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Psychiatric Mental Health Nursing

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1. INTRODUCTION

The decade of the 1990's has been characterized by an emphasis on the reform of the health care systems, in most countries, as part of significant changes in the role and functioning of government in different sectors including health. This reform is affecting how health care services are planned, financed, delivered and evaluated. While there is variation in some aspects of the reform in different countries, a number of common elements are seen. There is growing concern about costs and cost benefit while assuring coverage to a basic package of health care; at the same time the trend is toward reducing the size of government and a continuing process of decentralization. With a renewed emphasis on social participation, and because nursing personnel comprise 50-80% of the work force in health, an active involvement of nursing in this reform process is fundamental.

As we near the year 2000, and consider the progress made in achieving the goal of Health For All, WHO/PAHO and our Member Governments are renewing the commitment to the goal and to the principles which will guide our future work. Nursing personnel and the health workers they supervise are the continuing and closer contact of the health sector with individuals, families and the community in all health care settings. The nursing and health care they provide will, therefore, need to be a key component of programs, projects and interventions developed to bridge the gaps in health status and health care access which the reality for vulnerable population in our countries.

Psychiatric mental health (PMH) nurses, from their biopsychosocial perspective, bring to the care of patients and families quality interventions, safe and improved outcomes with opportunities for mental health promotion, teaching, therapeutic maintenance, integration with the spectrum of interventions, and interdisciplinary collaboration with other health care providers. These established nursing functions are within the scope of psychiatric mental health nursing practice, and are ones that are positively received by both patients and families.

Psychiatric-mental health and addictions nursing involves the diagnosis and treatment of human responses to actual or potential mental health or addictions problems. It is a specialized area of nursing practice employing theories of human behavior as its science and purposeful use of self as its art. PMH & addictions nurses deliver care which includes the continuous and comprehensive services necessary for promotion of optimal mental health, prevention of mental illness and addictions, health maintenance

management, and/or referral of mental and physical health problems, diagnosis and treatment of mental disorders and their sequelae and rehabilitation. Because of its scope, PMH and addictions nursing is holistic, emphasizing the needs and strengths of the whole person. These nurses apply theory to human phenomena through the processes of assessment, planning, intervention or treatment and evaluation. The theories providing the basis for PMH and addictions are derived from various sources including biological, cultural, environmental, psychological, and sociological in addition to nursing.

Care and caring have been and continue to be the cornerstone of nursing delivery of services. The scientific advances of the past decade are changing the understanding of the human brain, mental illness, and biochemical treatments of mental disorders. Psychiatric nurses continuously must integrate the neurosciences, particularly psychopharmacology, into nursing practice in order to ensure safe and effective care of people with mental illness and the advancement of the specialty. Psychiatric nurses are among the primary health care professionals working on a daily basis with the long-term management of psychiatric patients on the continuum of prevention, diagnosis, treatment, maintenance, and rehabilitation. Given the present array of treatment options, this nursing management includes considerable attention to concurrent medical problems and complex interactions between behavioral, emotional, physiological, and psychopharmacologic events. Psychiatric mental health nurses are unique in that their training and experience enable them to assess the biological as well as psychosocial needs of patients. Nursing interventions offer patients and families high quality and cost effective care. Psychiatric mental health nurses worldwide will continue to refine and demonstrate their evolving role in the mental health field.

From 8-11 February 1998 a group of mental health nursing leaders from the Region of the Americas met in San Juan, Puerto Rico to hold a group consultation on current issues and strategies to improve mental health services and programs through nursing.

The event took place at the Faculty Club of the Medical Sciences Campus in the University of Puerto Rico and was co-sponsored by the Pan American Health Organization, the University of Puerto Rico School of Nursing and the Secretary of Health of Puerto Rico.

1.1 OBJECTIVES

- Provide an update on psychiatric and mental health nursing for Puerto Rican nurses and prepare a videotape of selected presentations for future use.

- Review past and current technical cooperation in mental health nursing and make recommendations for future work by PAHO, in collaboration with other partners, to improve mental health services through nursing.

- Compile presentations into a scientific-technical document on mental health nursing for dissemination in the Region.

1.2 PARTICIPANTS

This sentinel event included participants from nine Member Countries, representatives of WHO Collaborating Centers, nursing associations, and a number of other interested individuals from across the Region.

2. HIGHLIGHTS

Common themes occurring in the Region related to nursing in psychiatric/mental health services were:

2.1 STRENGTHS

- Positive experiences in Region;
  - Psychiatric Nurse Practitioner, Belize and Guyana;
  - World Bank Project on Mental Health Reform in Jamaica; and
  - Rockefeller Project on Education of Psychiatric Nurses: Italy Meeting.
- Evidence of functioning of the network of psychiatric/mental health nurses;
- Some well prepared competent nurse leaders, and
- Some good specialization programs.

2.2 WEAKNESSES

- An assignment in psychiatric nursing is often seen as a punishment. As in other clinical areas, nursing services are affected by severe shortages of nursing personnel and poor distribution of limited staff.
- Inappropriate learning materials (language/culture/development level).
- Basic nursing programs (professional and auxiliary) in some countries do not prepare nurses for mental health and psychiatric services at primary care level.
- Not enough access to specialty preparation for nurses in key positions (service and education).
- Psychiatric/mental health nursing content “less” in integrated curriculum.

2.3 OPPORTUNITIES

- PAHO Mental Health Program views nursing as a key provider.
- New attention to mental health and psychiatric illness.
- New emphasis on interdisciplinary approaches.
- Regional depression and epilepsy projects.
- Restructuring of psychiatric care - New opportunities for community psychiatric nursing.
- Professional status of health workers and valuing of contribution of various disciplines.

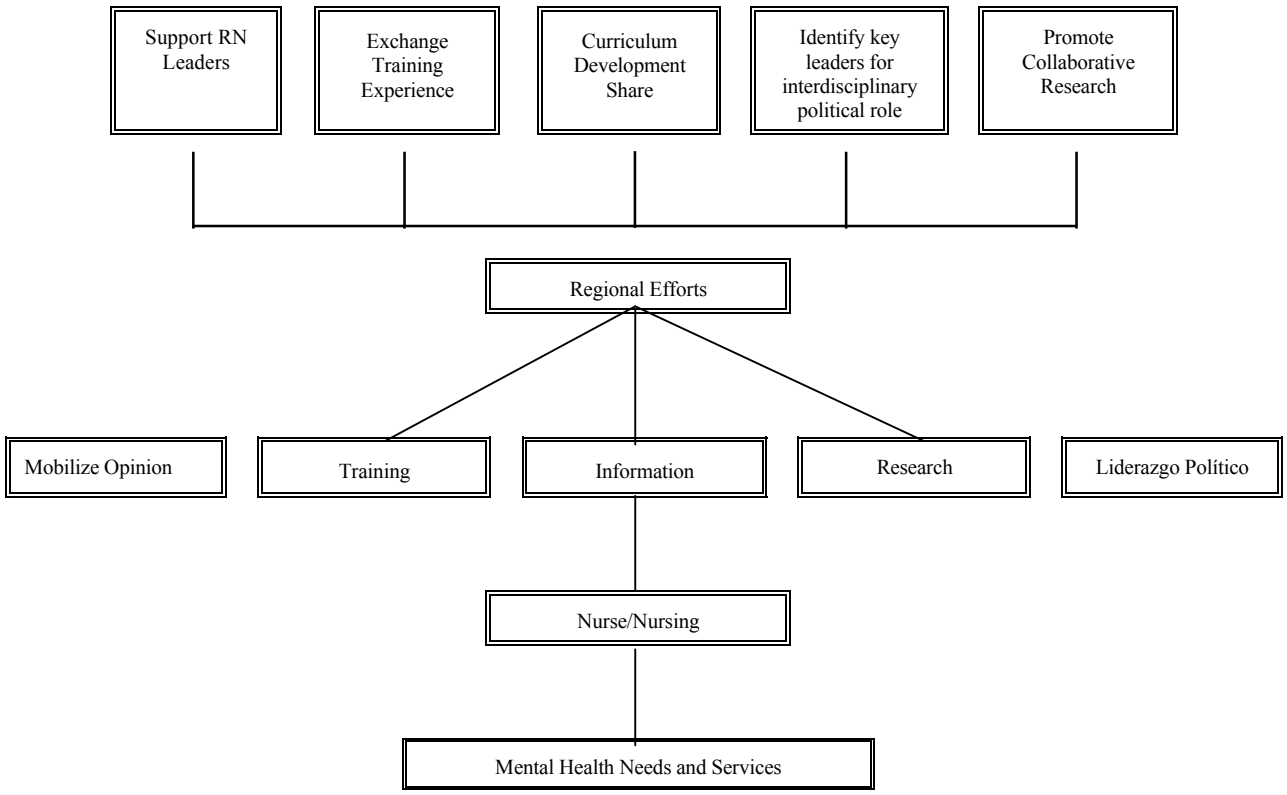
2.4 THREATS

- Devaluing of the profession due, in part, to gender overlays.
- Nurses not included in interdisciplinary efforts.
- Nurses are not on list of consultants for interdisciplinary work.
- Nursing structures are being lost in reorganizations of health sector.
- Specialty education is increasingly interdisciplinary and nurses have limited access to these programs.

3. STRATEGIES AND PLANNED ACTIVITIES

Five groups representing three Sub Regions, Puerto Rico and the Regional level considered these issues and trends and proposed strategies for future work by PAHO with the Member Countries and with the partners represented in the meeting. Individuals committed to be responsible for specific tasks to be accomplished and to working collaboratively. While there were a number of common strategies some differences can be noted in the summaries which follow.

3.1 REGIONAL GROUP STRATEGIES



3.2 REGIONAL GROUP - PLANNED ACTIVITIES

- Support public mental health nursing leadership by articles in APNA Journal, which interview nurses from Latin/Central America. (APNA).

- Support for Clearinghouse of existing public mental health nursing materials (UPR).

- Update on standards of clinical Nursing Practice for Public Mental Health Nurses Workshop. Subregional selected sites (ANA).

- Collect extra curriculum from sites (nursing schools) for review by expert panel of interdisciplinary members to select key plus necessary components and areas for emphasis, identification of strengths and gaps. Final would be shared through PAHO (PAHO).

- Develop a guideline notebook on "how to develop Public Mental Health Political Nurse Leaders" (ANA/ANF).

3.3 CARIBBEAN GROUP - STRATEGIES

3.3.1 Strategy #1

To increase Psychiatric/Mental Health Nurses educational level in the Caribbean (BSN-MSN):

- University of Puerto Rico }

- University of West Indies } Linkages

- Distance universities (WHO Centres)

- Annual meeting of academics and practitioners

- Develop/implement minimum Psychiatric/Mental Health Nursing education Standards within Caribbean

3.3.2 Strategy #2

To increase the exchange program (academic and clinical) in the Caribbean, and to initiate exchange programs to other parts of the world

- Students

- Faculty

- Practicing Nurses

3.3.3 Strategy #3

To reduce the stigma associated with mental illness.

- Nurses get involved at community grassroots level
- Nurses facilitate support groups
- Nurses to use media for education/awareness
- Engage the religious community and law enforcement sector
- Use celebrities in Region to support causes

3.3.4 Strategy #4

To increase cultural sensitivity in psychiatric mental health nursing

- courses in cultural aspects
  - historical beliefs
  - political values
  - ethnic
  - religion
  - socioeconomic
  - formal (universities)
  - in service education
  - administration
- research initiatives
  - (participatory-grounded theory)

Table 1: Caribbean Group – Planned Activities

Who	When
Stigma - Production videotape Asking PAHO to make with input from Augustina Eligio Tina and Purnima Sen The Belize Program Cheryl Killion to assist to research into a script Tricia Stiles - Input Canadian picture	1 year (Conference calls)
Exchange Cheryl Killion can take a faculty at University of Michigan Tricia Stiles can take a nurse for observation of various roles of psychiatric Nurses in Canada	Within a year Next six months

3.4 CENTRAL AMERICA AND MEXICO GROUP STRATEGIES

- To prepare, to update educational materials in Spanish for the formal education of nursing at all levels.
- To establish programs of continuing education with consultation for teaching institutions in mental health and psychiatry in order to improve care.
- To establish agreements between the ministries of health and nursing schools.
- Financial support in order to train nursing personnel in mental health psychiatry.
- To provide consultation or technical material for the preparation of mental health indicators.

3.5CENTRAL AMERICA AND MEXICO –PLANNED ACTIVITIES

- Inventory of materials educational in Spanish available in Central America (Sara Torres, Marlene Farrell).
- Examine education materials for their utilization in our Region (Sara Torres, Marlene Farrell).

- Field test materials in a pilot country (Sara Torres, Marlene Farrell, María Teresa Orozco).

- Explore the sources of financing and agreements with institutions (Marlene Farrell, Sara Torres).

- Review the program of the different levels of care of the JMP, to send these programs to the countries of the Region for its adaptation, to the personnel of nursing responsible for the area of Mental Health and Psychiatry (María Teresa Orozco).

- Standardize the curriculas of nursing of the Region to include a minimum of theory/practice in Mental Health and Psychiatry of the Region.
  - To carry out an inventory of the curriculas of nursing of the Region (PAHO, ANA).
  - To request financial support for a meeting with stakeholders of the Region for Training for psychiatric and mental health nursing (Marlene Farrell, Sara Torres).
- To improve the administration of nursing services in mental health and psychiatry
  - To prepare a manual in administration of the nursing services in the area of Mental Health and Psychiatry (Alas).

3.6 SOUTHERN CONE GROUP - STRATEGIES

3.6.1 Mental Health Nursing

- Constructing consortium of mental health nursing resources of the Southern Cone and U.S.

- Educational strategies for new and innovative mental health nursing services:
  - Basic education for attendants and auxiliary nursing personnel in psychiatric services;
  - Specialization and credentials in distance education for RNs.;
  - Continuing education toward building new models based on populations and mental health.
- Testing of multisite nursing models, interventions, and outcomes (evaluation and research); publishing.

- Dissemination at professional meetings
  - American Academy of Nursing, and
  - ICN.

  - Internet network of American Mental Health Nursing
    - Web Page;
    - And-mail;
    - List of discussion; and
    - Others.

- Innovative mental health nursing practices and services towards transition from traditional psychiatric to mental health concepts and practice in an integrated model of service delivery.

- Interdisciplinary cooperation and collaboration in the implementation of the strategies. Relation with other groups and professional associations.

3.7 SOUTHERN CONE GROUP - ACTIVITIES

3.7.1 Strategy #1

Consortium of mental health nursing resources at the Southern Cone

- mobilize the universities of Córdoba (AR), Chile, Republic (UR), Asunción (PAR), Iyui (BR) and disseminate the project. Silvina Malvárez.

- organize first meeting in Cuba in August 1998 (Silvina Malvárez with PAHO) for planning.

- mobilize support from the University of Washington for initial exchange and continue implementation (Marilou Siantz).

- identify available resources in mental health, research and education to support activities.

- develop proposal for funding (Marga Coler).

- mobilize Paraiba University for meeting of consortium (Marga Coler).

3.7.2 Strategy 4: Dissemination

- Participate in the AAN meeting in Acapulco presenting our SCP of MHN:
  - Marilou Siantz attends--call Afaf Meleis

  - Itzhak Levav
  - *Sandra Land*
  - Silvina Malvárez attends with Kellog support
  - Marga Coler - Rita Carty

- Send to WFMH and ICN a brief report of this meeting and project (Marilou Siantz and Marga Coler).

- Initiate to develop of IN network (Silvina Malvárez).

Strategies: 2. 3, 5 and 6 will be planned specifically in August.

3.8 PUERTO RICO

3.8.1 Strengths of the University of Puerto Rico, School of Nursing

- Academic preparation of faculty;
- Language;
- Administrative support;
- Health reform;
- Interdisciplinary efforts underway;
- Physical plant;
- Persons involved in international matters;
- Program for continuing education.

3.8.2 Weaknesses

- Curriculum review needed;
- Few research projects;
- Current statistical data;
- Poor approach to promotion in mental health by the School of Nursing.

3.8.3 Strategies

- To strengthen research;
- Interdisciplinary approach;
- Creation of international center;
  - Nursing in mental health and psychiatry
- Development and implementation of programs for education based upon social need;
- Massive promotion;
  - Nursing Organizations.

3.9 ACTIVITIES

3.9.1 Promotion

- Professional Nursing Association;
  - Courses in continuing education.
- To create working groups;
  - Educational institutions.
  - ASSMCA.
  - Professionals in Mental Health and Psychiatric Nursing.
- Resource of training of ASSMCA to strengthen the interdisciplinary approach;
- To promote interdisciplinary courses at university level in Mental Health and Psychiatry.

3.10CONTACTS

Contacts for initial follow-up are:

Region:	Sarah Raphel
Caribbean:	Hemsley Stewart
Central America:	Sara Torres
South Cone:	Silvina Malvárez
Puerto Rico:	Cecilia del Valle
Overall Coordination:	Itzhak Levav
	Sandra Land

4. MENTAL HEALTH PROGRAM

Table 2: Mental Health

The need for mental health care in the Region, both now and in the near future, requires creative and scientifically-based intervention programs, as well as political will and social consensus for their promotion. The distribution of these needs is not random; the more adverse the living conditions, the greater the needs. Hence, investment in programs and services for the preservation and recovery of mental health at every age will increase the populations that attain sustainable human development. Response to these needs is possible thanks to the significant advances made in knowledge about the brain, in psychology and sociology, and in the development of prevention models and technologies at all levels of care.

This document examines the bases for action, the objective of the program, and its principal components, as well as the functional approaches to technical cooperation. The document discusses two initiatives in particular: (1) the initiative to restructure psychiatric care, which promotes the improvement of psychiatric services and their transfer to the community, thereby facilitating their integration into primary health care and the development of programs to reduce the prevalence of depression, epilepsies, and psychoses; and (2) the initiative to promote mental health and the psychosocial development of children.

At its 120th Session, the Executive Committee adopted a resolution for consideration by the XL Directing Council (CE120.R20, Annex) aimed at: (1) supporting promotion and prevention activities in mental health through the formulation of national mental health plans articulated with health and human development plans; (2) ensuring the inclusion of mental health services in the care provided by all health services; (3) supporting the restructuring of psychiatric care; (4) implementing community programs to reduce the prevalence of untreated neuropsychiatric disorders of the type described above and their psychosocial impact; (5) fostering activities to promote mental health and the psychosocial development of

children; (6) strengthening the managerial capacity of the divisions/departments of mental health (or in their absence, establishing them); and (7) fostering the development of technical personnel to serve as leaders in mental health.

