularly among men. Among drinkers, the average amount consumed is also high, again particularly among men. Male drinkers consume 3 to 4 times as much alcohol as females, and these high levels of use have implications for individual health which must be addressed (GENACIS 2006). The Principal investigator was Dr. Claudina Cayetano, Psychiatrist, Belize. The Statistical Institute of Belize (SIB) was the executing agency, and the PAHO/WHO Division of Drug and Alcohol in Washington, DC provided the majority of the funding. Technical support and some additional funding came from the Centre for Addiction and Mental Health in Canada (CAMH).

The leading causes of consultations related to mental health services in 2005 were psychotic disorders, secondary to the use of substances, mainly marijuana. Clinical depression was another common disorder, followed by anxiety disorders, problems of domestic violence, and stress-related disorders.

In 2005, 12,318 patients were seen at various psychiatric units throughout the country and in 2006 the number increased to 14,556. Of the total number of patients seen in 2005, 26.8 % were new patients; 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" conditions (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, though anecdotal accounts of the devastating, long-term effects of these conditions on individuals and families are plentiful, and evidence of the confounding of each is well established (Kohn, et al., 2005). The 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.

Situational Analysis

Mental Health Program

BELIZE

APRIL 2008

Section 2

Situational Analysis

MENTAL HEALTH REFORM IN BELIZE

Health services or systems are incomplete without comprehensive attention to the mental health needs of the population. In fact, mental health encapsulates that which is “most human” in health and health care. This is clearly emphasized in the World Health Organization’s definition of health as “a state of physical, mental and social well-being” (ref). However, despite this realization, mental health services in Belize have been fragmented and insufficient.

In the past, mental health services in Belize have been equated with institutional psychiatric care and care for the severely mentally disabled. While this kind of care is critically important and is covered in this policy, mental health services should also include the treatment of less severe mental health problems, the prevention of psychological problems, and promotion of mental health through public mental health services and education. The ability of people to conduct themselves effectively in social, interpersonal and work relationships is considered to be central to health as well as to national social and economic development.

While a number of diseases are now being controlled through public health and medical interventions, in developing countries there is a notable increase in mental, behavioural and social pathologies, resulting in an ever-increasing health burden. In the 2001 World Mental Health Report, mental health problems accounted for 8.1% of Disability Adjusted Life Years (DALYs) lost in developing countries. This was higher than, for example, DALYs lost due to cancer (5.8%), heart disease (4.4%), malaria (2.6%) and other communicable diseases (5.3%). This increasing burden has been precipitated by factors such as urbanisation with its associated informal settlements; “modernisation” of stable rural cultures; poverty; poor working conditions; and increases in chronic diseases profiles. There have been corresponding increases in alcoholism and drug abuse, suicide, and gender-based violence – especially against women and children.

Projections for the year 2020 indicate that mental health problems will account for an even higher proportion of DALYs lost. Univocal major depression will be the single highest cause (5.6%), with self-inflicted injuries, bipolar disorder, alcohol use, schizophrenia and obsessive compulsive disorder among the top 30 causes of DALYs lost.

The cost of **not** providing mental health services is invariably greater than the cost of the services themselves. The prioritisation of mental health and the allocation of resources to improve mental well-being are thus essential elements in the pursuit of health for all, as well contributing to national growth and stability.

As mental illnesses become even more pervasive, it is critical that as a country Belize develop and implement a comprehensive mental health policy which will set



the framework for the provision of services that are more relevant and in line with modern, progressive ideas and experiences in the provision of mental health services.

This policy document has been prepared, in line with WHO's framework, by a local committee comprised of key stakeholders and service providers. This document will form the basis for the evolution of the mental health program, facilitate the development of an annual plan of action for the delivery of mental health services, and address the urgent need to improve mental health care in Belize. Over the next five years, the annual action plan will focus on service development and outline strategies and a timeframes for achieving the targets that this policy sets.

THE NATIONAL MENTAL HEALTH PROGRAM

The Mental Health Program (MHP) aims to promote mental health, prevent mental illness, and serve the needs of persons with mental disorders, enhancing their quality of life and creating networks that guarantee the delivery of care within the community. Each of the programs at the Ministry of Health is headed by a Technical Advisor dedicated to the coordination and administration of the program. Thus, the MHP is required to have a dedicated technical advisor but due to limited resources the current clinical psychiatrist, also functions as the technical advisor. Recently the Ministry of Health created a mental health coordinator post at the Ministry to assist the technical advisor with the coordination of the program.

Administration of the MHP is consistent with the national decentralized approach. Under the Health Sector Reform program, the administration of health services is divided into four regions, and each region has a regional manager who serves as the focal point for all health operations, including mental health.

Over the last decade the MHP has been steadily expanding the quality, accessibility, and range of services that it provides. Today there is a mental health clinic in every district that is manned by Psychiatric Nurse Practitioners (PNPs). The district clinics, along with the Acute Psychiatric Unit in Belmopan, have reduced reliance on the Rockview Mental Health Hospital (Rockview) since emphasis is now on community care more so than custodial care.