4.1 INTRODUCTION: THE BASES FOR ACTION

The technical cooperation provided by the Program on Mental Health of the Pan American Health Organization is based on the analysis of current factors operating in the countries of the Region: conceptual (e.g., the definition of health), operational (e.g., epidemiological), or mixed (e.g., health and human development policies, state of the services). It also recognizes that it is the Program's responsibility to interpret in its field the policies and program priorities established by the Governing Bodies, as expressed in mandates at the global (*1*) and regional levels (*2,3*).

4.1.1 Definition of Mental Health and Mental Life

Mental health is an integral component of the definition of health adopted by the Member States. However, societies and governments are still a long way from granting its due importance. Indeed, it has been repeatedly pointed out that mental life does not occupy the place it deserves on society's scale of values, despite the fact that it is what makes human beings human. This is expressed in numerous ways, e.g., in the absence of national mental health policies and in the limited resources assigned to national programs.

4.1.2 Integral Nature of Health

Health and disease are of an integral nature. Significant discoveries in the biological component of medicine have blurred our vision on the role of behavior in health, whether in its promotion (e.g., the development of healthy lifestyles), preservation (e.g., the reduction of toxic agents in the physical environment), or recovery (e.g., adherence to a course of treatment). Noteworthy, in 1990 behavior was a critical factor in at least 4 of the 10 leading causes of death in the developing countries and in 6 in the developed countries (*4*). Behavior, however, is a factor that is frequently glossed over in health

policies and health activities at both the individual and collective level.

4.1.3 Development and Mental Health

Society has begun to recognize the intimate link between human development and health in general. This interdependence is equally true where mental health is concerned, especially for populations living in adverse situations. Indeed, the more these populations succeed in preserving or recovering their mental health, the better they can negotiate successful solutions to their problems or, at the very least, avoid behaviors that generate new obstacles (e.g., alcoholism or violence). Economic and social development in the Americas has wrought many changes. One of these is related to the changes in habitat faced by large population groups as a result of migration from rural to urban settings, causing people to suffer discontinuities and losses (e.g., loss of social supports, loss of values) and has affected the mechanisms for personal and collective adaptation. All this has translated into a variety of mental disorders and psychosocial problems such as violence, substance abuse, and demoralization.

4.1.4 Mental Health Care Needs

The epidemiology of psychiatric disorders and psychosocial problems in the Region indicates that the magnitude of the situation is overwhelming. In the United States of America, the ECA (Epidemiologic Catchment Area) study, which included several urban and one rural population (N=19,640), reported a lifetime prevalence of 32% and an active case rate for the previous year of 20% (1991) (*5*). In Canada, a study conducted in Edmonton using a similar method yielded a lifetime prevalence rate of 33.8% (1988) (*6*). A multicenter research study in Brazil (1993) reported prevalence rates ranging from 19% to 34% for a series of psychiatric disorders requiring treatment (*7*). In Chile, the lifetime prevalence rate calculated in a study was 33.7% (1993) (*8*). It should be noted that these rates covered selected disorders only. Children are no less immune to psychiatric disorders. A study done in Puerto Rico reported a prevalence rate of 16% for moderate and severe psychiatric disorders (*9*). Projection of this rate to the population of Latin America and the Caribbean would yield 17 million children between the ages of 4 and 16 currently suffering from disorders that warrant intervention (*10*). With regard to epilepsies, the prevalence rates reported for Latin America range from 1.3% to 5.7% in the general population (*13*). The prevalence rates (per year) for affective disorders is around 4.1%, and for schizophrenic psychoses (in both Latin America and the Caribbean),

1.1%. The prevalence rates for alcoholism and substance abuse are equally high and are being addressed by the corresponding PAHO program.

As for the impact of mental illnesses on the populations of Latin America and the Caribbean, the World Bank has estimated that 8.0% of the disability-adjusted life years lost are attributable to them, a greater proportion than for cancer (5.2%), or cardiovascular diseases (2.6%) (*11*). It has also been estimated that five of the leading 10 causes of disability worldwide (1990) are psychiatric in nature, with depression ranking first (*4*). The economic burden is also heavy. To illustrate, in the United States the yearly cost of depression has been estimated at $43 billion (1990) (*12*).

It should be recalled that the distribution of mental illness in the population is not random; there is an inverse relationship between socioeconomic level and the aggregate rate of mental disorders. The needs are also greater in the higher-risk groups, such as indigenous populations (*14*) and the victims of war, persecution, and displacement.

4.1.5 Future Needs

Mental health care needs in the countries will increase even further toward the beginning of the century due to the projected demographic changes, which will result in a greater number of people entering the ages at risk for psychiatric disorders. No less than 88 million people will suffer from some sort of mental or emotional disorder in Latin America and the Caribbean in the year 2000 (*15*)*;* the proportional increase will be greater than the increase in the general population. Estimates indicate that by the year 2010 Latin America and the Caribbean will have more than two million people with schizophrenic disorders and more than 17 million with affective disorders.

Health for all will elude societies and governments unless creative mental health policies and programs backed by firm political resolve are implemented.

4.1.6 Situation of the Services

Although there are variations throughout the Region, the organization of psychiatric care and the situation of the services reveal troubling deficiencies. Care is usually based in mental hospitals, institutions with low coverage and limited access that often carry a stigma. Not infrequently, such institutions are

geographically, physically, or socially isolated, and the human rights of their patients are violated, either by omission or commission. Furthermore, there is little or no integration of these services with the general health system. This type of structure does not take it into account that the network of mental health care is broader and includes the individual (self-care), the family, social support groups, community leaders, health workers, and the different levels of health care (*16*). It also ignores the fact that there is a range of specialized services that differ according to the changing psychopathological and psychosocial needs of the patient. A service structure so conceived will not permit the health sector reform adopted by the countries (including decentralization, social participation, intra- and intersectoral linkages, health promotion) to be fully implemented.

The situation of the services is doubly worrisome in light of the fact that the undergraduate and graduate training provided in mental hospitals does not offer health professionals—whether specialized or not—the opportunity to acquire the knowledge, skills, and attitudes needed to exercise an integrated practice in the community and ensure their rapid incorporation into the programs for the control of affective disorders, epilepsies, and psychoses.

4.1.7 PAHO Policies

The Program on Mental Health is responsible for interpreting and carrying out the resolutions of the XXIV Pan American Sanitary Conference regarding the Organization's Strategic and Programmatic Orientations, 1995-1998 in the Program's area of responsibility (*2*). From these resolutions emerge new challenges for the mental health programs of the Region, with respect to promoting social policies to improve the quality of life of the individual, the family, and society in general, and strengthening the interaction between health and human development of which it is a part.

4.1.8 Scientific and Technical Advances

The scientific and technical advances in the mental health field are considerable. If they proceed at the present rate, even further progress can be anticipated in our knowledge of the brain, psychology, and social psychiatry. Intervention models and technology resources have also increased, and if properly implemented, can produce the desired impact on the health of the populations. It is the Program's responsibility to duly apply these new developments in its technical cooperation and to disseminate them in the countries.

4.2 GENERAL OBJECTIVE OF THE PROGRAM ON MENTAL HEALTH

The general objective of the Program on Mental Health of the Division of Health Promotion and Protection is to provide technical cooperation to the countries to promote mental health, prevent mental disorders at all levels, and focus on the psychosocial aspects of health and social development. The Program utilizes the functional approaches common to all the technical units (promotion of policies, plans and programs; training; mobilization of resources; research; information, and direct technical cooperation) in order to collaborate with the countries of the Region to foster the preservation and recovery of mental health and health in general, and to promote human development.

4.3 SPHERES OF ACTION OF THE PROGRAM ON MENTAL HEALTH

- Control of neuropsychiatric disorders;
- promotion of mental health and primary prevention of psychiatric disorders;
- intervention in the psychosocial factors affecting health and development.

4.3.1 Control of Psychiatric Disorders

The Program's technical cooperation, based on the needs identified in the countries, is currently geared more toward the control of psychiatric disorders than toward the other two components.

The restructuring of psychiatric care, which PAHO initiated jointly with the countries and regional and international organizations, is an initiative aimed at reorienting this type of care to respond more effectively to the needs of the populations and to promote "community-based care that is decentralized, participatory, integrated, continuous, and preventive" (Declaration of Caracas, 1990). The initiative is a response to the orientation still present in the organization of psychiatric care, its isolation from the rest of the health sector and other social sectors, and the stigma associated with psychiatric disorders (*17,18*).

Implementation of the initiative is complex. Technical cooperation is therefore provided through several means, which support:

- monitoring respect for human rights (*21*);
- strengthening the entire network of care, which includes the mobilization of community agents inside and outside the health sector;
- action to involve consumers in programs and services;
- promotion of legislative reform that will establish the legal framework for reorienting the services and safeguarding human rights;
- action to adapt teaching at the university and postgraduate levels to community needs;
- operational research;
- promotion of a social and professional culture consistent with the principles of the Initiative (*14*).

Technical cooperation is guided by the Declaration of Caracas, adopted in November 1990 by the Regional Conference on the Restructuring of Psychiatric Care in Latin America, which brought together professionals, politicians, jurists, social communicators, and users and was sponsored by several international agencies, among them WHO and the OAS (*17*). The initiative is monitored periodically by the Program (*14*). Despite formidable obstacles, the results indicate that virtually all the Latin American countries have taken some sort of action to reorient their psychiatric services. For example, the initiative has been debated in the national legislatures and the media in seven countries, thus enabling societies to make more informed decisions on the type of care best suited to their culture and technical resources. The Program has recently launched activities to study the cost of community care in order to generate information that will facilitate more objective decision-making.

The reorientation of the services toward the community will facilitate the implementation of community programs to control affective disorders, epilepsies, and psychoses by reducing the prevalence of untreated disorders and their impact on individuals and society. With this in mind, the goal is to utilize the resources at both the primary care level (e.g., for the identification and management of the clinical intervention) and in the community, both inside and outside the health sector (e.g.,

mobilization of support groups), in addition to adopting public policies (e.g., to permit the full exercise of citizenship) and relying on the mass media (e.g., to eradicate or reduce the stigma). This reorientation will also make it possible to improve the delivery of care to the population groups at greatest risk, such as indigenous peoples and the victims of armed conflict and displacement.

This initiative, which has focused on Latin America, will be studied in the English-speaking Caribbean at a subregional meeting scheduled for late 1997, with a view to improving care.

4.3.2 Promotion of Mental Health and the Primary Prevention of Psychiatric and Emotional Disorders

This is a new area of technical cooperation that is being carried out in fulfillment of the Regional Plan of Action for Health Promotion in the Americas (CE113/15, 2 May 1994) approved by the Governing Bodies. This component includes:

1) Support for activities to raise the level of mental health on society's scale of values through the mobilization of key figures in the countries, such as the First Ladies (*19*), utilization of the mass media, and the forging of intra- and intersectoral alliances. The purpose of the latter is to integrate mental health knowledge and techniques into the policies, programs, and services of other sectors.

2) Promotion of behavioral changes to encourage the adoption of healthy lifestyles (*3*), e.g., the reduction of violent behavior; incentives to promote peaceful relationships.

3) Coordination with other PAHO units and international and regional organizations (e.g., OAS, UNICEF, UNESCO, Instituto Interamericano del Niño) for joint implementation of a regional plan of action to promote the psychosocial and mental development of children that has two principal components: promotion of early childhood development (affective, social, and cognitive) and reduction of violence against children (corporal punishment and child abuse). This plan is being discussed by subregion, so that the countries will adopt analogous strategies with integrated and intersectoral characteristics.

The possibilities open to the Program in the promotion of mental health are numerous, despite the relative newness of the conceptual and operational frameworks and the relative scarcity of empirical evidence. With this in mind, the Program is preparing documents to orient its technical cooperation efforts.

With regard to the primary prevention of mental and psychosocial disorders, in 1988 WHO prepared a document that lists effective interventions (*21*), some of which are found in the Interagency Regional Plan of Action to Promote the Mental Health and Psychosocial Development of Children (*10*).

4.3.3 Psychosocial Aspects of Health and Development

Activities in this sector vary. They include: (1) technical support to promote the inclusion of behavioral components into training for health workers to increase the effectiveness of their interventions; and (2) the dissemination of knowledge and techniques that will enable communities to better stimulate human development. The Program seeks to provide technical support to countries directly or indirectly affected by the armed conflicts in the Region, which have created a number of high-risk population groups (e.g., displaced persons, refugees, and people suffering from trauma).

5. AGGRESSION: ELEMENT FOR VIOLENCE (POLITICS, SOCIOCULTURAL, AND ECONOMIC)

By Sara Torres

5.1 INTRODUCTION

Aggression is a worldwide phenomenon, although it is not manifested in the same way or to the same extent in all individuals. Aggressive or abusive behavior may be defined as any action by which a person tries to control others or impose his/her own desires by inflicting physical or psychological harm on others. Domestic violence includes aggressive behavior from a partner that may be physical, psychological and sexual. This paper will present an overview of the political, sociocultural and economic impact of domestic violence in Latin America, as well as current prevention and treatment programs.

5.2 OVERVIEW OF DOMESTIC VIOLENCE IN LATIN AMERICA

In 1986, 517,465 deaths from violent causes were recorded in the 28 countries of the Americas (Yunes, 1993). Violent deaths as a proportion of total deaths ranged from 3.7% in Jamaica to 26.8% in El Salvador. Death rates in infants (i.e., less than 1 year of age) due to violent causes were higher than rates due to infectious diseases in countries with low overall mortality such as Canada, the United States, Puerto Rico, Trinidad and Tobago, and Chile. For those between 5 and 24 years of age, all the countries in the region had higher death rates due to violent causes than due to infectious diseases. This same relationship was observed in those between 1 and 4 years of age in all countries, with the exception of Brazil, Ecuador, Mexico, Panama and Paraguay, which had higher rates of death due to infectious disease than due to violent causes in this age group.

When violent death rates were examined in both sexes, higher rates were observed in men than women (Yunes, 1993). The author interpreted this as being due to men being more frequently exposed to certain risk factors, compared to those to which women are usually exposed in their life style. Further, the author suggested that as women's educational attainment was increased and they entered the work force their rates approximated those of men. The author found that compared to the other countries in the region, in

the United States, Argentina and Cuba, where there was relatively more opportunity for both sexes, there were less gender-related differences in mortality rates due to violent causes (1.9/1 men to women ratio in Cuba and 2.7/1 men to women ratio in Argentina and the United States.) Although this study did not separate deaths due to intentional injury by an intimate partner (i.e., domestic violence) from those due to injury from other persons, legal intervention or as a result of war, it indicates that mortality due to violent causes deserves greater attention.

Recent data indicate that domestic violence in Latin America is a serious problem. In recent national study surveys in Antigua, Barbados, Chile, Costa Rica, Guatemala, Mexico and Suriname, 26% to 54% of women interviewed reported being physically assaulted by an intimate partner (United Nations, 1995). The United Nations Secretariat's Division for the Advancement of Women (United Nations, 1991), in compiling information on domestic violence in various countries, found that of 1,170 cases of bodily injuries in Colombia occurring during 1982 and 1983, one of five was due to conjugal violence, and 94% of those hospitalized were battered women. Diaz Chalarca (1997), in her review of the Colombian Demographic and Health Survey of 1990, reported that one of every five women in Columbia has been forced by her husband or boyfriend to have sexual relations.

A recent study of 300 women in Chile and Nicaragua found staggering levels of domestic violence (Morrison & Orlando, 1997). In Chile, more than 40% of women suffered some type of domestic violence, and in Nicaragua over 52% suffered abuse. In a study of 359 women in Peru, Gonzales de Olarte and Gavilano Llosa (1997) found that 88% of the women had suffered some type of abuse from their partners during the last year. The most common form of violence was psychological abuse, which was reported by 84% of the women; 31% reported physical violence, and 13% claimed to have suffered some type of physical harm as a result of physical abuse; sexual coercion was reported by 49% of the sample.

5.3 POLITICS AND VIOLENCE -LAW ENFORCEMENT AND LEGISLATION

In June 1994, the General Assembly of the Organization of American States adopted the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women ("Convencion de Belem Do Para"), signed in Brazil on June 9, 1994 (Organization of American States, 1994), which established a series of rules and mechanisms to be implemented by the states to seek to eliminate discrimination against women and violence exercised

against them. Among the actions to be carried out by the states were to: prevent, investigate and punish violence against women, include penal, civil and administrative codes in legislation necessary to prevent, punish, and elimination violence against women, modify or abolish laws or judicial practice that supports tolerating violence against women, establish just and efficient legal means for women subjected to violence which include protective measures and fair treatment.

At the national level many countries have taken action in response to violence against women. Domestic violence laws have been passed in the Bahamas, Barbados, Costa Rica, Trinidad and Tobago, and the United States (United Nations, 1995). Generally, these acts clarify the definition of domestic violence and empower the courts to issue women "orders of protection." In Brazil immediate protective measures are provided by police and non-governmental organizations for victims of domestic violence and sexual assault and rape (Mesquita da Rocha, 1997). Jamaica provides shelters, non-governmental organizations and/or financial assistance to victims of domestic violence, incest and sexual assault and rape (Macaulay, 1997).

Costa Rica has implemented plans within its institutions to formulate comprehensive solutions to the problem of domestic violence. In 1994 Costa Rica developed a national plan to deal with and prevent intra-family violence, which was coordinated by the National Center for the Development of Women and the Family, and was promoted by the Office of the First Lady of Costa Rica (Villanueva, 1997). The plan is of a multidisciplinary and inter-institutional nature and involves various government ministries: Justice, Public Safety, Health, Labor and Social Security, Housing, Information, and Culture, Youth, and Sports, as well as other institutions and public offices, among them, the state universities, the Public Defender's Office, and nongovernmental organizations related to the area.

Longer-term measures to curtail domestic violence include comprehensive legislative reforms and legal literacy programs for women to protect them and ensure their rights, as seen in Argentina. Argentina has created a government agency, La Dirección General de la Mujer, which creates public policy on the development of women and fosters their participation in the community through diverse programs and projects (Dirección General de la Mujer, 1997). Included it its mission is assistance in combating the problem of family violence, through external intervention from community agencies, the police, family judges and legal assistance offices.

5.4 SOCIOCULTURAL IMPACT OF VIOLENCE

Various sociocultural characteristics have been identified in abused women and their abusers. In a study conducted in Peru poor women have were found to suffer more violence of all types (physical, psychological, or sexual) than women who were not poor (Gonzales de Olarte & Gavilano Llosa, 1997). Besides poverty, other factors that were important in explaining abuse were young age of the man, lower educational level of the man and woman, and not being married. In a review of domestic violence incidents reported to a special police unit in Brazil, it was found that the man was likely to be the woman's husband, the couple was typically poor and poorly educated, and in terms of culture, the couples were characterized by the woman's faithfulness and the honor of the man (Mesquita da Rocha, 1997). The woman who typically sought out the assistance of the special unit had already been assaulted several times, and did not wish to break up the relationship in which the violence had taken place. Resorting to the special unit often occurred because mediations by the family, neighbors, or community were not effective.

In most of the cases of domestic violence reported to a hotline in El Salvador, the abuser was the victim's spouse or companion (Valdez, 1997); in fewer than half of the cases was the abuser under the influence of drugs or alcohol. The abusers tended to have stable employment.

Domestic violence is a social problem that expresses itself in health through physical and mental injuries that debilitate the woman and destroy her self-esteem.

5.5 IMPACT ON HEALTH OF DOMESTIC VIOLENCE

Domestic violence has devastating psychological and medical repercussions on the family. Mothers may transmit to their children their own feelings of low self-esteem, helplessness and inadequacy. Children themselves may become victims of their father's abuse if they try to defend their mother. Boys who witness their father beating their mother are likely to emulate this behavior.

Domestic violence against women also impacts their children's educational attainment. In Chile and Nicaragua, children in homes with domestic violence were found to be more likely to suffer

disciplinary problems in school than children from homes without domestic violence (Morrison & Orlando, 1997).

Children who witness violence may be deeply affected. In a review of the literature on child exposure to community violence in the Untied States Putnam and Trickett (1993) suggest that community violence results in difficulties with attention, cognition, and memory.

Exposure to aggressive acts, such as war, is likely to be stressful and contribute to immediate and long-term mental health problems in adults and children. In a review of the literature relating to the consequences of ethnic and political violence, Ladd and Cairns (1996) reported that children exposed to ethnic and political violence were more likely to develop behavior problems, sleep disturbances, somatic complaints, and altered levels of cognitive functioning and moral reasoning. Children exposed to war in Central America have also shown mental health symptoms and their mothers have exhibited posttraumatic stress disorder (Locke, Southwick, McCloskey, & Fernandez-Esquer, 1996). Similar findings were reported by Diehl, Zea, and Espino (1994) in their study of 52 Central American children, aged 7-16 years. The authors found that exposure to war violence was a strong and consistent predictor of subjects' number of PTSD symptoms and cognitive functioning. The authors interpreted this to mean that such exposure had a negative effect on cognitive and emotional development.

Abused or battered women undergo serious physical injuries such as miscarriage, sexually transmitted diseases including AIDS or recurrent gynecological disorders as a result of deliberate assaults by their partners (Campbell & Alford, 1989; Chapman, 1989; Smith & Gittelman, 1994). In addition to the physical damage, victims often suffer crippling dependence, depression, anxiety, PTSD, an incapacitating assault to self-esteem, respect, and confidence, irritable bowel syndrome, chronic pain, substance abuse, and suicidal temptation beyond the initial traumatic event (Bergman & Brisman, 1991; Campbell, 1989; Hilberman, 1980; Kerouac, Taggart, Lescop, & Fertin, 1986; Kurz, 1983). Dobash and colleagues (1992) reported a range of 43% to 65% of women psychiatric inpatients in an U.S. hospital had suffered physical or sexual abuse.

In recent years many Chilean and El Salvadoran migrants have left their countries after experiencing systematic torture or a traumatic experience linked to political repression. In a study of El Salvadoran and Chilean migrants who had experienced torture or trauma, Thompson and McGorry (1995) found that survivors of torture showed higher levels of PTSD, psychosomatic impairment, and stress response disturbance than trauma and non-torture/trauma groups.

5.6 ECONOMIC IMPACT OF VIOLENCE

The economic cost to society of dealing with the problem of violence is enormous in terms of medical treatment and counseling for the victim, introduction of preventive measures, and the abused woman's reduced earning capacity. The economic costs of domestic violence to developing societies are great. In a study conducted in Chile and Nicaragua (Morrison & Orlando, 1997) domestic violence was shown to impact women's earnings. In the Chilean study, women who suffered severe physical violence earned only 39% as much as women who did not suffer this abuse; in Nicaragua, the percentage was 57%. The authors cite many reasons for this impact on wages, including increased absenteeism, reduced ability to concentrate on the job, or the impact of stress on worker productivity.

The reduced wages, in turn, impact the two countries' economies. In Chile, all types of domestic violence reduce women's earnings by 1.56 billion dollars, or more than 2% of the 1996 GDP, and in Nicaragua, domestic violence reduces women's earnings by 29.5 million, or 1.6% of the 1996 GPD (Morrison & Orlando, 1997).

5.7 DOMESTIC VIOLENCE TREATMENT PROGRAMS

Some countries have started domestic violence treatment programs for batterers. In Mexico City, the civic organization, the Men's Collective for Egalitarian Relationships A.C., or CORIAC, has established a voluntary, self-help group program to re-educate men who consider themselves violent (Cervantes Islas, 1997). The program is based on the following notions: (a) there is a necessary condition for violence (i.e., the existence of a certain imbalance of power that can be defined culturally, by context, or by the interpersonal manipulations controlling the relationship.); and (b) masculinity has been organized in Mexican culture based on the belief in superiority over women in general and other men in particular. The network of beliefs, values, attitudes and behaviors with which men construct their sexual identity is a process of learning codes that constantly reinforce the position of men, particularly through the implementation and daily verification of that identification with the possession of power, be it real or symbolic.

Since February 1993, the voluntary program has been continuously open to men who want to stop being violent (Cervantes Islas, 1997). The current model includes three levels of training: (a) exploration of the elements of violence as it is practiced daily, (b) deeper identification of participants' emotions and needs, and

(c) learning and consolidation of strategies, to seek greater equity with one's partner. Each level has 16 weekly two-hour sessions.

From a 1997 sample, 100% of participants in the program were found to have engaged in psychological abuse, 38% in physical violence, and 29% in sexual abuse of their partner (Cervantes Islas, 1997). Approximately 50% attended only once, 30% went beyond 5 sessions. The remaining 20% completed the first level lasting 16 weeks. During the 54 months that the self-help group has been being operating, an average of 8 to 12 new men has been attending monthly.

There is little available information on the effects of treatment intervention programs with children exposed to conflict situations. In many countries, lack of trained personnel is a serious constraint (Richman, 1993); the continuation of conflict and other stresses, and lack of finances are also limitations in providing material and emotional support.

In Guatemala, a recent program, Creative Workshops for Children, indicates that such workshops are important tools in the recovery process of Guatemalan Mayan children experiencing situations of war and state-sponsored terror (Lykes, 1994). The workshops are an international, interdisciplinary program organized by mental health workers from Argentina, Guatemala and the United States. Through the use of drawing, story telling, collage and dramatization in a group process, the workshops seek to create a space and time in which the child can express himself/herself, communicate experiences to others, and discharge energy and emotion connected to previous traumatic experiences. The workshops enhance the child's natural means for communication that facilitate the expression of physical and mental tensions and the development of a capacity to construct an identity that is not exclusively subject to the dehumanizing and traumatizing reality of war.

5.8 DOMESTIC VIOLENCE PREVENTION PROGRAMS

Many countries have developed domestic violence prevention programs. In Puerto Rico, hotlines provide a means for women victims of violence to ask for information and advice. The Women's Commission of the Central Government and the Women's Office of the Municipality of San Juan created their respective hotlines which women can call to ask for advice (Isis, 1997a). In El Salvador there is a government initiative to prevent and eradicate domestic violence, referred to as the Better Families Program (Programa de Saneamiento de la Relación Familiar) (Valdez, 1997). This program,

associated with the Salvadoran Institute for the Development of Women, provides a comprehensive set of services to assist people in the metropolitan area of San Salvador who contact the Friend of the Family (Teléfono Amigo de la Familia) hotline, which operates 24 hours a day, 365 days of the year. The Better Families Program provides family members with a range of emotional, psychological, social, medical, and legal services, and endeavors to address and prevent domestic violence, with particular reference to its impact on women and children. In the two years in which the program has been operating, 22,500 people have directly benefited. Most of the cases have been emotional abuse (67%), intra-family violence (24%), and child abuse (6%).

In Brazil, women are actively making efforts to use available resources, such as special police units, to stop their partners' violence (Mesquita da Rocha, 1997). In 1991, these special units, or Special Units to Attend to Women, received 2,685 reports of bodily injury involving women and 82 incidents of rape. In 1996 reports in both categories increased dramatically to 6,264 reports of bodily injury and 228 incidents of rape. Mesquita da Rocha believed this increase in reports of wrongful bodily injury depicted the heightened visibility of assaults, which was one of the reasons for the success of the Special Units, namely the encouragement of victims to make complaints and seek support. Furthermore, the victims were ensured support, recuperation in their self-esteem, and comprehensive attention from the specialized attention that they received. Mesquita da Rocha believes the special units could serve to prevent the occurrence of severe violence such as homicide by providing the women a place to go to report threats and assaults, which may be ignored at the local police stations, who may not see these as important to investigate.

In Venezuela, a non-profit organization, the Venezuelan Association for an Alternative Sex Education (AVESA) was created in 1984 for the purpose of investigating and providing educational and psychotherapeutic services to victims of sexual abuse and partner abuse (Asociación Venezolana Para una Educación Sexual Alternativa, 1997). These direct services were later augmented with educational projects and workshops to assist police in preventing sexual abuse. These projects focus on factors, which contribute to sexual abuse and on the specific needs of the abused person.

Because the policeman receiving the abuse report is generally the first and perhaps the only person the abused person turns to once he/she decides to make a report, the policeman is in a unique position to serve the needs of the abused person (Asociación Venezolana Para una Educación Sexual Alternativa, 1997). According to AVESA, victims of sexual and physical abuse tended to report being treating badly, not being understood, or being blamed by

police and professionals, which is indicative of the social conception, myths and prejudices which operate against the problem of sexual and domestic violence in Venezuela.

The AVESA (Asociación Venezolana Para una Educación Sexual Alternativa, 1997) program has been successful in its plans to include workshops in local police training centers and other locations in the country and outside the country. There are now many police, at many different levels, and institutions that know how to treat persons who have been sexually or physically abused.

In Mexico, an inter-institutional team effort to prevent domestic violence was established in Nuevo León by twelve institutions working in the fields of health, welfare, and higher education, headed by the State Population Council in Nuevo León (Granados Shiroma, 1997). This effort followed publication of results of a State Population Council study on reproductive health and violence against women conducted in 1995 and 1996 in metropolitan Monterrey, which found that 46% (or 491) of the 1,064 women selected at random from the population 15 years of age and over had answered yes to at least one of the questions about whether they had been or continue to be subjected to psychological, physical, and/or sexual violence by their partner; 39.3% of the respondents stated that the degree of violence was high or very high. From January 1, 1997 to June 30, 1997, 4,073 cases were served by the institutions that were members of the Inter-institutional team. The working group report stressed the importance of joint action in combating domestic violence (Granados Shiroma, 1997).

In Jamaica, Women Inc., Women's Media Watch, Sistren Theatre Collective, and Women's Centre are the member organizations of the Association of Women's Organizations in Jamaica (AWOJA), which deal with domestic violence and its victims and perpetrators (Macaulay, 1997).

Women Inc. commenced work in 1984 with women victims of violence and their children and provides counseling for them and for the abuser; it is the only organization which provides shelter for the victims of violence (Macaulay, 1997). Women's Media Watch formed in 1987 is engaged with harmful stereotyping of women by the media; it conducts workshops and film shows/discussion sessions and produces brochures to raise the public awareness of the causes of sexual violence. Sistren Theatre Collective is an organization of grass roots women employed in textile production, theatre productions, and workshops facilities; it provides and performs live plays and skits, depicting various discriminatory practices against women, including domestic violence. The Women's Centre foundation provides education and counseling to build self-esteem and skills training

for pregnant teenagers, teenage mothers, and expectant teenage fathers. It engages its participants in chicken farming, acqua culture, and sewing for the purpose of instituting an ethic of self-sufficiency in the wound women.

The Association of Women's Organizations in Jamaica (AWOJA) itself is engaged, particularly through its legal committee members, in lobbying for new legislation and amendments to existing legislation for gender equity (Macaulay, 1997). It monitors the application of the laws, analytical critiques, and engages in media discussion programs on the condition and status of women in society. Given the increasing number of domestic violence despite all the launched programs, AWOJA has been operating on-going educational workshops in the capital Kingston, inner city communities, and rural communities of Richmond, St. Mary, Montego Bay, and Mandeville since 1996. AWOJA is now seeking funding to support its collaborator, Father's Inc., so that it can effectively reach both men and women at each workshop.

5.9 IMPACT OF THE MEDIA ON DOMESTIC VIOLENCE

In July 1997, the World Association of Community Radios, AMARC, based in Montreal, Canada, with members in almost every Latin American country, launched a campaign against violence to women (Isis International, 1997b). In Venezuela, two non-governmental organizations, Foundation for the Prevention of Domestic Violence to Women (FUNDAMUJER) and the Venezuelan Association for Alternative Sex Education (AVESA) recently collaborated on a national campaign against domestic violence (Isis International, 1997c). The effort consists primarily of a publicity campaign aimed to inform women about their rights and to encourage them to denounce violent situations.

At the international level, various United Nations agencies, in coordination with women's groups launched a violence awareness campaign in July 1997, in Latin America and the Caribbean. This effort was convened by the United Nations Fund for the Development of Women (UNIFEM) in order for the UN as a whole to support the message of women's groups presently launching various components of this campaign. The main efforts at the regional level will be the production of posters, an inter-agency briefing kit for policy-makers and the press, and the development of a media campaign, including TV spots addressed to men, women and younger people on the issue. Other proposals in the work include music concerts, pins and bumper stickers, as well as the multitude of national-level activities which women's groups, UNIFEM, United Nations Fund for Population Activities (UNFPA) among other various partners, are

organizing throughout the region to commemorate 1998 (International Human Rights Year) with the message that Women's Rights are Human Rights.

5.10BEST PRACTICES FOR PREVENTION OF DOMESTIC VIOLENCE

Policies and programs are needed to reduce the prevalence of domestic violence, which consider the social, cultural, and ethnic aspects related to the domestic violence. Despite the presence of national and international legislation condemning domestic violence, for a variety of reasons, it is difficult for women to report abuse and seek assistance. It is important for government officials to recognize the magnitude of the problem of abuse, and the importance of supporting programs to prevent it. Cultural barriers, which prevent reporting and accessing services need to be considered and overcome.

Successful programs are those that make the problem of domestic violence visible, through the efforts of training programs for police and the judiciary, radio programs, establishment of hotlines, and other means. State institutions, nongovernmental organization and international organizations should be involved in endeavors to stop violence. Women need to be made aware that physical and sexual violence against women should not be tolerated and is a violation of her human rights. They should be made aware of appropriate services where they can obtain assistance and where their safety can be assured.

5.11CONCLUSION

Research indicates that violence has serious political, sociocultural and economic impacts. The problems of domestic violence are ones, which must be faced by society, all state institutions, nongovernmental organizations, and international organizations. All must involve themselves in the search for solutions. It is a matter of public interest that must form a part of the state policies of every country. Governments must continue to make the elimination of domestic violence a national priority and continue to institute comprehensive legislative reforms to protect women against domestic violence, for without this the abuse of women will continue, and domestic violence will continue to perpetuate a status quo of political, social and economic discrimination against women.

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6. INNOVATIVE APPROACHES IN MEETING A COUNTRY'S HEALTH NEEDS: A CASE STUDY OF BELIZE

By Purnima Sen

6.1 ABSTRACT

In the late 80s, Belize, a Central American country, experienced an increase in mental health problems and realized that the country had no health personnel trained in the area of mental health and psychiatry. A project was planned to meet the challenge, which would make mental health services available in all regions of the country, and yet be cost effective. The project was implemented in 1991 and completed in 1993, training several Registered Nurses to perform as Psychiatric Nurse Practitioners. The effectiveness of the training program was evaluated in 1995 and results revealed that: (1) the stakeholders, who participated in the study, expressed satisfaction and confidence in these nurses, and (2) these nurses' performances was significantly superior to that of a control group when tested for knowledge and competencies.

6.2 INTRODUCTION

Traditionally, a country's health needs imply inadequacies in health service areas like maternal and child health, children's immunization, or basic sanitation. The health needs in Belize, the country in question, were in the area of mental health-psychiatric services. In the late 80s, Belize health officials, particularly senior nurses, expressed concern about increased incidence of substance abuse among youth, change in family structure, and lack of trained health personnel in the area of mental health and psychiatry. A project was planned and initiated in the early 90s to meet the mental health service needs of the country. This paper will discuss briefly about the nature of the identified problems, action taken and the effectiveness of the action.

6.3 BELIZE AND BELIZEANS

A brief description of the country and her people will provide an appropriate context for the paper. Belize is a subtropical country in Central America surrounded by Mexico in the north, Guatemala in the west and south, and the Caribbean Sea in the east.

Being the only English speaking country in the region, it has close ties with other Caribbean countries in several areas, e.g. education, economy, health service and culture. Belize also has to relate with other Central American countries because of her geographical location.

Belize has a population of 205.5 thousand and of this population 43.9% are of age 14 years and under, 51.9% are between age 15 and 64 years, and 4.2% are 65 years and over (1). In spite of the small population, the country can boast of a diverse ethnicity. Mestizos constitute 43.6% of the population (a sharp increase due to the influx of refugees from the neighboring countries), Creole 30%, Garifunas 6.6%, Ketchi Mayas and Mopan Mayas 8%, and Mennonites, Chinese and East Indians constitute the rest of the population (2). English is the official language but a vast majority also speaks Spanish and Creole.