The purpose of the Belize Mental Health Program is to provide high quality mental health care so that the population of Belize can achieve the best mental health status possible. This will be achieved through the development and improvement of programs and user-friendly psychiatric services that prevent and reduce the incidence of mental illness and that are accessible, efficient, and cost-effective.

MENTAL HEALTH SERVICES

The services provided are organized and implemented through the Director of Health Services (DHS).

The services comprise 4 components, each one serving different needs.

- a. Outpatient Services
- b. Outreach Services
- c. Inpatient Services
- d. Emergency Psychiatry

OUTPATIENT SERVICES

These services are provided countrywide. There are a total of 6 mental health clinics in the various districts and three in Belize City. In Belize City, the Mental Health Clinics are located within public health clinics known as polyclinics. These are Port Loyola, Cleopatra White, and Matron Roberts polyclinics. Only two of the polyclinics have permanent PNPs, due to limited human resources. There is also a weekly counselling clinic attended by the psychiatrist at the Karl Heusner Memorial Hospital (KHHM) which is the national referral hospital. The clinic at this hospital treats medical patients with psychiatric problems, who are less likely to attend mental health clinics due to the associated stigma. On the other hand, this helps to integrate mental health care into the health system.

The services provided at the various out patient clinics are:

- Clinical assessment
- Crisis intervention
- Mental health education
- Individual and therapeutic work with family
- Psychosocial rehabilitation
- Management of medications

Each of the mental health clinics has at least one PNP to provide mental health services and the psychiatrist visits on a rotational basis to assess the more complex patients and review first-time patients. Typically, patients are brought by family members or referred by general practitioners from the out-patient department of the general hospitals and the polyclinics to the mental health clinics. The mental health clinics serve as the first point of entry for almost all patients admitted to Rockview Hospital or the Acute Psychiatric Unit in Belmopan.

The psychiatrist and the PNPs have multiple duties, providing the range of services mentioned above. In addition to assessment of patients and follow-up care, the nurses visit the schools, visit patients who are non-compliant with medication and provide mental health education to health care providers.

Each mental health clinic has a consultation room allocated for assessment, except for the Port Loyola Polyclinic where there are two consultation rooms, a medication room and a holding room for patients who require sedation before being transferred to an inpatient facility. At the Port Loyola Polyclinic, in addition to having more space for psychiatric services, there are also larger staffs. This consists of 3 PNPs, one social worker and one Psychiatric Nurses Aide (PNA). This team is responsible for the mental health out reach services within Belize City limits and the surrounding villages. The team is also responsible for the training of health practitioners and Community Nurses' Aides in the identification and management of mental and behavioural disorders.

OUTREACH SERVICES

These services are provided countrywide, especially in places where there are vulnerable populations, patients that are not compliant or patients that require visits from the mental health team. In Belize City, this service consists of:

- **Street and home visits:** Visits are made to patients who are non-compliant or cannot come to the clinic due to their financial situation, patients without good family support and are in crisis, and those who need constant attention from the team.
- **Visits to institutions:** These institutions include children's homes, the prison, Mercy Clinic, Sister Cecilia Home and Golden Haven Home for the Elderly, St. Vincent De Paul Shelter and Raymond Parks Centre for the homeless.
- **School visits:** Regular school visits are organized to provide opportunities to discuss mental health issues and drug education. Through a partnership with National Drug Abuse Control Council (NDACC) in Belize City, a list of high schools with adolescents that display high risk behaviour was developed, and regular visits are scheduled to these schools.
- **Mobile clinic:** The mobile clinic visits villages in Belize District and the two Cayes. While the school, street, and, home visits are conducted weekly, mobile clinic visits are scheduled on a monthly basis. Provisions of these services are contingent on the availability of transportation for the PNP. In addition, the mental health professionals

provide lectures and conduct workshops and seminars on mental health issues for NGOs and other government organizations.

- **Prison outreach:** No prison staff member has had any formal training in the management of psychiatric emergencies or in dealing with violent patients. In addition, inmates suffering from mental disorders share quarters with the general prison population. Difficulties arising from this situation include frequent physical and verbal altercations between inmates and exploitation of the mentally ill by other prisoners. One of the prison officers and the nurse at the prison have had minimal exposure to understanding mental illness, and importance of medications. This officer is the person assigned to work with the mental health team that visits the prison and during these encounters time is sometimes allocated for informal training.

The personnel from the Port Loyola clinic provide mental health services to the inmates at the prison once monthly. Care components include diagnostic assessment, medication treatment intervention, monitoring, and follow-up.

Aftercare services are offered at the clinics, but because there is currently no requirement to inform the mental health services of inmate discharge, mentally ill patients are often discharged from the prison to the community without assessment or follow-up by psychiatric services. Similar situations and conditions are experienced in all the lockdown facilities in the country.

INPATIENT SERVICES

Inpatient services are provided in the following places:

- Rockview Hospital
- Acute Psychiatric Unit, Belmopan Hospital
- Districts Hospitals and Regional Hospitals
- Karl Heusner Memorial Hospital

Rockview Hospital

The Sea View Hospital for the mentally ill was relocated to mile 21½ on the Western Highway in 1979, and renamed Rockview Hospital. It consists of a five-building complex divided into one male and one female acute/chronic admission ward; an administration office; a multipurpose building that holds the occupational therapy unit; 2 dining rooms (one for staff and the other for patients); storeroom; kitchen; laundry facility; and an open shed. The whole complex sits in an open area without fencing.

Each ward has two sections, one assigned to acute cases and the other to chronic patients. Both female and the male acute wards have access to 4 single toilet facilities and four common showers.

The section in the male ward assigned to chronic patients is designed as a 'lock down' and consists of a large room with 13 beds. It has a wooden back door and wooden windows and is accessed by a single wooden front door. The position of the nursing station allows for observation of both the acute and the chronic ward, and this is also the case in the female wards. The total bed capacity of the institution is 55 and 36 of these beds are occupied by long-stay patients, 60% of whom are male.

Providing structure and organized therapeutic activities by having an Occupational Therapy Program for patients was introduced at the inception of Rockview; however this was discontinued due to lack of personnel to run the program. A few years ago it was restarted through assistance from the Volunteer Services Organizations (VSO). There were two therapists; both came for 2-year contracts, and when they left the country, again there was no program in Rockview since there are no locally trained Occupational Therapists (OT) working with the Mental Health Program. During the past year the OT program through the Belize-Cuba Agreement was re-introduced the Occupational Therapy Program. There

are currently two occupational therapists who provided, who organize a range of recreational and therapeutic activities for patients. The activities recommended for each patient depend on their level of function.

Most of the patients at Rockview Hospital suffer from chronic disorders and do not need to be hospitalised but do need assistance to live more independently. Unfortunately, most are homeless, with no family support, and are non-compliant with their medications when outside of the hospital. Isolation from the community adds to stigma and discrimination, and makes it more difficult to foster family re-integration. There are few patients who are brought under police warrant, pending court attendance for minor offences or under the vagrancy law because they are wandering on the streets.

Approximately 60% of the patients are over 50 years of age and all have become institutionalised. The younger patients, although in their productive years, generally have a low level of education, poor social support and little or no employment history. These factors, together with their mental health problems, make it almost impossible for patients who leave Rockview to find steady employment and become productive citizens. Administration of Rockview continues to be a daily challenge. Transporting staff to and from Belize City takes up the largest share of the hospital running costs; greater than the allocation for salaries, food, and medications.

Another challenge is inadequate access to, and provision of, general health care services to patients of the Rockview Hospital, which has been a longstanding and recurrent concern. Staff members do not have direct access to basic or specialist medical aid in the event of an emergency. Ambulance service to and from the Karl Heusner Memorial Hospital, the nearest referral hospital, is unreliable, and long delays in response time are the rule rather than the exception. A medical practitioner is assigned to visit Rockview on a weekly basis, but these visits often do not take place if the doctor is on sick leave or out of the country for any reason.

Each patient has a chart that contains personal medical information, admission history, progress notes, lab tests, drug chart and nursing notes. Despite the deteriorating physical structure of the institution and the human resource issues, many staff members have demonstrated remarkable resilience in their dedication and interest to provide care for the patients.

In summary, the Rockview Hospital functions as a stand-alone custodial care institution. Its current physical plant and functional program promote and perpetuate stigmatization of, and discrimination against, the mentally ill. The physical plant is in dire need of repair and the service has an inadequate mix of mental health professionals and material resources to meet the basic health care needs while ensuring patient dignity, safety, and privacy.

Acute Psychiatric Unit - Belmopan Hospital

This unit represents a positive step in the development and support of a modern mental health program in Belize. It is the first psychiatric unit located within a general hospital in Belize. Funds for the construction of this unit were provided by the Japanese Grassroots Grant Program and were accessed through the Mental Health Association (MHA). It was opened to the public in 2001.

The Unit is dedicated to the treatment of those persons in acute crisis and in need of in-patient treatment. It was constructed to provide privacy, respect, and safety for both patients and staff. There are 4 rooms, each with one bed, a bedside table and a fan. There is also an enclosed nursing station that allows the nurses to monitor the patients; a doctor's office; a kitchenette for patient use; an occupational therapy room; a television room; female and male bathrooms; and a garden.

Since this unit is part of the general hospital, patients have access to specialists, pharmacy and laboratory services. The average length of stay is 10 to 15 days during which time patients can receive regular visits from their families, thus decreasing their isolation and stigma.

In addition to the ongoing therapeutic activities, an innovation to the current services is the introduction of weekly hippotherapy (therapeutic horse back riding) organized by the Occupational Therapist.