Administratively, Belize is divided in six districts with paved roads and airstrips connecting all the district towns. The only exception is the two southern districts, which have unpaved roads and are often impassable during the monsoon. Smaller villages are connected by feeder roads, accessibility being widely varied. In spite of the small size (8,867 square miles), many parts of the country are not easily accessible. Belize City, Belmopan (the capital), and other district towns are spread out over several miles with an inadequate public transport system.

In the *National Health Planning System 1990-1994*(3) the Government of Belize has included a primary health care strategy using community participation as a mean of achieving the WHO goal of health for all by the year 2000. The plan spells out major areas of health needs in the country. Most of the population meets their health care needs by services provided by the Government of Belize at primary, secondary and tertiary levels. Private sectors and NGOs also contribute to health care service needs of the country. The physicians, though employed by the government, are allowed to do private practice, creating conflict of interest and periodic problems.

As for mental health services, Arana's report (4) provides the current state of psychiatric services in Belize. Mental Health is a section of the Ministry of Health; Mental Health Services are provided through Rockview Hospital for Inpatient Services (some patients are admitted in district hospitals only as emergency cases). Outpatients Psychiatric Services are provided through district psychiatric clinics (including Belize City clinic) and community psychiatric services which includes services to other facilities (e.g. nursing homes, youth hostel, and prison). The Belize Government has also established the National Drug Abuse

Control Council in 1990 (5), which has branches in all the districts. Pride Belize, as a private voluntary organization, provides training and research. The agency works with schools, community groups and individuals on problems related to drug abuse (6). Le Patriarche is the only organization (NGO) which provides treatment and rehabilitation for people with addiction problems.

6.4 MENTAL HEALTH - PSYCHIATRIC SERVICE NEEDS OF BELIZE

Mental health disorders are one of the largest causes of lost years of quality-life in the world (17). Estimated projection of increase in mental disorders will affect 88 million people by the year 2000 in the Caribbean countries and Latin America (8). Epidemiological studies have revealed an inverse relationship between social class and mental disorders. Economic crisis, increasing and unplanned urbanization, substance abuse and violence are some of the factors that contribute to mental disorders (9,10). According to Desjarlais et al (7), mental, social and behavioral health problems are overlapping clusters of problems, which intensify each other's effect on health and well being through continuous interaction. These conditions further deteriorate from an interaction with global politics and economics.

Belize has been experiencing many social changes as well. Emigration of adult Belizeans leaving their children in the care of grandparents changed the family structure resulting in stress related problems. Drug and alcohol abuse and a continuous influx of refugees from neighboring countries have made a complex problem even worse. These changes caused stress on limited human resources, particularly on the health care system of Belize.

Belize had no psychiatrist (until 1992) and no other health personnel trained in the area of mental health and psychiatry. Periodically, psychiatrists or mental health nurses visited Belize from Voluntary Services Overseas (VSO). Belize health officials had to meet the challenge to provide regular service to the people afflicted with emotional and psychiatric problems.

Though no incidence or prevalence rates for emotional disorders were available, the magnitude of the problem became apparent. Theoretically, need assessment is desirable prior to the initiation of a program but Belize Government decided to act based on urgency of the situation and lack of trained personnel (11). The author of this paper was requested for help, and, together with Belizean nurses, a project was planned and submitted to the Belize

Government for approval and subsequently was funded by the Canadian International Development Agency (CIDA) in 1990.

6.5 BELIZE PROJECT

The strategies used for project planning were:

1) Accessibility - the services should be available and accessible to all the districts.

2) Cost effectiveness - The district population could not sustain psychiatrists in each district, specially trained nurses should be able to provide the services and meet the manpower needed.

3) Sustainability - the services should be sustained after the project life was over.

4) Quality improvement - Rockview Hospital service should be improved which was staffed by a few Practical Nurses and untrained attendants.

5) Ownership - Effective use of local resources for teaching and clinical experience would create increased awareness and commitment.

Thus, a project, entitled *Training Programs for Belize Health Personnel in Mental Health and Psychiatry*, was jointly planned by Belize School of Nursing and Memorial University School of Nursing.

The goals of the project were to:

1) Meet the current mental health and psychiatric services needs for Belize.

2) Make Belize self-sufficient to meet the future needs in the area.

The project plan proposed four programs:

1) Ten-month training program for 3 years to prepare registered nurses to perform in the role of Psychiatric Nurse Practitioners.

2) A 3-month training program for psychiatric hospital attendants to function as Psychiatric Aides.

3) Two curriculum workshops for Belize School of Nursing faculty members to integrate and strengthen mental health and psychiatry components in the professional nursing curriculum.

4) In-service education for Medical Officers to update their knowledge in psychopathology and psychopharmacology. This part was to be offered by the Chairman, Faculty of Medicine's Psychiatry Department at Memorial University. This part could not be implemented due inaction of the Medical Department in Belize.

Another proposed component for the Bachelor of Nursing Degree Program for Belize nurses was not approved by the Belize Government, hence it had to be deleted from the final proposal. Though the first three programs were successfully completed, the Psychiatric Nurse Practitioners' (PNP) Training Program was the crucial component of the project. Therefore, the rest of the paper will devote in discussing this program.

6.6 PSYCHIATRIC NURSE PRACTITIONERS' TRAINING PROGRAM IN BELIZE

The Psychiatric Nurse Practitioner (PNP) curriculum adapted an eclectic model reflecting the socioeconomic reality of Belize. It had a pragmatic approach protecting the essence of nursing. The curriculum design stated at the outset that the ten-month formal program was only the beginning of the process and learning should be continuous and life-long process to gain proficiency.

The curriculum design adopted the Belize School of Nursing philosophy, framework and structure. The program consisted of two semesters; each of fourteen weeks duration and two months of clinical work at the end of the two semesters, with a total of 44 credits (theory 24 and clinical 20). Courses taught in the first semester were Personality Theories, Individual Counseling, Mental Health Assessment, Substance Abuse, and three clinical placement experiences. Semester two included: Psychiatric Nursing, Psychopathology and Treatment, Group Dynamics and Counseling, Rehabilitation Nursing and two clinical courses. The courses on Mental Health Assessment, Psychopathology and Counseling received the strongest emphasis.

The biggest challenge faced was the complete lack of clinical facilities required for professional training. Rockview Hospital was the only psychiatric facility, which provided custodial care and had no Registered Nurse (RN), on staff. Clinical experience, therefore, had to be organized using all available facilities.

These included areas like outpatients clinics in Belize City Hospital, Community Health Clinics (particularly Maternal and Child Health Clinic), patients admitted to Belize City Hospital (general areas), and Belize Psychiatric Clinic. Rockview Hospital was also included as part of the clinical experience.

Several NGO sites were also included for clinical experience, thus providing them with a wide range of clinical experience incorporating primary, secondary, and tertiary levels of care. One VSO Psychiatrist was in Belize during this period conducting clinics in Belize City as well as in other district towns and provided clinical supervision for the students. This was an excellent opportunity for clinical experience where these nurses were subsequently placed after completion of the program.

Thus, the program had a community focus from the very beginning to meet the country's needs. The program duration was of ten months and the last two months of the program required clinical work in the districts where students were expected to start performing in PNP roles. Clinical experience was integrated throughout the other eight months (or two semesters) of the program.

A tutor was hired from Canada to teach and coordinate the training program. The teacher's salary, learning materials (including hard and software of audio-visual aids), transport, and student's sustenance allowance were funded by the CIDA grant. Belize Government provided the physical facilities, students (with full salary support), and other support services, e.g. secretary and driver. Several local experts from NGOs made a significant contribution to the PNP program through direct involvement. A total of sixteen (16) RNs successfully completed the PNP program between 1991 and 1993 and were placed in various settings and regions of the country, including Belize School of Nursing (preparing future nurses), Rockview Hospital and Belize City Psychiatric Clinic.

Evaluation - Did the Project Meet the Needs?

It is recognized that the area of health care organization is very complex and politics, economics and conflicting subcultures shape its policies and actions. Much of the planning is not subject to rational-comprehensive analysis. Often planning relies on expertise, empiricism and experience, immediate and ultimate tests of a solution do not exist. Also, experts in the field of evaluation recognize the complexity of health care services and organization. Several experts have suggested adaptation of a pragmatic approach that is responsive to the situation and should be designed and implemented with the stakeholders' interest in mind (12-17). Based on literature review, a pragmatic approach was taken in designing the evaluation research.

This study[1] was designed primarily to explore the effectiveness of a PNP Training Program and its impact in the areas of Mental Health and Psychiatry in Belize. The project focused on three broad objectives:

1) To determine the adequacy of the PNPs' functioning in their new role.

2) To determine what impact the PNPs have on mental health services.

3) To obtain information on the PNPs' competence and their satisfaction with their new role.

For the purpose of this paper only the issue of adequacy will be discussed.

This issue is examined through patients' expressed satisfaction with PNP service, DMOs' and Focus Groups' perception of PNP performance adequacy, and group difference between PNPs and their controls on five competency testing vignettes in the area of mental health-psychiatry.

This study design included survey, quasi experimental, and focus group techniques. The survey approach was appropriate for obtaining information dealing with concerns of adequacy, impact and satisfaction in this study. A quasi-experimental procedure was useful in determining PNP competence relative to a nurse control group; such a comparison was important in order to show that the PNPs had acquired the appropriate knowledge and skills in areas of mental health and psychiatry beyond that possessed by ordinary nurses. Focus groups were employed to confirm adequacy of performance and impact.

Data were collected through face-to-face interviews using open-ended questions and focus group technique. All interviews were audiotaped and transcribed. Data were analyzed both quantitatively and qualitatively.

The study sample included the major stakeholders, i.e. PNPs' patients/clients - 109; PNPs' direct supervisors - 5; PNPs - 14; non-PNP nurses (control) - 28; and community representative - 23. Focus group technique was used for the last subject subgroup.

[1] Note: The research study was done by P. Sen, M. Laryea, L. Gien, A. Kozma of Memorial University of Newfoundland and T. Palacio of University College of Belize. Research was funded by PAHO and IDRC.

Tables 3 and 4 indicate the adequacy of PNPs' functioning from the clients' perspective. These findings reflect the subject's expression of confidence and satisfaction with the PNPs.

Table 3: Patients' General Satisfaction with the PNP Service and the Recommendation of the Service to Others

RESPONSES	SATISFIED WITH SERVICE		RECOMMENDED TO OTHERS	
	Frequency	Percentage	Frequency	Percentage
Yes	104	95.4	103	94.5
No	1	0.9	1	0.9
Missing	4	3.7	5	4.6
TOTAL	109	100%	109	100%

Table 4: Resources Persons Used to Obtain more Information on Illness and Drugs

RESOURCE PERSON	ILLNESS[1]		DRUGS[2]	
	Frequency	Percentage	Frequency	Percentage
PNP	62	56.9	65	59.6
Physician	20	18.3	13	11.9
Family and Friends	11	10.1	5	4.6
Nobody	11	10.1	11	10.1
Not Applicable	—	—	4	3.7
Missing	5	4.6	11	10.1
TOTAL	109	100%	109	100%

1. $X^2 = 178.2569$; D.f. = 6; $p<.001$

2. $X^2 = 107.8349$; D.f. = 4; $p<.001$

Some direct quotes from clients are given below as illustration of client satisfaction.

I was over satisfied because they have me a great help, like ... once you were blind and now you can see.

They really help. They help you get back your life together.

I wish that they had more nurses like her, to sit and really talk to you. Get down to the problem and understand what you are

going through and do not judge you. Just listen and give you good advice.

One of the chief criteria of PNP competence and adequacy is their performance on tests of knowledge compared to non-PNP nurses. The PNPs' knowledge and skills were evaluated in relation to those of a control group. Five vignettes were presented to each group, followed by questions based on the information in each vignette. The vignettes included two cases of acute psychoses, one with severe and persistent mental illness, one with loss of body function resulting from accident and one teenager with possible drug abuse. Both experimental and control groups were asked to response to the questions for each vignette.

These responses were summarized and sent to five judges (Psychiatric Nursing Experts) for rating of the response. Original transcripts were also sent to the judges for referral, should they need to refer to them when judging the protocols. Any clues that would have identified the two groups were eliminated in order to obtain blind scoring. The mean scores obtained by the two groups are given in Table 5.

Table 5: Mean Rating Scores of Judges on Performance of PNPs and Control Group

	PNP	CONTROL
Vignette 1	2.2	1.4
Vignette 2	4.8	2.4
Vignette 3	3.0	1.9
Vignette 4	2.9	2.5
Vignette 5	3.0	2.2
TOTAL	15.9	10.4

These data were analyzed by 2 (Groups) by 5 (Measures) MANOVA procedure. The analysis yielded a significant overall multivariate group effect [$F(5,36) = 12.17$; $p<.001$]. These results clearly indicate a superior performance by PNPs over their control group. In order to determine the source of group differences, Univariate Effects were calculated for each measure.

The groups performed differently, in favor of PNPs, on Measure 1 [$F(1,40) = 29.51$; $p<.001$], Measure 2 [$F(1,40) = 33.68$; $p<.001$], Measure 3 [$F(1,40) = 20.04$; $p<.001$], and Measure 5 [$F(1,40) = 19.60$; $p<.001$]. Only Measure 4 failed to differentiate between PNPs

and their control group [F (1,40) = 2.63; p<.001], although the trend is in the appropriate direction.

Table 6 reveals the score for self-perception assessment. It should be noted that confidence in Role received the highest rating while perception of Program Adequacy for Responsibility received the lowest.

Table 6: Rating Scale - Self Perception Assessment (Respondents - 13 PNPs)

Question	1 None	2 Low	3 Average	4 Good	5 Excellent	TOTAL
Confidence in Role				9	4	13
Confidence in Responsibility			1	7	5	13
Program Adequacy for Role			3	8	2	13
Program Adequacy for Responsibility			5	6	2	13

The next subgroup interviewed was the PNPs' supervisors who were District Medical Officers (DMOs). The major findings from this subgroup are summarized below:

1. Four of the five DMOs expressed confidence in the PNP's ability.
2. None of the DMOs had any problem with PNPs making diagnosis and prescribing medications.
3. PNPs and DMOs sought each other's advice and assistance as needed.
4. They work as a team and meet frequently - formally and informally.
5. PNPs need transport for adequate delivery of services.

Some direct quotes from this group will illustrate DMOs' perception.

There is a demand for the area, yes, definitely. Since she is here on a regular basis, it definitely has a good impact on the area.

I would like to emphasize that the PNPs have been doing a great job. And it has helped me and the hospital and the surrounding areas, dealing with this particular problem.

Well, yes, she is a lot of help ... I think she is very essential, I think she is a very essential person in our hospital setting ... Her presence is very, very, very essential.

The last subject subgroup was Community Representatives and it consisted of 23 members in 3 groups. Focus group technique was used for data collection. They represented education, social services, health services and law enforcement officers who have regular encounters with mental health problems in Belize. The major findings are:

1) Recognized emotional problem as a serious issue, especially among children.

2) Recognized PNPs to be well qualified for their roles and responsibilities.

3) Perceived PNPs' main role: educating public to promote mental health; providing support to patient and family; acting as advisor and liaison person

4) Need more PNPs in each district to help teachers and children.

5) Need of transport and support for PNPs to deliver services at appropriate time and place.

Members of the focus groups perceived that the PNPs were well qualified for their roles. They were of the opinion that the training program was good and valuable. Their description of PNPs' role was consistent with the way PNPs functioned in their district.

These results indicate that the PNPs are providing adequate services in their respective regions and they also possess the competency required to provide the services. There is congruency in the perception of all the subjects participating in the study.

6.7 CONCLUSION

The evaluation research indicates that one component of the project, i.e. PNPs' Training Program has been effective and the

PNPs are meeting the mental health-psychiatric service needs as perceived by the subject subgroups. The study also revealed some of the gaps in the service related to facilities and support necessary for providing such services. One of the impacts of the project has been increased awareness about mental health and need for services among all the stakeholders who participated in the study.

Belize has now one Belizean psychiatrist in the country, at last, one PNP for each district and Rockview Hospital. Through their innovative approaches, PNPs have reached the schoolteachers who face children's problems in their everyday work, police officers who are called to handle psychiatric emergencies, and other professionals working in related areas. These approaches have helped to reduce stigma and increase awareness about the nature of mental health.

Belize has met her challenge of mental health service needs through a pragmatic approach, but the need for vigilance to sustain the services and concerted effort to improve them should be kept in mind.

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7. PERSPECTIVES AND CHALLENGES OF PSYCHIATRIC NURSING FOR THE 21ST CENTURY

By María T. Orozco

Lack of attention to mental health problems in Mexico, as in the majority of Latin American countries do not stem only from lack of resources or preference for fixing other health priorities but because of our culture that does not realize that these problems occur also outside impatient facilities. Nonetheless it is necessary to point out that the mental health problems occurring in our societies in particular in our big cities due to poverty, unemployment, lack of family integration are cause and consequence of psychological disorders.

In addition, mental health services, existing within the national system (de IMSS, and the ISSSTE and in the office of the Secretary for Health), as well as in some private facilities, show a great variability of quality of care.

The WHO esteems that at least the 1 per cent of the Mexican population suffers from mental disorder in a given year, and that at least 10% of he population experiences a mental disorder during their lifetime.

Studies conducted by the MPI show a point prevalence mental disorders between 35-55% for Mexico, D.F., that are seen in primary and secondary care facilities. About 21% of cases are Affective Disorders that show minimal gender differences. The elderly show high prevalence of Depression and cognitive disorders (often associated with depression and alcohol use). Adolescents show a high prevalence of substance use disorders. Inpatients are more likely to suffer from schizophrenia, mental retardation and organic psychoses.

Thus, De La Fuente points out several problems in primary attention: 1-developmental, neuroses, and adjustment. Therefore, these disorders require a primary care model following the Alma Ata declaration, rather than hospital care. There, the emphasis is put on early detection, prevention, diagnosis and rehabilitation of mental health problems, conducted by an interdisciplinary team that is in contact with the patient and with the community.

7.1 SECONDARY CARE SERVICES

The MIP and other national institutions have shown that our availability of secondary care services is insufficient. These patients require psychiatric and medical care simultaneously that is; they are general hospital patients who seldom would end in a psychiatric hospital. Because of this shortage, both general and psychiatric hospitals have seen an increase in the amount of care devoted to mental health problems.

Unfortunately, we also lack the human resources needed to fulfil the demands for our three levels of care.