District Hospitals and Regional Hospitals

Consultation liaison is a service provided in all the district hospitals including KMHM for patients with medical conditions who also present psychiatric or mental health problems, and for whom their treating physicians request psychiatric consultation or follow-up.

Emergency Psychiatry

Every district and regional hospital has an emergency room. Patients with psychiatric problems from time to time present themselves as emergencies and the medical officer is required to do an evaluation, provide treatment, and, if necessary, contact the PNP or the psychiatrist. Generally the difficulty with this situation is the limited availability of medications in the emergency room; other difficulties are the emergency health care providers' negative perceptions and attitudes towards psychiatric patients.

ESSENTIAL DRUG PROCUREMENT AND DISTRIBUTION

The official drug formulary lists all the essential psychotropic medications recommended by WHO. Drug procurement and distribution is the responsibility of the MOH. The Central Medical Supply unit of the MOH reviews the essential drug list in collaboration with the mental health technical advisor and develops a forecast for each fiscal year.

Below is the list of drug classes of psychotropic medications included in the National Drug Formulary.

1. Psychotropics
2. Antidepressants
3. Mood stabilizers
4. Benzodiazepines
5. Antiparkinsonian
6. Stimulants

Unfortunately, many of these psychotropic drugs are not consistently available, placing patients at risk who do not have the financial resources to purchase these medications privately. As a result of lobbying by the Mental Health Consumer Association some of the newer psychotropic drugs have been recently introduced into the drug formulary.

Information System

Mental health information is currently being incorporated into the Belize Health Information System (BHIS) using the ICD-10 classification of disorders. However, this system is still not yet available for use at the Rockview Hospital. The data collected include admission/discharge from the districts and regional hospitals, and patients seen at the Out-patients clinic by the mental health team at tertiary, secondary, and primary care levels.

This information is recorded on patient record sheets and is collated centrally in the Epidemiology Unit of the Ministry of Health. The information system collects and reports monthly, quarterly, and yearly data on all activities of the health care providers and is output-oriented. Other data are recorded on specific forms by the PNPs, and include reports on school and other visits, activities for patients, etc. This information is submitted by the various health regions and is subject to monitoring by the psychiatrist and the statistician. The data also report on the various specific psychiatric disorders and their prevalence, and this can be presented in graphs, and tables.

Human Resources

The human resources mix is one of the most valuable resources in the delivery of mental health services. Sufficient and appropriate mix of personnel helps to ensure the provision of efficient services and prevents team members from being overburdened. While the number of Psychiatric Nurses may appear to be sufficient, they currently perform many duties, including clinical, administrative, managerial, and emergency. The same applies to the psychiatrist. The lack of other mental health care providers, such as child and adolescent psychiatrists, psychologists, social workers, and therapists, increases the demand for the services of the PNPs and for the lone psychiatrist. There is a clear need to expand the mental health team to include a wider range of skills and competencies related to the delivery of mental health care.

Fifteen PNPs are deployed to out-patient clinics in the districts and five PNPs, along with practical nurses, provide the inpatient services at Rockview and the Acute Psychiatric Unit.

The human resources currently available to provide mental health services in Belize are illustrated in the box below.

Classification	currently available	Clinical service allocation
Psychiatrist	2	1 clinical 1 Clinical and administrative
Psychologist	0	Clinical
Mental Health Officer	0	Administrative
PNP	19	2 - RH; 3 - Bmp Unit 14 - MH Clinics
Practical Nurses	5	2 - Bmp Unit & 3 - Rockview H
PNA	4	Rockview Hospital
Attendants	12	Rockview Hospital
Social Worker	1	Port Loyola Health Centre
Occupational Therapist	2	1½ - Rockview Hospital ½ Bmp Unit

Over the past 12 years formal training has been provided for two cohorts of PNPs and one cohort of PNAs. The Ministry of Health is considering training another cohort of PNAs. These formal training programs are done only as necessary, and depend on multiple factors, such as availability of trainers and staff.

Every year there is a two-day training/meeting for PNPs organised by the Ministry of Health to discuss the mental health plan and related issues. This allows for group cohesiveness and for continuing medical education. In addition, monthly staff meetings at Rockview and the Belmopan Acute Unit currently include educational sessions for all staff members in these locations. In the districts, training is done by the PNPs with the CNAs, public health staff and other health care providers, and during the psychiatrist's visits sessions are organized for the medical staff.

Through the partnership with Homewood Health Centre, a private psychiatric hospital in Canada, the PNPs have the opportunity for 8 weeks' exposure/training at the Homewood facilities. All expenses related to these trainings are covered

by Homewood, and the scheduled is customized to suit the training needs of the staff. These arrangements are covered in a memorandum of understanding between the Ministry of Health and Homewood Health Centre; so far 12 PNPs, 1 medical practitioner and 1 psychiatrist have participated.

Financing

The 2008 financial budget includes a line from mental health, which is the first time there is a separate budget. Prior to that the budget for mental health care was embedded within the general health care budget and the percentage of the **overall health budget** spent on mental health is 2.5 %. The Technical Advisor of the program develops a budget that is included in the Director of Health Services' budget. The budget allocated to the Rock view Hospital is incorporated into the Central Region budget. In each district, spending on mental health services is incorporated into the regional health budget leaving disbursement dependent on other players in the system and psychotropics medications are purchased from the medical supplies budget.

Advocacy

Non-Governmental Organizations

- a. **Mental Health Association:** The Mental Health Association, formerly known as the Mental Health Advisory Board, is a registered NGO and is a strong advocate for patients with mental disorders. It was instrumental in the construction of the Acute Psychiatric Unit and the decriminalisation of attempted suicide. Among other initiatives, it promotes the observation of World Mental Health Day.
- b. **Consumers/Users and advocacy groups:** For the past 4 years several consumer groups have been established in various districts of the country. These consumer associations are made up of service recipients and their families, and are supported by mental health personnel. They have monthly meetings, plan activities for socialization and some are now engaging in self-help cooperatives where they advertise their skills to raise funds and support themselves. They have also organized themselves to advocate for issues that benefit the group and for improvement in services to the mentally ill. For example, they met with the Minister of Health and successfully advocated for better medications.

International Organizations

- a. **PAHO/WHO:** This intergovernmental technical cooperation organization has played a very instrumental role in the development of the mental health program in this country, from training health care providers to providing printed material and offering technical support to improve the quality of mental health services. Mental health activities are always scheduled in the biennial technical cooperation program agreed with the Ministry of Health
- b. **Homewood Volunteer Association:** Associated with the Homewood Mental Health Facility in Ontario, Canada, this NGO has provided training for PNPs, computer systems and supported the telepsychiatry project. Currently there is a memorandum of understanding between the Ministry of Health and the Homewood Health Center to address issues relevant to the project.
- c. **Mount Sinai School of Medicine:** Professionals from the Department of Psychiatry have been visiting Belize on an annual basis to conduct health clinics. In 2006 the program was expanded and a psychiatrist was assigned to work for one month at the mental health clinic, providing training and working along side the nurses. The plan is to have this program continue on a yearly basis. The Fellows are sponsored by the school, and room and board are provided by the Ministry of Health.
- d. **Jefferson Alcohol and Drug Center (JADA):** Two psychiatric nurses have received training in Drug Rehabilitation and Clinical Dependency treatment at Jada in Louisville Kentucky. There is an ongoing partnership between

the University of Belize (UB) and the University of Louisville and this had led to a collaboration with the mental health program.

World Mental Health Day

The annual observation of World Mental Health Day (WMHD) on 10 October has become part of the outreach service. It is an opportunity to get the community involved and raise awareness of mental disorders. The activities planned for the observation of WMHD vary by districts and include mental health walks, mental health fairs, public lectures, and radio talks. In Belize City the activities are planned in conjunction with the Mental Health Association and PAHO/WHO.

SECTION 3

NATIONAL MENTAL HEALTH POLICY

1.0 Introduction

The focus of the Ministry of Health is to establish a mental health program which provides community mental health services which are accessible to all. A community mental health focus will ensure the deinstitutionalization of psychiatric services and the integration of mental health services into the primary health care system. The information contained in this document represents Ministry of Health's concrete commitment for reforming mental health.

2.0 Vision

Improvement and maintenance of the mental health of the entire population of Belize, with promotion of mental health and prevention of mental disorders, especially among the more vulnerable populations, with due regard for the human rights and fundamental freedoms of all persons.

3.0 Mission

Provision of integrated, comprehensive and accessible mental health services to the entire population of Belize, focusing on promotion, prevention, early detection, treatment and rehabilitation, and emphasising community-based services and respect for the human rights of the mentally ill and their care providers.

4.0 Objectives of the Mental Health Policy

The National Mental Health Policy will:

- I. Promote and protect the human rights of people with mental disorders.
- II. Establish quality community-based mental health care as the foundation of the system, and integrate mental health care into primary, secondary and tertiary levels of the health care system.
- III. Provide acute psychiatric care within general hospitals and provide effective rehabilitation services in community settings.
- IV. Sensitize communities to mental health issues and change negative perceptions.
- V. Advocate for adequate financial support for improvement of mental health services.
- VI. Offer equitable access to quality treatment (availability of medications, qualified staff, and treatment free at the point of provision) for the population.
- VII. Provide quality and specialized services to identify and treat childhood mental disorders.
- VIII. Strengthen the collection, analysis, and use of mental health information for evidence-based decision-making at all levels and for monitoring and evaluation of relevant programs and services.
- IX. Strengthen decentralization of decision-making, resources and services for mental health care, allowing for greater participation at the primary and community levels.
- X. Implement promotion and prevention programs for at-risk populations and the general population in understanding the impact of social and environmental factors on mental health.