Our resources in terms of infrastructure include 8,313 beds in federal, state, with subsidies and also private for our population of 93 Million citizens with right to psychiatric and mental health care. We also have 203 health clinics at the first level care, which includes psychiatric care with 134 general practitioners, 195 psychiatrists, 125 MD s on call and 83 MD s involved in other activities. Nursing includes 1501 nurses on call, 92 nurses involved in other activities, and 4803 beds. Compared to the recommended rate of 5 MD s and 10 nurses for each 100,000 persons, we have 2 MD s and 0.4 nurses per 100,000 persons.

Moreover, it is necessary to train our nursing personnel at each distinct level of care and also in psychiatry and mental health care. Our current challenges in mental health nursing are thus enormous.

Such deficit of human resources coincides with a period of change and scientific progress in psychiatric, with a greater medical presence than in the past, brought about by discoveries in molecular genetics and neurosciences as they unravel the biochemical disturbances in the CNS of psychiatric patients. Next to these basic science advances, we have now a new technology that allows us to examine with detail the structure of the living brain. It is also worth mentioning that we have become aware of the link between life events and mental disorders, at the psychosocial end of psychiatric research.

All of the above would seem to anticipate hat nursing services have also benefited from

Important gains and advances: **unfortunately, this is not the case**.

However, I do not favor the idea that nurses might get into psychiatric specialty directly. This should come after some general

training in the field of general nursing. To accomplish his goal we need to expand our curricula in Nursing so as to include psychiatry within its three levels of care. For example, such curricula might include liaison community psychiatric nursing as secondary care and psychiatric nursing for acute and chronic patients in hospitals as well as programs for MCH nursing, geriatric nursing, violence.

Thus, we work within the framework of the epidemiology of mental disorders in our country, as well as within the parameters fixed by our human, material and financial resources that we can devote to public mental health. In confronting the next century, we should be aware of he difficulties faced by mental health workers in countries like ours, where economic and social circumstances, overwork and lack of institutional resources, in addition to the poverty of our client population make our task particularly challenging.

This is why we need to remember that the nurse has always been seen as a resourceful worker and we need to keep it that way. However, if we fail to inform our practice with the available knowledge and technology, we will make a disservice to our profession and our clients.

7.2 THE FUTURE OF THE NURSE AND PSYCHIATRIC NURSING IN THE 21ST CENTURY

The future of psychiatric nursing is full of challenges. We should implement population-based educational mental health programs to decrease the stigma of mental illness and the impediments that mental health personnel face in providing services to their clients. Therefore, it is necessary to integrate recent developments in science and technology into our practice, education, and research if we want to be successfully prepared for the changes involved in caring for the mental health patient and intervening at the family and community levels.

Due to the projected increase in mental disorders during the 21st Century, psychiatric nursing will confront very important changes that will lead to the design of new programs at three levels of care: community psychiatry, liaison psychiatry, and general psychiatry. In addition, psychiatric nursing will need new programs for training nursing personnel at these three levels of care. Perhaps more than in any other specialty, the development of science and technology will change the way psychiatric nurses think about patient care. Therefore, nursing personnel from other specialties will need to pay more attention to the changes encountered by psychiatric nursing. These changes will require new

thinking concerning nurses' roles as caretakers of patients with emotional, cognitive, and mental problems and in the management of these problems in general hospitals and in other nursing specialties.

A priority task for nursing personnel in the area of psychiatry and mental health is to develop and publish educational material created for nursing personnel and nursing assistants. Finally, the psychiatric nurse in particular needs to renew his/her commitment to listen to the patient and family in order to attend to the non-biological contributions to illness and its manifestation.

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8. EMPOWERMENT FOR THE 21ST CENTURY: SUPPORT FOR THE MENTAL HEALTH OF CHILDREN AND FAMILIES

By Mary Lou De Leon Siantz

Abstract: As the 21st Century approaches numerous social changes continue to challenge the family, in the United States and in Latin America. These societal developments have profoundly affected the integrity of family life and the growth and development of children. Family stress has thus increasingly placed children at risk for mental health problems. At the same time, the mental health care of children has been a low priority in the United States as well as in many parts of Latin America. Children have never been able to speak for themselves, and thus need professionals to empower them. Children remain invisible until they have been described, counted, and publicly addressed. This is particularly true of disenfranchised groups like the poor, those of color, migrant or immigrant, those deemed among the marginal of society.

With the year 2000 so quickly upon us, it is critical that mental health professionals like psychiatric nurses collaborate nationally and globally in partnership with families and their children, regional governments, and local communities, universities and Schools of Nursing to develop in a timely manner, a strategic culturally sensitive interdisciplinary mental health plan that will not only empower these children and families to achieve successful outcomes but prepare the community mental health nurses of the future for the next century. The role of the Pan American Health Organization (PAHO) in this partnership will have to clearly demarcated. Policies, programs, and interventions that assure the mental and physical health of these children must build on longitudinal information about the range of developmental trajectories that these children and their families experience in a variety of world communities and the factors that promote the attainment of their potential in an increasingly global society. The purpose of this paper is to identify the multiple factors that must be considered in the incremental development and evaluation of such a plan in a cost-effective manner.

8.1 SUMMARY

The purpose of this paper has been to identify the multiple factors that must be considered in the incremental development and evaluation of a mental health plan for children and families in a

cost-effective community based manner. The importance of the school in providing mental health intervention among children and the need for early identification was also discussed. One final note concerns preventive intervention.

Nurses interact with children and families in schools, homes, and communities. They are, therefore, in a good position to determine whether the assessment and intervention of a child is needed. They can educate and support parents and children in a variety of settings (Johnson & Baggett, 1995). Above all, they can empower children and their parents to take increasing responsibility for their mental health and emotional development by helping them to understand this very important developmental stage as their social world expands at home, at school, and in their community.

Empowerment supports a child to become a responsible, caring individual who can make sound choices and effectively solve problems (ISDD, 1995). The outcome of empowerment is an independent and competent child. Empowerment occurs by helping a child develop self-esteem, providing feedback that conveys a positive regard for and acceptance of individual ideas and feelings. It communicates respect for the child. It means responding to the child in a nurturing manner so that they can develop their potential.

If we want to understand a child's continuing development through the school age years, it is no longer enough to concentrate on the influence of the family or on socialization practices in the earlier years of life. Social and emotional development is a foundation for relationships that give meaning to life experiences at home, school, and in the community. Important aspects of social and emotional development during this period are the emotional support and secure relationships that engender a child's acquisition of self concept and self esteem, as well as their ability function as a member of a peer group, and achieve in school and later life (National Goals Panel, 1995).

8.2 GLOBAL TRENDS AND CHARACTERISTICS INMIGRATION

8.2.1 Global Migrants

Estimates are that 100 million people are globally on the move today (Meissner, Hormats, Walker, & Ogata, 1993). Migration occurs in three patterns with the majority migrating within their own countries. The next largest group is from countries that share boundaries with less developed countries, and then migrate to them. A relatively small group of migrants are living in countries that

share borders with developed countries and migrate to them (Meissner, Hormats, Walker, & Ogata, 1993). The United Nations Higher Commission for Refugees (UNHCR), the U.N. agency that is responsible for refugee assistance and protection, has estimated that in 1993 there were about 18 million refugees worldwide. In 1980 there was less than 8 million. An additional 24 million have been involuntarily displaced within their own countries in refugee-like situations. They are unable to cross international borders (GCIR, 1994).

Refugees reflect the political successes and failures of the world. When citizens are displaced, it is largely a result of a breakdown in their home government, an external aggressor abusing their countries' citizen, or the government's inability to function (U.S. committee for Refugees, 1993). Because the decision to migrate may be influenced by a combination of economic, social, and political factors, migration should be considered in the context of environmental, developmental, foreign policy, political, security, and human rights issues.

8.3 FACTORS AFFECTING GLOBAL MIGRATION TRENDS

8.3.1 Political

During the last ten years, an overwhelming and unforeseen global trend toward the democratization of political systems has occurred, accompanied by a much greater participation of people in determining their own future. However, in spite of the end of the cold war, tensions between East and West, regional and local conflicts and warfare have continued or developed. The benefits of peace have either not yet emerged or have been used to maintain the peace of these regions. Few, if any, resources have thus been available for human development (WHO, 1995). At the same time, refugees and displaced persons have increased in numbers with multiple health care needs.

8.3.2 Economic

Within the region of the Americas, for example, attempts to integrate and share problem solving approaches have resulted in economic integration pacts and agreements to liberalize trade among nations such as the North American Free Trade Agreement (NAFTA) and the Southern Common Market (MERCOSUR). Another sign of peaceful coexistence has been the emergence of collaborative political initiatives such as the Latin American Parliament (PARLATINO) (WHO, 1995). In 1994, this trend toward cooperation culminated in the

Summit of the Americas in Miami. During this meeting, leaders from 34 countries worked toward integrating their economies, liberalizing trade, strengthening their democratic institutions and improving their general development (WHO, 1995).

However, privatization and decreasing investments in social sectors such as education and health have resulted in increasing inequities in health care delivery, particularly in mental health (PAHO, 1994). Socioeconomic and political changes have, in part, contributed to the mental health problems prevalent in the Region of the Americas, problems with direct impact on children. These problems, include violence, weakening of the family structure, anxiety and depression, effects from political repression and human rights violation, social fragmentation and weakening of social supports, psychosocial suffering among children, youth, and the elderly, substance abuse, chronic mental illness, and unhealthy working and living conditions (PAHO, 1995).

Long term growth in the ability of the world economy to supply goods and services has led to improvements in material standards of living for some of the world's population (WHO, 1995). However, poverty has continued and will continue to be a major world problem. Poverty is the single major determinant of individual, family, and community health. The number of poor people has increased substantially both in the developing world and among the underprivileged groups and communities within developing countries, especially in the slums of the big cities. During the second half of the 1980's, the number of people in the world living in poverty increased, and was estimated at over 1.1 billion in 1990. This is more than one fifth of humanity (WHO, 1995).

8.3.3 Historical

The manner in which contemporary migration to the United States has developed has been the unintended result of American expansion to its post - WWII global prominence. Immigrant communities in the United States today have been related to its history of international military, political, economic, cultural involvement and intervention, particularly in the Asian, Latin American and Caribbean Basin. In the post WWII period, legal immigration to the United States has been associated with family preferences in the allocation of immigrant visas and by kinship networks developed over time, rather than by economic cycles and deliberate recruitment (Jasso and Rosenweig, 1990). This particular family trend has had tremendous implications for children, implications which are addressed later in this session.

At the beginning of the century 67% of all immigrants were men. As of 1941, the majority (55%) of immigrants have been women (INS, 1994). Since 1970 most immigrants legally admitted to permanent residency have come from Asia, Latin America and the Caribbean. The 19.8 million foreign-born persons counted in the 1990 Census, were the largest immigrant populations in the world in absolute terms. In relative terms, only 7.9% of the U.S. population was foreign-born, a lower proportion than at the turn of the century (INS, 1994).

8.3.4 Displacement, Labor, Family Reunification

In the United States, the immigrant of today, reflects a polarity that ranges from the very poor, uneducated manual laborer, to the well off, highly educated professional, a polarity in very different historical and structural contexts than in the past. For example, among political refugees and asylees, admission to the U.S. began with the 1948 Displaced Persons Act. This was the first legal act to officially recognized refugees in United States (Rumbaut, 1995).

A second immigrant group includes the highly skilled professionals, executives and managers, who have entered under employment-based visa preferences as refugees, students, or other temporary statuses (Rumbaut, 1995). Undocumented laborers are the third group whose numbers began to increase after the termination of the Bracero Program in 1964. This program was started to meet the labor shortages in the southwest during WWII but continued during the postwar years of rapid expansion of the U.S. economy. This group continued to increase since the passage of the 1965 law and its amendments of 1976 and 1978 which abolished the national-origins quota system and gave greater priority to family reunification over occupational skills. Until this law was passed, Western Hemisphere immigration had not been restricted (Rumbaut, 1995). With the passage of the 1990 Immigration Act, the immediate relatives of adult citizens can enter without limit.

Changes in the U.S. immigration laws, which abolished the national origin quota system and changed the preference system to give greater priority to family reunification over occupational skills, have been the principal reason for the new immigration and the change in the national origins of its composition. However, these policies have recently changed with stricter laws in place that deter such reunification. For children, the family helps to define their experiences in the U.S., with the family structure and dynamics key to their success (Board on Children and Families, 1995). Until this family reunification law was passed, Western Hemisphere immigration had been unrestricted, largely because of

American agribusiness (Rumbaut, 1995). During WWII, immigrant farm laborers were needed to temporarily replace Americans who had gone to war.

8.4 GLOBAL TRENDS FROM A CHILD'S PERSPECTIVE

Every year, more than 145 million children are born in the world. The short existence of many, is marked by pain, disease, and early death. During the last decade, more than 1.5 million children were killed in wars, and more than 4 million were physically disabled. More than 5 million were forced into refugee camps and more than 12 million lost their homes (UNICEF, 1993). Ten million suffered mental health problems (Organización Panamericana de la Salud, 1995). The famines and deprivation endured in Chad, Ethiopia, Liberia, Mozambique, Somalia, the Sudan, and Uganda were either caused or exacerbated by military conflict. Crops, roads, markets, schools, and clinics were destroyed, with trade and commerce, and the means to earn a living disrupted. Civil liberties were also destroyed (UNICEF, 1993). Thus economic and political factors have provided a strong impetus for global migration.

In spite of all the setbacks that have globally occurred according to UNICEF (1993), more progress has been made in the last 50 years than in the previous 2,000. Since the end of WWII, the average incomes of the developing world have more than doubled. Infant and child death rates have been more than halved. The proportion of the developing world's children starting school has risen to more than three-quarters. Polio has been eradicated (PAHO, 1995). During this same time period, colonialism has been overcome; apartheid brought to the edge of extinction, and the chains of fascism and totalitarianism broken. Within a decade, child malnutrition, preventable disease, and widespread illiteracy could be overcome (UNICEF, 1993). Global political and economic changes in the world are starting to create conditions which offer renewed hope for overcoming the worst aspects of world poverty, especially as they affect the world's children.

8.4.1 Health and Mental Health Status

In the presence of such progress, about 15% of the world's children experienced risk factors of war, social and family violence, trauma, poverty, and exploitation from labor, which negatively affected their growth and development. This number includes about 100 million who were exploited by their work, more than 100 million that were abused, about 50 million who live on the streets and more than 20 million who are refugees or displaced by

war or natural disasters (Organización Panamericana de la Salud, 1995).

Health status worsens over time for many immigrant children and families. Research has documented that on every measure of health status, immigrants who have lived in the United States for five years or less were healthier than foreign-born persons who had lived here 10 or more years (Stephen, Foote, Hendershot, & Schoenborn, 1994). Among Mexican-American mothers, those who are recent immigrants are more likely to give birth to healthy full term infants, experience fewer physical problems during pregnancy, breast feed and for longer periods than their American born Mexican females (Siantz, 1996). Interestingly, for many immigrants health practices exist within the culture that protects mothers. These include insuring appropriate food intake, rest, and support from the family network during pregnancy, labor and delivery. These diminish over time in the United States. U.S. born Mexican-Americans who experience poverty, are more likely over time to develop the diseases of poverty: alcoholism, drug abuse, depression than those who were born in Mexico. In a recent study that aggregated data across all immigrant groups, it was found that on every measure of health status, immigrants who had lived in the United States five years or less were healthier than foreign-born persons who had resided in the United States for at least ten or more years. (Stephen et. al., 1994).

These findings may be due to immigrants arriving with existing physical conditions that are masked during their initial settlement period. They may develop high-risk health behaviors over time such as drinking, smoking, of changes in their lifestyle that increase their risk. On the other hand, because health status is so highly correlated with family income, if it declines over time poor health may be due to socioeconomic factors (Carlin, 1990; Stephan et. al., 1994).

These families are also less likely to have access to a regular source of health care because their work does not provide health insurance or they cannot afford it. Children as a result as they grow and develop will seek health care for acute problems, but not for prevention or early intervention. If a mother has not sought prenatal care, it is unlikely that she will seek well childcare as her child grows and develops.

Immigrant children and families of the United States, face conflicting social and cultural demands while trying to acculturate to a new host country whose hospitality can range from inviting to hostile, unfamiliar, and even discriminatory. Both children and parents must deal with loss, separation, and family disruption in addition to the stress from the migration itself. These events

place enormous stress on individuals for personal change and adaptation. These children and their families must adapt to a new and very different social, cultural, linguistic, and climatic environment (Laosa, 1989). It is easy to understand why both parents and children are at risk for depression from the stress of migration (Esquivel, 1990; Golding and Burnam, 1990).

Migration and acculturation requires children to deal with stress, particularly from loss of familiar surroundings, and significant persons in the child's life (Garcia Coll, 1995). The reaction to loss is affected by their stage of development. During early childhood, emotional support is sought from parents rather than friends who are playmates. Consequently they may more easily leave their friends than they might otherwise late in life (Maccoby, 1983). A young child is more likely to obey their parent's decision to migrate while an adolescent may challenge their parent's decision. Separation from primary caretakers will be more stressful children 6 months to 4 years than an older child. It is during this period that children establish selective attachments and begin to maintain relationships during a period of separation (Garcia-Coll 1995). Cognitive development will also affect grief reactions of children (Rutter, 1983).

While migrants encounter stress, refugees frequently encounter more stress because of the nature of their pre-departure experiences (Rumbaut, 1991). Among Central American refugees exposure to war was the strongest predictor of stress (Leslie, 1993). Refugee children have been overlooked because they cannot speak for themselves, and they are overshadowed by the needs that adult refugees express (Eisenbruch, 1988). Refugee children in particular experience violence, loss, and severe deprivation that place them at risk for Post-Traumatic Stress Disorder (PTSD) (Athey and Ahern, 1991; Rumbaut, 1991). The symptoms and severity of the reaction are associated with the degree of violence, presence or absence of personal injury, age of the child, and access to family support (Athey and Ahearn, 1991; Munroe-Blum, Boyle, Offord, and Kates, 1989). Children who remain with their biological family have lesser signs of psychological disturbance because of the stronger bonds that develop from the crisis the entire family shared Ressler, Boothby, and Steinbock, 1988).