5.0 Values and Principles

The values and principles identified are those considered to be relevant to the delivery of mental health care. These include human rights, accessibility and equity, integration of mental health care into general primary health care, community-based care, mental health promotion, prevention of mental disorders, and inter sectoral collaboration. Mental health services should be provided based on the following values and principles:

5.1 Human Rights

The promotion of mental health and the prevention, care, treatment and support of mental disorders in the general population should be provided in line with the individual's basic human rights.

- People with mental disorders shall enjoy full human rights, including the right to appropriate health care, privacy, confidentiality shelter and employment and freedom from discrimination, exploitation, harm, abuse and unlawful restraint.
- Mental health treatment and care shall promote and protect the autonomy and liberty of people with mental disorders.

- People with mental disorders have the right to be treated in the most effective, least restrictive and least intrusive manner.
- People with mental disorders, due to their particular vulnerability to human rights violations, may require specific legal and quasi-legal frameworks and safeguards to ensure that their human rights are promoted and protected.
- Care delivered to people with mental disorders and their medical records shall be strictly confidential. However there are situation where this information may be shared, particularly in cases where not sharing the information may result in possible danger to the patients or to others.

5.2 Accessibility and Equity

People with mental disorders may require deliberate intervention due to the longstanding and pervasive stigma held by the public, professionals, and policy makers against the mentally ill.

- Services of the highest quality shall be accessible to all people regardless of their geographical location, economic status, gender, race, age, social condition, mental or physical disability, sexual orientation, religion, HIV/AIDS status, and health status.
- People with mental disorders shall not be subjected to discrimination on the basis of their mental illnesses.
- Mental health services shall have parity with general health services.
- Timely and appropriate mental health services shall be available in all districts of Belize and across all levels of care (primary, secondary and tertiary levels).

5.3 Integration of Mental Health Services

Mental health services should be integrated into the general primary health care system. This will guarantee one entry point for a comprehensive and continuous serve for patients and their family.

Persons with acute mental disorders should be admitted to and treated in general hospitals. The service provided should be of the highest standards administered by trained personnel and include provision of appropriate medications.

5.4 Decentralization and Community Care

Authority, resources, and services are being decentralized with more emphasis on primary and community care. This ensures a higher level of participation in the decision-making process and greater accessibility.

- Inpatient care shall be accessed only after all alternatives for community care have been exhausted.
- People with mental disorders shall be cared for using the least restrictive form of care and as close to their own homes and communities as possible. Active family involvement should be encouraged and facilitated.
- Community-based rehabilitation activities shall be provided to reduce disability and improve the quality of life of consumers of mental health services. These shall include non-discriminatory employment opportunities for people with mental disorders.
- Rehabilitation and recovery services shall take place within the communities.

5.5 Prevention

There are various social factors that can contribute to mental conditions. Therefore, some mental health problems and illnesses can be prevented through early identification and treatment.

- Screening services shall be available and provided for vulnerable populations.
- Education and sensitisation programs shall be designed and integrated into existing health, social, and educational services in order to help people to make better personal choices and reduce risk-taking.
- Services shall promote therapeutic patient-centred care and should move away from reliance on custodial care

5.6 Inter-Sectoral Collaboration

Building and maintaining strong partnerships is essential for the strengthening of mental health services. As a result, it is anticipated that:

- Mental health services shall work jointly with other sectors and organizations such as the social services network, criminal justice system, housing, education, labour department, NGOs, National Drug Abuse Control Council, National Council on Ageing, international agencies, and other relevant agencies.
- Services shall be designed to connect with and utilize complementary care providers, and to integrate all available, evidence-supported facets of health care and prevention.
- Coordination and collaboration with private, public, local, national, regional and international organizations and agencies shall be strengthened in order to ensure the optimal mobilization and utilization of resources.

6.0 Principal Areas and Strategies for Action

The following areas for action are set as priorities and strategies to address the various objectives identified.

6.1 Coordination

In order to assure the development and continuity of the various Mental Health programs at the local and regional levels, it is necessary to:

- Strengthen the coordinating unit for mental health in MOH,
- Create a post of technical advisor in mental health in the MOH, and
- Have a cost centre allocated for all finances related to mental health activities

6.2 Legislation

Mental health legislation shall consolidate and guarantee that the dignity of people with mental disorders is preserved and that their fundamental human rights be protected. Updating legislation will be a useful and effective instrument to improve the situation of people with mental disorders and is essential to ensure the protection of the mentally ill against human rights violations, as well as to ensure the promotion of autonomy, liberty and access to health care

The legislation shall be updated using recommendations developed by a cross section of Belizean stakeholders and experts in Mental Health based on human rights and fundamental freedom of people with mental disorders.

6.3 Financing

Adequate and sustained financing is an essential mechanism to improve mental health services to the community. The decentralization of a budget for mental health to all regions will enhance quality, accessibility and the development of a trained workforce.