8.4.2 Acculturation

The process of acculturation requires that an immigrant child integrate the culture of their parents and into the mainstream culture in which he or she lives. It has been reported that immigrant parents expect their children to become bicultural and bilingual. They are expect to not only maintain their cultural

heritage and native language but also adopt strategies that will make them successful and accepted by their host country (Lambert and Taylor, 1990). One of the major difficulties in accepting two cultures is the transgenerational-transcultural conflict it causes. As children are encouraged to succeed, they become alienated from the culture of their homeland. The normal generational conflict that parents and children experience is exacerbated when socialization occurs in different cultures leading to parent-child conflicts (Cropley, 1983).

8.4.3 Bi-culturalism

While immigrant children in the past have been considered torn between two worlds, a more recent concept of bi-culturalism has emphasized the ability to persons can effectively function in two or more cultures without negative effects (Ogbu, 1994). What this means is that children can live in two cultures by becoming competent in the cultural beliefs and values of both cultures, developing positive attitudes about them, and effective relationships within them, along with communications skills, a range of culturally acceptable behaviors, and a sense of acceptance in both cultures (LaFromboise, Coleman, & Gerton, 1993).

8.4.4 Ethnic Identity

Migration has an impact on a child's social and ethnic identity development, particularly during adolescence as he or she develops in a context that might be racially and culturally different from the host culture (Garcia Coll, 1995). Historically, ethnic identity has often been defined as ethnic labeling. More recently it has been suggested that it has several dimensions: self-categorization, knowledge, attitudes, and feelings, as well as behaviors related to one's culture (Bernal et al, 1990; Rosenthal & Hrynevich, 1985). Ethnic minority children learn about their ethnicity and ethnic group memberships through social learning experiences provided by families and communities, as well as the dominant society. As they develop, particularly cognitively, they learn more complex information and integrate past learning with present learning (Bernal et al, 1990).

Language in particular has been linked with the formation and maintenance of an ethnic identity. Those who speak English are more likely to identify as American. On the other hand, those who are fluent in their national language are more likely to select a national identity. Those who are bilingual are more likely to select hyphenated identities (Mexican-American; Chinese-American) (Rumbaut, 1995).

8.4.5 Impact of Parenting

Immigrant children are part of a family and cannot be considered in isolation. Family structure, dynamics, parental mental health and behavior have a direct impact on a child's well being (Board on Children & Families, 1995). There is a long history of research on the negative impact of difficult life circumstances on family life. For example, stressful conditions such as poverty, large families, crowded living conditions, and unemployment are related to hostile and rejecting maternal behaviors, maternal depression, and a poor prognosis for a child's development (McLoyd & Wilson, 1991).

Conversely, parenting behavior that is sensitive to a child's personality, capabilities, and to the developmental tasks they face encourages a variety of highly valued developmental outcomes which include social competence, intellectual achievement, and emotional security (Baldwin & Cole, 1982; Belsky, 1984; Rutter, 1990). During the preschool years, high levels of parental nurture and control encourage the ability to engage peers and adults in a friendly and cooperative manner (Baumrind, 1971; Belsky, 1984; Garmezy, 1990; Luthar & Zigler, 1991). This trend continues through the school years with parental use of induction or reasoning, consistent discipline, and expressions or warmth (McCall, Applebaum, & Hagarty, 1973; Garmezy, 1990).

An example of research on the Mexican-American migrant farm worker child and family has underlined the importance of parental social support for a child's peer acceptance and school behavior (Siantz, 1994). Migrant fathers and mothers had different sources of social support within and outside the family. Fathers in particular sought support outside the home. Mothers and teachers had different views of the child's behavior, which may be due to differences in behavior that the child exhibited at home and at school. Feeling overlooked at home the child may misbehave to seek maternal attention. On the other hand, he/she may behave in school out of respect for the teacher and to comply with rules. Such behavior is expected by traditional Mexican families of their children when outside the home. The research findings further suggested the importance of identifying mothers and fathers who are isolated or lacks access to spouse, partner, family, and friends. The problem in access to these individuals along with the consequent isolation could have deleterious effects on their children's behavior at home and achievement at school (Siantz, 1994).

8.4.6 Stress and Resilience

When faced with life stresses, many children develop behavioral and psychological problems. Illness, the birth of a new sibling, divorce, moving, migration, frustration, and temporary absences of parents are common sources of stress. Yet, there are children who survive war, homelessness, earthquakes, and chronic poverty. These children are able overcome enormous stress in their lives and bounce back from circumstances that would blight the emotional development of most children.

The phenomenon of maintaining adaptive functioning in the presence of stress has been termed “resilience,” (Garmezy, 1991). Frequently, children who develop disorders have suffered an accumulation of greater stressors experienced over longer periods of time. Children who have been exposed only one of a number of stressors are often able overcome the stress. However, when two or more of these factors are present, the children’s risk of developing an emotional disturbance goes up fourfold or more (Rutter, 1987). When children are not overwhelmed on all sides, they can often cope with adverse circumstances.

Research has identified “protective factors” that may operate reduce the effects of such stressors (Garmezy, 1983: Rutter, 1987). Protective factors that contribute a child’s resilience include: a child’s personality, problem-solving ability, available social support, compensating experiences. Children who are friendly, sensitive other people, are independent and have high self esteem are better able cope with changing circumstances. Resilient children are likely to have a good relationship with supportive parents or have a close relationship with at least one significant adult. This significant relationship as well as a supportive school environment and successful experiences in school can help make up for a dismal home life (Garmezy, 1991; Garmezy, 1983).

Figure 1 presents an analytic model of the joint influences hypothesized to predict child outcomes. It is a model that I have applied in my research with Mexican-American migrant farm worker children and their families. It is not meant to be all inclusive, but rather provide a framework for the consideration of the joint influences that impact child outcomes. Represented within this figure are the key concepts of resilience theory: risk and protective factors, and child outcomes. Much of what has been presented can fit under these categories. The model builds on Garmezy's (1985) and Laosa's framework (1990) on stress and resilience and has been extended to include concepts relevant to successful outcomes among immigrant and migrant children. In this model, differences in environmental, family stress (risk factors),

parent and child characteristics (protective factors) are expected to influence child outcomes (adaptation or maladjustment). It emphasizes the joint importance of both parent and child characteristics on child outcomes. For an immigrant child, positive outcomes resulting from migration need to be highlighted. For example, research has identified the positive academic benefits that result from speaking two languages. This is largely due to a larger part of the brain being used in the process.

The concept of risk implies the identification of biological, psychological, social, and environmental factors that increase the probability of negative outcomes for children (Garmezy and Masten, 1990). Protective factors are presumed to inhibit the expression of negative child outcomes. They are those attributes of persons, environment, and events that appear to ameliorate predictions of poor adaptation based upon an individual's risk status (Rutter, 1990). Far less is known about these factors than about risk factors, especially among immigrant children. Factors that have been found to protect children include: (a) child characteristics of problem solving ability, temperament, perceived social competence, health status; (b) family cohesion, and (c) the availability and use of external support systems by both parents and children.

Why do some immigrant successfully adapt to their new environment, in spite of unusually challenging circumstances, excelling beyond the academic and social norms of U.S. natives, while others do not adapt positively? Among Hispanics, the prevalence of educational and mental health problems rises as a function of length of time in the U.S. (Baral, 1979; Borjas & Tienda, 1985; Canino, Earley, & Rogler, 1980; Valdez, 1986). Evidence suggests that Hispanic widely vary in their coping strategies, adjustment, development, and adaptation (Laosa, 1990; London, 1990). Their vulnerability to the events and processes associated with their immigration and settlement experiences also varies.

Increasingly, research has identified the importance of focusing on competence and positive child outcomes instead of on maladjustment in the presence of risk. In addition, immigrant children need to be studied in their own right disregarding the view that a "control" group is needed for adequate interpretation.

Nurses who work with at risk children need to assess the accumulation of risk factors they experience and identify the protective factors that are present in order to determine the level of vulnerability that exists. Intervention should be developed that will decrease risk, support and increase protective factors, and prevent potential problems from occurring. It is important to

realize that in general, children with stressful backgrounds are likelier to develop mental health problems. Just as support services help facilitate the lives of many parents, such services can also help children cope with some of the difficult realties of their lives. Early recognition and support of factors that promote positive outcomes for children undergoing stress are important areas of assessment and intervention.

8.4.7 Need for Prevention among Children

A clear need for prevention currently exists. Prevention is a multidisciplinary science that builds on basic and applied research from many disciplines that includes psychology, education, medicine, public health, nursing, sociology, economics, health education, communications, and criminal justice. Three types of prevention are differentiated based on the timing and basic goal of the intervention. Primary prevention involves interventions for normal populations in order to prevent the occurrence of problems. Children who participate in primary prevention programs function within the normal range. The goal is to intervene in order to prevent future problems. On the other hand, secondary prevention involves early intervention for those with sub-clinical problems to prevent the development of more serious dysfunction. Tertiary prevention occurs with those with identified problems to reduce the duration and negative consequences of existing disorders.

In 1994 the Institute of Medicine proposed new terminology for the prevention of mental disorders. The Institute suggested that only interventions developed to prevent the onset of new disorders should be considered preventive, discarding the tertiary prevention term. Distinctions should be made between universal preventive interventions and selective ones. According to Durlak (1997), primary prevention can be split into six categories based on the three major ways that populations are selected for intervention.

First, a universal approach targets all available children in a population, for example: children in high school, all high school freshmen. Another approach is the risk or high-risk approach, which targets populations that are at risk for eventual problems, but do not yet exhibit any problems. Examples include children of depressed or substance abusing parents who are at risk for a variety of forms of maladjustment. A primary prevention approach would target these children for intervention. Third, in a transitional approach, children about to experience a particular life transition or stressful life event are targeted for intervention. Since some transitions or life events like immigration or migration, can have negative effects the intervention assists these children to master or negotiate the

transitions or events successfully. Children whose parents are divorcing, or who are changing school would also be candidates for a primary prevention program.

The two major levels of intervention in primary prevention are person-centered and environment-centered programs, that is individual vs. ecological or systems level interventions. Person centered programs attempt to change individuals directly without attempting any major environmental change, whereas environmental programs attempt to influence children indirectly by modifying their environment. Environmental interventions usually focus on the social environment, such as interactions occurring between children and their peers, teachers, or family members.

Four levels of environmental intervention are possible: (1) familial, (2) interpersonal, beyond familial, including teachers and peers, (3) organizational including the classroom or school, (4) the community. Person centered interventions need to identify which individual characteristics are important to adjustment. Should the intervention target knowledge, attitudes, perceptions, specific behaviors, or all of these? A risk-approach needs reliable and valid methods of identifying risk status. How can we tell who is at risk? Those conducting environmental interventions must establish how to identify measure, and modify environmental features at different levels of intervention. Which aspects of family functioning, peer influence, and organizational and community life are most important, and how can they be changed? Transition programs have their own unique questions. Which events have important implications for adjustment and maladjustment? How does the transition process influence development? How can children be helped to negotiate stress and transition effectively? Research is needed concerning all of these questions (Durlak, 1977).

8.5 COMMUNITY SCHOOL BASED PREVENTION PROGRAMS FOR CHILDREN AND ADOLESCENTS

8.5.1 Issues in Intervention

The impact of the family and the school to successful mental health interventions for school age children cannot be overstated. The significance of the family to the development of a well-adjusted child has long been recognized in developmental research and practice. While nursing intervention with children has traditionally recognized the importance of family intervention and parent teaching, nursing models have traditionally focused on the individual patient, not the family system (Bishop, 1988). At times

nursing models have even overlooked the family's critical role in prevention, early intervention and successful outcomes.

Ideally, a school age child's mental health and psychological development is strengthened if a child is a member of a healthy family system, as has been previously discussed. Building on this assumption, nurses do not need to limit their activities to engaging the family to support or assisting their developing middle year's child. Nursing interventions that target mental health, should enhance the capacities of the entire family by nurturing and promoting positive development in all of its members. By strengthening the autonomy and competence of families, nurses will have established a solid foundation on which to plan programs that promote the mental health and well-being of school age children (Bishop, 1988). In this capacity, a nurse fulfills a dual responsibility, to the child and to the family.

Schools also provide an additional setting for nurses to promote mental health and early intervention. Children enter school at about five years of age. Prior to this age, parents and home have a major role in early development. Once a child begins school, they spend a large number of their waking hours there, for a number of years. It becomes a major influence in a child's cognitive and social development.

The school is often viewed as a helping institution that promotes a child's healthy growth and development. Parents frequently work in partnership with school personnel to guide their child's development during the school day. Many mental health problems are exhibited in the school. Identification and early intervention with children who exhibit symptoms of emotional or behavioral problems can have many benefits. A child's competence and confidence as a learner and person of worth may increase with their mental health status. Children who feel competent are less likely to feel frustrated and need to act out their distress (Opie & Slater, 1988). Ultimately, the children's mental health in the school needs to be addressed as aggressively as their physical health.

Early identification and intervention will greatly reduce the long-term effects of mental health problems. Children who are treated before their problems become severe are likelier to become well-adjusted adolescents and productive adults. School nurses are in a strategic position to provide prevention and early identification, especially if they have additional preparation in mental health, or collaborate with mental health professionals. School nurses are well known, respected and trusted by all who work with them (parents, children, school personnel). They have a dual advocacy role: for the child and for the family (Siantz, 1988).

8.5.2 Culturally Competence

The health care system of the United States has primarily served the majority population, with limited resources to meet the needs of persons that are poor, experience different illnesses, cultural practices, diets, or languages. The paucity of providers and programs that serve the primary and preventive health care needs of low-income populations has decreased available resources to Hispanics. While all poor families experience a shortage of available resources, the experience among Hispanic families has been further magnified by their linguistic and cultural needs (Lewin/ICF, 1991).

Bilingual ability by itself, however, is not enough to assure good and efficient care. Cultural sensitivity and a familiarity with the patient's culture are considered a crucial element. Health care providers who cannot establish a trusting rapport with patients due to their inability to communicate on a personal level experience less compliance with health care regimens among their patients. The social and cultural problems of miscommunication, misinformation, misunderstanding, and mistrust in the relationship between health care providers and clients only compound the barriers. (Rumbaut, Chavez, Moser, Pickwell, & Wishik, 1988). However, language nuances are lost to providers who are not multicultural. Researchers have found that establishing an open channel of communication requires sensitivity to Hispanic culture, in addition to establishing partnerships with patients in deciding how to best achieve improvement in their health (Pinderhuges, 1989). Research Partnerships with Latin American psychiatric nurses have the potential of helping us to understand, identify and evaluate culturally sensitive nursing interventions, and ways to prepare psychiatric nurses of the 21st century to be culturally competent.

8.5.3 Culturally Competent Health Care

Culturally competent health care involves systems, agencies, and health care providers, which value their ability to respond to the unique needs of populations whose cultures are different from their own. (Isaacs & Benjamin, 1991). Culture connotes an integrated pattern of human behavior, which includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. Competence, on the other hand, implies a capacity to function within the context of a culture's integrated patterns of behavior as defined by a group. Together, cultural competence facilitates the development of a congruent set behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or

professional to effectively operate in a cross cultural situation (Cross, Bazron, Dennis, & Isaacs, 1989). Cultural competence demonstrates honor and respect for the human dignity, beliefs, interpersonal styles, attitudes, and behaviors of all persons, thus the principle of personhood is an important one to apply. It should also be reflected in organizational policies, administration, training, and service.

Five essential elements have been found to contribute to a system's institution, or agency's ability to become more culturally competent. These are: (a) valuing cultural diversity; (b) the capacity for cultural self-assessment; (c) consciousness of the dynamics inherent when cultures interact; (d) institutionalized cultural knowledge, and (e) adaptations to service delivery that reflect an understanding of cultural diversity (Cross, Bazron, Dennis, & Isaacs, 1989). These five elements should be reflected at every level of an organization's policy making, administration, and practice activities, including attitudes and structures.

8.5.3.1 Valuing Cultural Diversity

Persons, who value cultural diversity, respect its worth and integrate such values into the policies, programs, and services that are being developed (Isaacs & Benjamin, 1991). Individuals within a community all share basic needs, although they will differ according to their specific needs and the types of environment that support growth.

8.5.3.2 Cultural Self assessment

Health Care Organizations must not only assess themselves but also develop a sense of their own culture in order to understand how their system interfaces with other cultures. Courses of action that minimize cross-cultural barriers can then be identified (Cross & Benjamin, 1989).

8.5.3.3 Cultural Interaction

Without an understanding of cross-cultural dynamics, misinterpretation and misjudgment can occur. By understanding these dynamics the cross-cultural communication is more likely to occur (Lynch & Hanson, 1992).

8.5.3.4 Cultural Knowledge

Organizations that serve persons of color with a chronic condition or a disability, or who are at risk for a disability,

must incorporate cultural knowledge into their model of service delivery. Every level of a system needs accurate information or access to it. Mechanisms must be developed within the system to achieve the knowledge it needs (Cross & Benjamin, 1989).

8.5.3.5 Cultural Adaptation

As a system providing policy, programs, or projects for persons with a disability from diverse cultures and their families develops its cultural competence, it will adapt its approach to institutionalize cultural inclusion as a legitimate approach.

8.5.4 The Role of the Pan American Health Organization

The role of PAHO in the initiation, design, and implementation of a preventive mental health program for children and their families should include advocacy, technical cooperation, and administrative and managerial support. Its role in the strategic planning of community health nursing research and intervention in the Southern Cone is an example of such support.

In its advocacy role, PAHO can support community mental health that is culturally competent and makes full use of community resources, including the family, community leaders, and local health and psychiatric nurses. In addition, appropriate cost effective technologies and interventions should also be supported by continuing to provide leadership in coordinating regional meetings of nurse educators, practitioners, and researchers to develop collaborative plans for new and innovative approaches in mental health. Program development should be seen as a transient time limited investment. Through meetings such as the present one, it is increasingly clear that PAHO supports the conceptual formulation of a strategic community mental health plan and has already identified sources of technical cooperation. However, support is also needed for administrative and managerial support, plan objectives, and strategies for implementation, and evaluation that include working toward the identification of a broader base of support for programmatic efforts.