- To secure a budget for mental health that will provide better quality of services at both regional and central levels.

6.4 Provision and organization of services

Proper provision and organization of the services will allow the achievement of objectives and also the delivery of effective and equitable mental health interventions to vulnerable populations.

- To develop and promote comprehensive mental health services in each of the districts to the general population. This will extend acute care within all general hospitals, emergency services, outpatient services and psychosocial rehabilitation. This will allow patients to be treated within their community, closer to where they live.
- To plan and run appropriate facilities to provide mental health care in the community based on patients' needs, and to close down Rockview Hospital.
- To plan and implement a care and referral system that facilitates timely care of the physical health needs of those with mental disorders.

6.4.1 Inpatient Services

i. Child and adolescent services

The mental health services will provide support and services at every level of the system that are more responsive to the needs of children and adolescents with serious emotional disturbances at every level of the system. If in-patient intervention becomes necessary, children and adolescents will be placed in age-appropriate health facilities.

Services for adults

If inpatient treatment becomes necessary the client will have timely access to an appropriate hospital bed in the least restrictive environment, depending on history and on level of assessed risk.

6.4.2 Outpatient Services

i. Child and adolescent services

Families will be centrally involved in the coordination of care for their children and adolescents. A system of care will be established within and across sectors (Education, Health, Social Services) that includes mechanisms to promote communications and referrals among professionals such that children and families receive appropriate services regardless of how and where they seek help and irrespective of the nature of their problems.

ii. Services for adults

Adults are to have access to mental health services that suit their needs. Individualized health care plans are to be developed with the participation of the patients. This care plan should include action to be taken in a crisis, and should advise health care professionals how to respond if the client and carers need additional help. The care plan should be updated regularly. Mental Health education for families will be part of the services provided and patient support groups are facilitated to increase compliance and provide mutual support.

iii. Day services and rehabilitation

All individuals diagnosed with a severe mental illness will receive care which promotes recovery and community reintegration, anticipates and prevents crises, and reduces risk to self and others.

Development of Day Hospitals, to provide rehabilitation services for the reintegration of the patient into the community and creation of facilities that provide life skills training programs for people with mental disorders.

The focus of mental health is towards the delivery of services in community. All district and regional hospitals will establish community-based mental health centres. The centres will provide prevention and rehabilitation activities together with the public health team. This will include day hospitals, sheltered housing, resource centre, etc.

6.4.3 Psychiatric Emergencies

In every regional and district hospital, psychiatric emergencies will be dealt with after working hours and during weekends and public and bank holidays. Emergency medications will be available at every emergency room and emergency personnel will be trained in the management of psychiatric emergencies

6.4.4 Mental health response in disaster situation

The Mental Health Program recognises that the number of persons exposed to extreme stressors is large and that exposure to disaster situations is a risk factor for mental health and social problems. The program's work on mental health in emergencies will focus on vulnerable populations that have been exposed to disasters and on capacity development for other health and non-health personnel that could play a key role in an emergency. The aim is to develop a plan for disaster preparedness and response during disaster.

6.4.5 Forensic Psychiatry

The mental health services will improve access to appropriate services for people with mental health problems and mental illness who are in contact with or at risk of criminal justice involvement.

6.4.6 Substance use Disorders

Substance abuse is a contributing factor for many mental disorders identified. Services will be provided to patients with substance abuse disorders.

- **Community-based services** – Alcohol and drug counseling and other therapeutic services will be offered at the community level on a non-residential basis, including early identification and brief interventions.
- **Detoxification services** – Services to assist persons to safely negotiate a process of substance withdrawal will be offered and will include detoxification provided in outpatient services.
- **Dual diagnosis** – people with a dual diagnosis of mental illness and drug/alcohol problems shall be assessed and have their needs met wherever and whenever they present themselves for care whether it is in the community, at a mental health in-patient facility or a substance abuse treatment facility.

6.4.7 Care for the elderly

Older adults with mental health needs/concerns will have access to adequate and quality mental health services that provide for their needs in a way that takes account of their particular life stage.

7.0 Human Resources and Training

Human resources are the most important assets of the mental health system. The improvement of quality depends on the knowledge, skills, and motivation of the people responsible for delivering these services.

- Increase the training opportunities for mental health professionals at all levels including traditional healers and community health workers.
- Recruit and train sufficient numbers of mental health care providers specialized at different levels of care, to be able to provide appropriate decentralized quality mental health care.
- Design of comprehensive Plan for the Development of Human Resources in Mental Health

8.0 Intersectoral Collaboration

People with mental health problems have different needs that go beyond the health sector. Those needs can be related to sectors such as education, social services, housing, labour, justice, etc. Each one of these sectors have a role to play in the management of mental health issues in the community.