9. INDIGENOUS HEALING: A HELP OR HINDRANCE IN MAINTAINING MENTAL HEALTH

By Cheryl M. Killion

ABSTRACT

This paper discusses the impact of indigenous health traditions and practices on mental health with specific focus on the country of Belize, Central America. A case study is used to introduce and emphasize the significant role of indigenous healing in the community. Five themes are derived from the case study and discussed:

1) the sharing of healing traditions across ethnic boundaries;

2) the complementarity of indigenous and conventional methods of healing;

3) the primacy of traditional health beliefs and strategies of healing;

4) the linkage of culture, ecology, health and healing, and

5) parallel and integrated systems.

The role of the nurse, in effectively using indigenous healing strategies and traditional healers as valuable resources in the community, is highlighted. Limitations and precautions are also considered.

Although the hegemony of westernized, scientific, conventional medicine is apparent worldwide, the World Health Organization asserts that eighty-eight percent of peoples living in developing countries use traditional or indigenous healing methods as their primary source of health care (Pillsbury, 1982). This pattern is related to access to health care but is often based primarily on the choices of individuals and their families. In this paper the impact of indigenous health traditions on mental health will be discussed. Focus will be on the country of Belize, Central America.

The current status of Belize and its social, political and economic history generally parallels, but is quite distinct from that of other Caribbean countries. Belize is situated on the eastern coast of Central America. It is divided into six districts, and occupies territory slightly larger than the state of

Massachusetts (Brenner, 1990). Belize is the most sparsely populated country in Central America yet its people and topography are quite diverse. The coastline is bordered by one of the largest barrier reefs in the world. Swamps, numerous lagoons and rivers punctuate the northern low-lying plain and forests cover a major portion of the plateau farther inland. The Maya Mountains are to the south and west. Belize has been plagued by a series of hurricanes and their devastating effects have significantly influenced the country's economic development (Bolland, 1988).

Several ethnic groups coexist in the country of Belize. Most are descendants of slaves and indentured servants who were transplanted from Africa and other continents to supply labor for the earlier development of the region. A dearth of mental health services exists for this multi cultural population and few health professionals are available to meet their mental health needs. There is evidence however, that traditional health practices are widely used (Killion, 1990).

The following scenario, derived from an informal interview that took place a few years ago with the husband of a distraught, Mestizo woman in Cayo District of Belize, Central America, is one example of indigenous health traditions of the region.

Elsa, a 52-year-old woman had tried to commit suicide for the third time in the last two years. She quarreled often with her husband and accused him of not being a good provider despite the fact that he had a good paying job as a foreman at a local lumber mill. Elsa complained bitterly about their never having enough money and sold odds and ends to supplement what she considered to be her husband's meager income. Although the couple lived in a spacious home, she complained of being crowded and not having enough furniture. With the exception of their soon to be launched eighteen year old son, the couple's other children were grown and lived on their own. Elsa also experienced transient poor vision, and she had a number of other somatic complaints. Everyone in the community knew about Elsa and her problem. She and her husband often fought in public and almost everyone was aware of the suicide attempts. The husband was desperately searching for a permanent "cure for his wife."

Elsa was able to recover from episodes of illness with what seemed to be the help of the local nurse. When Elsa was the most agitated or in the most pain, the nurse administered "live water". In other words, she started intravenous fluids on Elsa. After the intravenous infusion, Elsa's condition improved remarkably. The nurse also prescribed a bottle of tonic, a vitamin B complex solution, which she obtained from the pharmacy in Belize City.

These prescriptions were temporarily effective in relieving Elsa's symptoms.

The essence of this case was that a curse had been put on Elsa by an obeah man. Elsa had meddled in the marital affairs of her brother-in-law and had caused serious problems in his household. As a consequence the brother-in-law consulted an obeah man. The obeah man brought forth the following to Elsa: A piece of paper, a coin, and a "tin" of dirt from the graveyard. According to the obeah man, the coin was an indication that Elsa would always have financial problems. The piece of paper symbolized the notion that there would always be conflict and dissension in Elsa's life. The dirt from the graveyard represented death (Killion, 1986).

This brief case history brings to light the nexus of health and culture in this particular setting. It gives focus to a key, yet understated element in the healing systems of Belize: folk beliefs and the practice of traditional healing. Several themes emerge from the scenario that has relevance for understanding the interaction of culture and mental health.

1) Sharing of Healing Traditions Across Ethnic Boundaries

Obeah, a practice derived from West Africa, is akin to voodoo and witchcraft and was retained among the African slaves when they arrived on this continent. Essentially, obeah is a magical means that allows an individual to: obtain his/her personal desires; eradicate ill health; procure good fortune in life and business; gain the affection of an individual or cause one individual to "fall in love" with another, even against his or her wishes; evince retribution or revenge upon ones enemies, and generally manipulate the spiritual forces of the cosmos in order to obtain ones own will (Morrish, 1982; Richardson, 1993). The power of obeah was so strong during slavery, that it sustained many slaves when they faced incredible odds. Slaves were made to feel invincible and they often were successful in revolts and incursions against slave masters because of their use of obeah (Richardson, 1993). The practice of obeah was outlawed nearly a century ago because it was so powerful. Remnants of obeah are practiced today, however, though the practice is rarely discussed openly (Morrish, 1982). Ethnic groups other than those of African descent make use of and are effected by obeah, as well.

This sharing or borrowing of health traditions is an important phenomenon because Belize is multiethnic and comprised of Creoles, Mestizos, Mayan, Garifuna, Asian, Mennonites and a small number of other groups including East Indian, Pakistanis, and Lebanese. Because of historic/political reasons, different ethnic groups have settled in particular areas of the country. Generally speaking, a

major ethnic group is concentrated in each of the six districts of the country. Moreover, the Creole and Garifuna have had a proclivity for residing in urban areas and the Mestizos and Mayan are more likely to live in rural areas. This pattern reflects cultural isolation, autonomous development and the identification of specific groups with predominant economic activities (Woods et al, 1996).

Belize has experienced the reverse of what usually occurs when a country is becoming more developed. During the last few decades, a major shift of Belize's population from a predominately urban pattern to a more rural orientation, has taken place (Woods et al, 1996). This redistribution has been associated with international population migration flows that have changed the ethnic mix of the country's population, as well as its spatial distribution. A mass exodus of Creoles, those of African/European descent particularly to the United States, has occurred (Payne, 1990). Concurrently, an influx of immigrants from neighboring countries such as Guatemala and El Salvador has increased. The country of Belize has increasing become latinized. Currently, the largest ethnic group is Mestizo (42.6%) and Creoles constitute the second largest (29.8%) group (Ergood, 1996). The two ethnic groups have reversed positions as far as numerical dominance. These population shifts have created an increased need to formulate creative approaches for dispensing services (including health care) through the country. Moreover, with the alterations in demographics, conflicts between groups have sharpened.

Despite these patterns, each ethnic group has retained distinct traditions of healing yet insidiously has merged and adopted select aspects of other group's healing lores and practices (Pedersen & Baruffati, 1985). These distinct and blended traditions have also been combined, in some instances, with conventional medicine.

2) The Complementarity of Indigenous and Conventional Methods of Healing

Elsa's case demonstrates how elements of conventional medicine were used effectively to treat what probably was an indigenously induced illness or culture-bound illness. While traditional healing is most effective in treating this type of illness, the nurse was able to ingeniously combine strategies that were operable (Kale, 1995; Pedersen & Baruffati, 1985). The nurse's knowledge of Elsa's history and condition, the couple's situation, and the healing resources in the community added to her credibility and enhanced her ability to devise a plan of care. It also helped that the nurse was well known and respected by members of the community and had delivered most of the children in the area. Use of culturally specific interventions, in this case, promoted the healing of an

indigenously induced condition. (Although based on the principles of obeah, a reversal of the curse by the obeah man may have been necessary for a complete cure) (Moorish, 1982). Indigenous healing may be effective in instances when conventional medicine does not work or it may be used to enhance the effects of conventional medicine. Members of the community independently use both paradigms of healing in order to meet their needs.

Decision making regarding health is based on several factors. The most critical of these relates to the perceived cause of a problem or symptoms. The question of the possible cause of symptoms often dictates not only what is deemed socially and culturally appropriate but also what type of healer is to be consulted. If a traditional healer is to be sought, selecting the particular type of healer to remedy a symptom or constellation of symptoms is necessary. When symptoms occur that suggest that an individual may be mentally ill, healers may be sought secretly to avoid the stigma that is pervasively expressed. Finally, sources of healing may be selected based on availability and the extent to which an individual or family may or may not be able to afford the service. While a range of health care alternatives is available in Belize, conventional methods to deal with mental illness are extremely limited. Usually citizens informally, yet strategically, select what is available. Therefore citizens supplement conventional methods with indigenous strategies that are more accessible to them.

3) The Primacy of Traditional Health Beliefs Strategies of Healing

The primacy of traditional health beliefs and strategies of healing was emphasized in the scenario. Many of the traditional health practices are designed to preserve cultural institutions and to help the individual live at peace with her/his family, community, tribe and inner self. The belief systems are primarily aimed at maintaining personal relationships, solidifying community relationships and enhancing the interaction between the individual's soul and the cosmos (Anyinam, 1995).

The retention of culture is particularly relevant in Belize because of the country's legacy of colonialism. Belize, a Crown colony since 1871, gained full independence in 1981 (Fernandez, 1989). Belize, like many other countries in the Caribbean, has a plantation economy. This system, the most salient historical manifestation of European imperial - capitalist presence, evolved roughly from the slave plantation, through indenture plantation cum multinational corporation (Beckford, 1982). The plantation economy is not merely an economic organization. Rather it represents a way of life that has dominated and still strongly influences the economic, political, social and cultural structures and processes

of Caribbean formations. The system has perpetuated persistent poverty and eroded the cultural life styles of all the people who were brought to the area as a source of labor (Bolland, 1988; Beckford, 1972).

Adherence to folk traditions such as obeah, serves as an important means of reinforcing some aspects of culture and retaining some semblance of control over ones life (Kapur, 1979). Even when conventional methods are available, many continue to resort to traditional sources of care. Given the demographic shifts in Belize, folk traditions also afford a degree of stability as group identities are being transformed (Pedersen & Baruffati, 1985).

4) The Linkage of Culture, Ecology, Health and Healing

While indigenous/traditional customs and ways of healing are being retained, the foundations from which they have evolved and their bases for operating are being eroded and exploited. The links between indigenous healing traditions and ecology are exemplified by a long tradition of healing powers associated with the earth's natural systems which include medicinal plants, animals and other elements in the environment. Both ecology and culture evolve and change and each produces alterations in the other. Healers use various forms of herbs, roots, leaves, bark, mammals and birds in the preparation of preventive, curative and protective medicine. In Belize and throughout Central America and the Caribbean, for example, rue which is an herb found in many gardens, is used as a treatment for all spiritual diseases when combined with zorillo. Skunk's root, bark of a vine, is taken as tea to ward off evil eye, evil spirits, black magic and envy. And capal incense, which is sacred to the Mayan people, is used to treat spiritual disease and to ward off evil spirits, fright, evil eye or black magic (Arvigo, 1994). Also, a range of plants and some wild animals are used to perform rituals, as an integral part of religious and cultural ceremonies. They may also be used to invoke and appease gods and witches and to secure immunity from bad luck, disease and enemies (Arvigo, 1994; Anyinam, 1995). Indigenous people who strongly adhere to traditional health beliefs often assign sanctity to certain portions of their natural landscape and regard them as worthy of devotion, loyalty, and worship. There is a kind of intuitive rapport, which has been established between indigenous folk and their natural landscape. According to many, God is embodied in the natural habitat (Anyinam, 1995). The integrity, diversity, and productively of natural systems have been damaged over the years, however.

Historically, the most important of Belize's natural resources have been its forests. Nearly ninety percent of the land is covered

by rainforests or pine forests. Agricultural, lumbering, and mining activities have significantly contributed to habitat loss in Belize as well as other countries in the region. Deforestation, in particular, has had tremendous ramifications for indigenous healing strategies (Anyinam, 1995). Transformation of local ecosystems, which have come about as a result of economic interests, has created severe constraints on the availability and accessibility of specific types of plants and animal species used for medicinal purposes. Degradation and destruction of the natural systems also pose a threat to sacred sites and spaces designated by local healers (Anyinam, 1995). Despite attempts to thwart these disturbing trends, usual, natural ways of healing continue to be tampered with (Arvigo, 1994). Means of staying mentally well are being destroyed without adequate alternatives being in place.

5) Parallel or Integrated Systems

The extent, to which folk or indigenous healing is incorporated into conventional medicine, parallels or is blended with it, varies from community to communities and culture to culture. The pros and cons of both arrangements have been widely debated but limited research has been conducted to investigate it more fully. Key questions have to do with cost, efficacy, safety, desired outcomes, and professional boundaries. With regard to cost, most traditional healers are compensated for their services directly from individuals or families who seek their help. According to some analysts, if traditional healers were incorporated or blended into conventional, medical practices, exploitation of the traditional healers would be likely. The traditional healers may become recolonized. In this arrangement the effective healing strategies of the traditional healer may be taken over by “professionals” and traditional healers would have to make significant adjustments in order to operate in an unfamiliar paradigm (Kale, 1995; Freeman, 1992). Timing and triaging are also crucial. It has been documented that in some cases, conditions have worsened because traditional healers were sought first for illnesses that should only have been dealt with through conventional means. Delays in treatment or effective treatment have sometimes been devastating (Jeffrey, 1982). Mutual referrals and agreements about “scope of practice” could rectify this, however, as desired outcomes and professional boundaries are considered.

The goals of the two paradigms are distinct. The scientific, westernized version of healing is to identify and treat symptoms (Newmann & Lauro, 1982). In contrast, traditional, indigenous healing is concerned with uncovering why a person was stricken in the first place (Airhihenbuwa & Harrison, 1993). The two approaches are not necessarily incongruent and can yield the same or different outcomes. In Elsa’s case, the nurse used conventional means to deal

with Elsa's problem. Her therapeutics, however, were primarily based upon her understanding of the context of the situation. While in some instances the overlapping of roles and strategies may be problematic, in this case the strategies used were effective and the outcome was positive.

9.1 IMPLICATIONS FOR NURSING

This paper considered some of the dimensions of indigenous healing, particularly those elements related to mental health. Focus was on the country of Belize, although much of the discussion may be applicable to other settings. Nurses, armed with a scientifically based practice that focuses on human responses to illness, are in a pivotal position to guide and support individuals and their families in their use of health care options in a pluralistic health care system. In some areas where indigenous healing predominates, nurses align themselves with traditional healers, share knowledge and skills and make referrals to one another and to other healers and health professionals (Nzimakwe, 1996). Usually nurses have a thorough knowledge of the communities for which they provide care and often know the patients and their families personally. Forming alliances with traditional healers may be one effective way to help meet the mental health needs of various communities in Belize. Despite the benefit, however, care should be taken not to romanticize this mode of healing. Other options need to be developed, accepted and made available. Both conventional and traditional modes of healing are needed for holistic care to take place.

Other significant elements need attention, as well, to ensure that comprehensive mental health services are rendered. Some clarity is needed as to how the lay and professional communities in Belize perceive and define mental illness. The extent to which Western psychiatric categories of mental illness (ethic) are used to identify symptoms and guide treatment is now known (Rappaport & Rappaport, 1981; Patel et al, 1995). While many diagnostic labels are shared cross-culturally, there are wide variations in the manifestations of specific disorders (Abas et al, 1994; Patel et al 1995). Moreover, there are a number of culture-bound mental illnesses. The evaluation of the dimensions of mental illness through understanding the context in which it occurs is critical for designing approaches to care. Societal factors must be considered that affect the mental health status of Belizian citizens. These factors include but are not limited to the pervasive, persistent poverty, the continued legacy of colonialism, the impact of immigration with the concomitant transformation of

ethnic groups and their relationships to one another; and the interaction of culture, health and the ecology.

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10. POST-BASIC EDUCATION IN PSYCHIATRIC NURSING: A NON TRADITIONAL METHODOLOGY

By Marga Simon Coler

This paper describes a methodology used by an international team of ten experts in mental-health nursing in the development of three generic post-basic educational modules to address problems common to all of the nine represented countries. These modules were developed according to a paradigm and framework developed by the group and have been adapted to fit the post-basic educational needs and culture of each country. The results of the pilot programs will be evaluated for revision of the modules. Information regarding the project has been disseminated via literature, presentations and conferences. There have been requests from psychiatric nurses in two other countries to participate in this pilot project. The project is non traditional in that the generic modules were developed by experts in psychiatric nursing from nine countries and adapted to different levels of post-basic education to meet the educational and cultural needs of qualified, practicing nurses globally.

Non traditional education in nursing is all but unthinkable in this decade of accountability to regulating bodies, to professional organizations, to advocacy groups, to colleagues within the profession and those on the interdisciplinary team, and to, of course, the client. Often the era of strict accountability leaves little room for creativity in building something to meet the actual needs of clients without restrictions.

This project, the development of three non traditional, graduate curriculum modules which would be pilot-tested internationally, had its origin at a meeting of the International Committee of the Society of Education and Research in Psychiatric Nursing (SERPN). As Chair of the committee, I recommended that the committee endorse my writing of a grant proposal to the Rockefeller Foundation to convene an international team of leaders in psychiatric nursing in a team residency to share models of psychiatric nurse education and practice toward a goal of developing pilot educational modules at the graduate level. (The purpose was justified a year later, when I received two reports released by the Pan American Health Organization [PAHO] about the state of psychiatric/mental health nursing in “countries of the Southern Cone” [PAHO, 1995], and, the status of mental health services in the same geographic region [PAHO, 1995]).

The SERPN International Committee enthusiastically endorsed the concept, and began to compose a list of potential candidates. I wrote the proposal, which was revised with committee input during the following year. At the following meeting (1995), the proposal was again revised since the composition of the committee had changed, and, subsequently, another draft was sent to the new committee members for final revisions. Letters with copies of the proposal were sent to potential candidates to inquire if they would be interested in attending the 10-day residency (if the proposal were approved) at the Bellagio Study and Conference Center of the Rockefeller Foundation. All responses were affirmative. After endorsement from the SERPN Governing Board another year later, I submitted the final draft of the proposal, with a list of the potential candidates (representing nine countries) to the Rockefeller Foundation.

The proposal was approved by the Bellagio Center Committee and the potential team members were notified. After a few changes, the ten member team received the list of attendees accompanied by a list of materials for them to bring (Copies of articles, brochure, in English describing psychiatric nursing practice in the country they represented: Argentina, Australia, Brazil, Chile, The Netherlands, Spain, Sweden, Turkey and the United States [a representative selected by the SERPN Board]).