- Increase the level of awareness of mental health issues for all those working in fields of education, social services, police, housing, labour, the judiciary, and other relevant disciplines.
- Develop specific guidelines that inform roles and duties and also assure collaboration between the different institutions that provide assistance in the management of patients with mental disorders.
 - Guidelines for police involvement in mental health services
 - Manuals and protocols for psychiatric emergencies

9.0 Advocacy

Advocacy is very important in mental health. It is crucial to change the negative perceptions of people about mental disorders and the mentally ill in order to achieve the objectives of this policy. Mental health service users, their families, mental health service providers and related organizations need to advocate for the rights of people with mental disorders, for improved mental health services and for broader public awareness about mental health. The Mental Health Association and the Mental Health Consumer Association are the two NGOs that have been working closely with the Mental Health Program.

- To support the development of strong mental health consumer groups to advocate for better mental health services and to be active participants in the decision making process.
- To educate and encourage consumer participation in advocacy as well as families and community members in order to better the mental health services and decrease stigma and discrimination for the mentally ill.

10.0 Research and Evaluation of Policies and Services

Research and evaluation are essential aspects of mental health, to provide information on the mental health needs of the population and to facilitate reviews of service provision. There is a need in Belize to develop a research culture within the mental health system in order to better evaluate and understand the extent of mental health problems, including substance abuse disorders.

- Essential information to improve mental health services and to guide policy and decision makers will be gathered through national research.

11.0 Information Systems

A mental health information system will be established in Belize as part of the Belize Health Information System (BHIS). This will require the integration of some mental health data and health statistics into the BHIS, and the standardization of data collection, processing, retrieval and analysis for mental health.

- To develop a mental health information system that meets concerns about confidentiality and efficient procedures to access information.
- To train mental health care providers in the health information system.
- To set up a routine data recording system for mental health, integrated in the general health information system*, at all levels of care, including the set up of indicators for evaluation of services and improvement in health outcomes

12.0 Quality Improvement

National quality standards for mental health care will be developed in consultation with all relevant stakeholders. Facilities will be regularly reviewed, assessed and accredited, and competencies of all health care staff assessed towards these standards. Clinical protocols will be developed.

- To develop national mental health standards for services and treatment, as well as to develop, disseminate and implement clinical guidelines and protocols.
- To monitor processes and outcomes, including information, education and other services within communities.

13.0 Promotion and Prevention

Mental health promotion aims to protect, support and sustain emotional and social well-being and create individual, social, and environmental conditions that enable optimal psychological and physiological development.

Mental disorder prevention focuses on reducing risk factors and enhancing protective factors associated with mental well-being, with the aim of reducing risk, incidence, prevalence and recurrence of mental disorders.

Comprehensive mental health promotion and prevention strategies will be developed related to primary, secondary and tertiary prevention.

- To implement promotion and prevention activities, including mental health school programs, prenatal counselling and life skills for stress management.
- To implement prevention programs for early recognition and treatment of people with major illnesses such as depression, suicide and schizophrenia.
- To implement brief interventions for persons with substance use disorders

ANNEX 1: DEFINITIONS

Mental health: The ability to function at one's optimum level in social, occupational and relational settings while taking responsibility for one's actions and their consequences. It entails staying in touch with reality, using good judgment in making decisions, and having the insight into one's mental process.

Mental disorder: An abnormal state of mind whereby the individual is not able to function, or functions partially, within the accepted values, principles, and norms of a given society at a given time in his/her life.

Mental health policy: An organized set of values, principles, objectives and areas for action to improve the mental health of a population.

Value: A cultural belief concerning a desirable mode of behaviour or end-state, which guides attitudes, judgements, and comparisons.

Principle: A fundamental truth or doctrine on which rules of conduct are based.

Areas for action: Complementary aspects of a policy that are separated for the purpose of planning.

Primary prevention: Alteration of conditions that precipitate mental disorders and behavioural problems.

Secondary prevention: Early detection and limiting the negative consequences once a psychological problem has manifested itself.

Tertiary prevention: Control of the long-term effects of chronic mental health problems.

(Definitions taken from Mental Health Policy Plans and Programmes, WHO, 2003)

ANNEX 2: Acronyms and Abbreviations

BHIS	Belize Health Information System
CAMHC	Centre for Addiction and Mental Health in Canada
CSO	Central Statistical Office
CNA	Community Nurses' Aide
DALY	Disability Adjusted Life Years
DHS	Director of Health Services
JADA	Jefferson Alcohol and Drug Center
MOH	Ministry of Health
MHA	Mental Health Association
NDAC	
NGO	Non-Governmental Organization
OT	Occupational Therapist
PNP	Psychiatric Nurse Practitioner
PNA	Psychiatric Nurses' Aide
PAHO	Pan American Health Organization
KHMH	Karl Heusner Memorial Hospital
SIB	Statistical Institute of Belize
VSO	Voluntary Service Overseas
WHO	World Health Organization
WMHD	World Mental Health Day

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**CLAUDINA CAYETANO
PSYCHIATRIST
MENTAL HEALTH PROGRAM
MINISTRY OF HEALTH
GOVERNMENT OF BELIZE**