The team met in May 1997 at the Bellagio Center, beginning with an orientation program on the night of arrival. The next day the team began its Herculean task of moving, within a 10-day period, from the presentation of the status of nursing service and education in each country to the development of three generic post-basic educational modules which would be pilot tested by the representatives.

The attendees, all were leaders in psychiatric nursing, yet, experts in human behavior. Even though it was comprised of strangers, with a variety of personal and professional agenda, each member was able to identify clarify personal issues and work toward achieving the group goal. There were nine academicians and one person who was self employed as a consultant in psychiatric nursing; there were eight women and two men. The age range was from the late thirties to the mid-sixties. There were no power conflicts as we set out to accomplish our well-defined common goal, the education of psychiatric nurses beyond the basic level. The team conferred around a large table in English. A requirement of membership was a comprehension of and speaking ability in English. A flip chart and a transparency projector were available in the room. Running notes were taken by one of the members on a laptop computer throughout the conference. The notes were Xeroxed and distributed daily for documentation to enhance comparative

analysis. Audiocassettes were made for archival purposes. The team had a daily schedule which it had approved and which it adhered to.

The team usually convened at 8 a.m., broke for lunch at 11:30, and reconvened at 1:30. Because the formal dinner was served late, the team was able to meet until 5:30 or 6 p.m. The conference area was a greenhouse with sanitary facilities. Coffee and cake were served mid-morning and mid afternoon. The accomplishment of this project will be explored through methodology of curriculum construction, development of content, and progress.

10.1METHODOLOGY OF CURRICULUM CONSTRUCTION

The methods utilized in order to produce the final products were Group Process, Environmental Sensitization, Presentation and Discussion, Conflict Identification and Resolution, Development of Content, Consensus Building, Curriculum Construction (generic and culture specific), Field Testing, and Dissemination.

10.1.1 Group Process

No group can be convened over time without an awareness of group process. Two factors are critical to note: stages of group development, and the formation of cohesiveness. Most works regarding the stages in-group development were authored in the sixties, the decade when group process was a way of communication, problem solving and therapy. Generally, four phases have been recognized; each identified according to the author of a particular work on group process; yet all followed a similar path, from orientation to termination. The Bellagio International Group for mental health nursing (BIGmhn) as it was called by the participants, followed the traditional path of the parallel phase, inclusion phase, mutuality phase and termination phase (Levine, 1991).

During the *parallel* phase most interaction was directed at the coordinator of the group. However, this stage was very short lived, less than an hour, probably because the group was composed of advanced practice psychiatric nurses, who felt comfortable communicating with everyone within a very short time frame. During this phase clarification was sought about administrative details. Once the individuals began the round of introduction, the group had begun its task of *inclusion* (the second phase), the period when the group becomes an independent functioning unit. Sub-grouping did occur along the line of comfort with language. It was not long into the period of group formation that two permanent sub structures

were created: the Spanish contingent and the English group (those individuals who had no knowledge of Spanish). Fortunately for group functioning the group was able to take advantage of this by having two equal language-specific subgroups each of which was able to identify commonalties and variances in educational protocol and in mental health problems and services of the representative countries.

As the group entered the *mutuality* phase, that of intimate relationships with each member, the language differences mattered less. Instead, achieving the common goal of developing curriculum modules took priority over individual country differences. Capitalism and socialism became merged as the framework; objectives and paradigm were developed. The paradigm, the end product, incorporated the objectives and framework (see Figure 1).

Figure 1

Social Mental Health Paradigm

This phase occurred early in the formation of the group, on the fourth day.

The last phase, *termination*, has not occurred although the group is no longer meeting formally. There is continuous progress toward the goal of a second reunion to examine the outcome data of the culturally specific pilot modules. As the coordinator, I continue to send email letters to all group members soliciting feedback, such as is the case in this document. Eight out of ten members have participated actively in providing such feedback.

10.1.2 Environmental Sensitization

Since, according to Grady, Harden, Moritz and Amenede (1997) the environment is pivotal in determining the well being of an individual or group, it is of important to illustrate a case in point. The natural ambiance of the Bellagio center was crucial in the realization of the goal outline in the proposal submitted to the Rockefeller Foundation.

The campus of the Bellagio Center provided an atmosphere for contemplation and scholarly pursuit. Nothing was lacking. Each team member had her or his own bedroom within an apartment of three (or less) persons. Each of the three largest apartments had a computer in a study area, a kitchen, and a living room. I, the coordinator, had my own apartment. Meals were served by formally attired waiters in the dining room or on the veranda for all of the residents at the center. The campus provided an ambiance for strolls in the foothills of the Italian Alps. The support staff at the Bellagio Center attended to every need of the team. Materials such as paper, transparencies and markers were provided. Equipment was but a phone call away. There was nothing lacking in the ambiance of scholarly pursuit. Never had I attended a conference where there was not one need left unattended. Consequently, the team did nothing but work. By choice of the team, the only Sunday was dedicated to task fulfillment.

10.1.3 Presentation and Discussion

The conference began by each member presenting a half-hour country-specific overview of the status of nursing. Similarities and variances were noted and listed for future analysis. Other presentations resulting from small breakout groups followed such work sessions. All presentations were in English.

Discussion occurred spontaneously during large and small groups generally in English, but sometimes in Spanish as the group became

more informal and realized that half of the group members were more comfortable discussing in English and the other in Spanish. Facilitation occurred in English.

There were two small groups work sessions during the residency. The first, consisted of two equal groups subdivided by language dexterity to identify global mental health problems from the presentations and the literature, the second was to finalize the educational product.

10.1.4 Conflict Identification and Resolution

There cannot be a meeting of people from nine countries with nine philosophies without conflict in attitudes, beliefs, values, and agenda. And so it was with this group. Perhaps, because all had the common base of being a psychiatric/mental health nurse, educated at an advanced practice level, conflicts were identified and discussed with sensitivity. The group functioned in a productive manner throughout the ten days. It was clear that there were those from a capitalistic orientation and others from a socialistic one. The philosophical ideologies were defended and followed by a discussion of differences. The informal process of political socialization during which the individuals analyzed their own attitudes, beliefs, values in relation to individual political systems was requisite to the forward movement of the group (Brown, 1996). Conflicts were discussed and resolved in light of the group goals. However, It became clear that the group had to: 1) develop a framework, list the objectives of the educational program and, 2) design a paradigm which would incorporate the framework and objectives (see Tables 7, 8).

Table 7: Hypothetical Framework for Societal Mental Health Paradigm

The concept of Societal Mental Health is defined as the state of optimal emotional well being (health) of each individual, family, group or community within society. It is affected by Biological and Social Processes, which are linked by specific operational components (biological cultural, ecological, economic, educational, ethical, organizational, political, psychological, and scientific). All components are linked to the objectives on which the post graduate educational modules are based. Mental Health is a vital component of Holistic Health, both of which are affected by society and the environment.
The goal of the paradigm is to illustrate the promotion of mental health, prevention of mental illness and, finally the promotion of the concept of caring by mental health nurses. It consists of three vital components, Health, Society and Mental Health.

HEALTH

1. Health is an individually determined, subjective state of being, influenced by society. It is social and is subject to societal politics in a particular time and in a particular culture.
2. Health is historically dependent on social processes, relative to style and quality of life of populations. It is linked to the conditions of accessibility, to various kinds of wealth (cultural, economical, political, geographic, affective, spiritual and others) in every place and at all times.
3. The State of Health of an individual, group or population is reflected in the scientific statements of, and influenced by the subjectivity of the individuals or groups defining this state. It is further influenced by a complex of factors in a particular time and culture from which are derived from the indicators of the state of the health or illness process.
4. The Process of Health Illness is expressed, not only in a variety of problems of illness and risk, but also in various conditions of daily life and social relationships.

SOCIETY

1. Society is not homogenous, nor uniform… nor is it a harmonic totality.
2. Society if characterized by inequities related to life in a particular time and space.
3. Society is an integration of social groups with different styles and qualities of life, with different interests, ideas, capabilities and powers. Those differences produce contradictions and conflicts, which continuously change the structure and dynamics of social life.
4. Social Process is historic, dynamic, complex, discontinuous, uncertain, ambiguous, conflictive, contradictory and is determined by multiple interactive factors. Social Processes are made dynamic by power relationships. It is this process that determines an individual's access to health services including those of health maintenance and illness prevention.

   The complex of Health and Societal factors may be classified into biological, environmental, ecological, historical, cultural, socio-economic, political, scientific, technical factors and as factors emerging from the organizing of health system and services. These factors interact with and are influenced by power relationships which, in turn, determine and condition the process of health and illness.

MENTAL HEALTH

1. The field of Mental Health is still unknown and unrecognized in many cultures. Therefore, it needs to be developed as a complex and transdisciplinary field focusing on the comprehension of subjectivity, singularity and differences within and between individuals and groups, thereby promoting an understanding of the complexity of healthy and unhealthy conditions of social life and processes.
2. Mental Health, or the State of Mental Well-Being is defined as a historically-determined social process characterized by the integration of the fundamental and conflictive elements of individuals and groups, that can be subjectively and objectively assessed. In the optimal state, the individuals and groups implement changes on themselves, their groups, and on their social environment. Mental Health is one component of holistic health of the individual, along with physical and social health.
3. From an etiologic point of view, Mental Health may be defined as a process determined and conditioned by a complex of factors: biological, environmental, ecological, historical, cultural, socio-economic, political, scientific, technical factors, and as factors emerging from the organizing of health system and services. All of these factors are interrelated.
4. From the political point of view Mental Health is a social subject which is reflected in the relations between Society and Health. It is one of the principal points of political responsibility of a legal system that promotes citizenship, freedom, democracy and solidarity, and that condemns discrimination, exclusion and violation of human rights.
5. From a scientific and epistemological point of view, Mental Health is comprised of elements of theory of many academic fields, especially those related to health and illness. Because of its integration, it is

neither possible nor convenient to limit its field.

6. Mental Health Care is defined as a complex of activities based on cultural and scientific theory that has, as its principal goal, the promotion protection, restabilization and rehabilitation of individuals and groups. Ideally mental health care involves the participation of all actors involved in the process.
7. Integral Mental Health Care may have as its focus the individual, families, groups, communities and society.

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cont.

8. Integral Mental Health Care includes a complex of sanitary, socio-cultural, scientific, political economic and organizational measures. Its mission is oriented to link it with general, holistic community health systems and services as opposed to the still existing custodial psychiatric hospitals.
9. Standardization in the Qualification and Education of mental health professionals, technicians and workers, is a structuring and dynamic factor in the provision of mental health services. They are vital components in generating and developing system change.

Table 8: Objectives for Mental Health Nursing: Advanced Nursing Practice

1. To develop knowledge of the relationship between mental health and cultural diversity and the skills to deal with problems related to it.
2. To develop knowledge and skills to work in the community/society (including hospitals) and other appropriate settings.
3. To promotion health and prevent illness: focus on health for the individual, community and society aimed at health and a healthy environment.
4. To be able to integrate theory and practice.
5. To demonstrate ability to develop/plan/implement/and evaluate mental health programs for and within the community. (i.e. alcoholism and violence/abuse).
6. To be able to analyze social and mental health reality in the context of world and regional changes and the way in which the changes influence mental health processes in every population and at all times.
7. To promote and develop processes for transforming mental health concepts into practices and services.
8. To identify and understand epidemiological profiles groups at risk for mental illness.
9. To be able to intervene in crises at individual, group, family and community levels.
10. To communicate and collaborate with other mental health professionals.
11. To be able to function within a research based framework.
12. To develop critical thinking about mental health problems towards a

goal of increasing quality of life in every population.

13. To develop intervention and outcome-based research methodology about health and risk factors.

14. To develop, use and evaluate a framework and paradigm for the assessment of conventional and non-conventional mental health problems.

15. To advocate for human rights.

16. To promote and facilitate the process of community organization in order to solve its problems.

17. To understand, analyze and critique different modes of thinking and practices in the field of mental health.

18. To analyze the ethical issues involved in the identification and implementation of care for persons with mental health problems.

19. To demonstrate ethical competency in practice by: a) assuming responsibility for decisions made for individuals whose decision making capacity is limited due to mental illness; b) facilitating the resolution of ethical conflicts.

cont.

cont.

20. To apply mental health epidemiological theory in order to influence the development of health care policy.

21. To analyze underlying theories and values related to the concept of power.

These had to be visible and amenable to change to move ahead in the planning of a global, generic curriculum.

10.1.5 Development of Content

The modules evolved from the large group discussion where the most prevalent problems were listed and rated on a scale by each country. The problems that were identified were: Violence; Disability/ Accidents; Terminal Diseases; Prison Populations; Low level of Education; Marginalization/Loss of Cultural Roots, Persistent Sensation of Fear; Breakdown of Communication, Effects of Population Repression/ Human Rights Violation; Uncertainty Regarding the Future, Unhealthy Stressful Working Conditions; Isolation; Indiscriminate Use of Pharmaceuticals; Insecurity/Threat to Personal Safety; Tension/Social Pressure; Anxiety/Depression due to Unemployment; Migration, Culture Shock. Subsequent clustering and identification of cross-country prevalence gave rise to the three modules, which were then developed generically in the three aforementioned groups.

10.2CONSENSUS BUILDING

10.2.1 The development of the framework

The development of the framework, objectives and paradigm became the path of consensus building for specific guidelines were established. Each had been developed on the flipchart and transparency projector. There was the simultaneous taking of running notes, which would be distributed for bedtime reading and morning discussion. Focus on the individual gave way to focus on society. The paradigm was the final product of merging the objectives and framework through diagramming. A new group identity was formed as the group identified itself, as the BIGmhn (Bellagio International Group for mental health nursing). The identity no longer consisted of the medically specific term “psychiatric” with the new focus on the community instead of the individual.

10.2.2 Curriculum Development

The preceding developmental phases were socially necessary before the final small groups of three could begin the task of curriculum development in English. Each of the groups convened in one of the apartments to work on the development of one of the identified modules: *Towards the Comprehension of Violence, Chronic Mental Illness from a Societal Mental Health Perspective,* and *Inter-cultural Competence in Mental Health*. These were developed during the morning session three days before the termination of the team residency according to the outline of Burns, Thompson and Ciccone (1993). The afternoon session was spent reading with each member reading and commenting on each module. Only a few changes were made during the presentation of each module to the large group. By 6 p.m. the task had been completed and the generic modules were ready to be taken to each individual's country for cultural and educational refinement and subsequent pilot testing. I took on the task of refining the framework, objectives and paradigm for dispersion via email to each member for final comments. These were then submitted to the Rockefeller Foundation with the final report.

10.3PROGRESS

10.3.1 Field Testing

The development of the culture-specific curriculum took different forms depending on the nursing and political structure of

the country and on the individual disseminating the information. Now, eight months later, generic modules have been translated and culturally refined in two countries. In Brazil, the three modules will become the major focus of a nine-month course at the lowest post-basic education level, *Aperfeiçoamento* (Perfection). The three modules will be team taught by nurses, sociologists and psychologists, strictly adhering to the outline. The first group of students will be the nurses practicing in psychiatric hospitals in the capital of the Northeastern State of Paraíba. The course will be sponsored by the Coordination of Mental Health of the State Secretariat of Health. The professors represent various faculties of the Federal University of Paraíba.

In Turkey, the module on Violence has been translated and adapted into the graduate program at Marmara University. In Australia the module on Cross-Cultural Competence is being taught at La Trobe University. In the United States various segments of all modules have been incorporated into the Master's level psychiatric nursing courses at Ohio State University. In Brazil, aside from the program that is planned for the course in aperfeçoamento, some of the content of all modules was incorporated into the Master's level course, Community health and development, where one three hour class was devoted to each and where the module on violence was utilized as the focal point of a community assessment.

Other team members have been less specific in reporting their progress to date. One member has reported that the program cannot be implemented because of national constraints. Another has not been heard from at this juncture.

Formative evaluation is being conducted informally as data are being gathered by each participant. The Summative Evaluation Instrument is one will be sent to the participants which will cross the general objectives with the modular objectives. This will yield data for the restructuring of the modules. (See Table 9).

Table 9: Module Objectives

VIOLENCE

1. To understand the nature and place of violence within the theoretical framework of this project and the way it is expressed behaviorally; to assess and interpret the diversity of manifestations and direction of violent behavior.
2. To examine theories and research about the rationale and effects of violence on the individual, families, groups and communities, especially focusing on long-term effects like post-traumatic stress.
3. To analyze the status of violence from conventional and non-conventional perspectives and to identify special cultural, political, economical, technological and other processes to the state of violence.
4. To analyze feelings, beliefs, attitudes and behaviors of self and others relative to individuals, families, groups and communities experiencing violence, and to develop ways for changing hose that are counterproductive.
5. To develop nursing thinking and strategies in order to manage and go beyond the situation of violence within the daily life of nursing work in the community.

CHRONIC MENTAL ILLNESS

1. To analyze the relationship between mental health and cultural and social diversity as it relates to chronic mental illness.
2. To develop and apply a methodology that promotes critical thinking through a nursing model that integrates theory and practice in psychiatric settings
3. To provide support to families and to facilitate community support networks for persons with chronic mental illness.
4. To advocate human rights based on the principles of justice and equity for all persons in respect to issues involving chronic mental illness.
5. To observe ethical principles in professional practice.
6. To work efficiently within a multi-professional team in the interest of the patient's individual and collective/community needs.

INTER-CULTURAL COMPETENCE

1. To understand and value the differences between cultures.
2. To analyze culturally related social/political and economic issues related to mental health.
3. To analyze and synthesize various cultural conceptualizations of mental illness.
4. To develop culturally sensitive tools for assessment and evaluation of culturally diverse individuals, groups, families and communities.
5. To accurately assess the mental health of individuals, groups, families and communities representing various cultures.
6. To design, implement and evaluate culturally specific programs both as an

individual mental health nurse, and as a member/leader of an interdisciplinary team.

7. To demonstrate skill in creating culturally specific interventions to promote and maintain mental health of diverse cultural groups, families, individuals and communities.

A meeting for summative evaluation before revision is anticipated in 1999. Before this date, an evaluation instrument will be dispersed to the team members.

Dissemination: The work of the team has been disseminated through verbal reports to nursing regulative bodies such as in the Netherlands. Along a scholarly vein, there have been presentations of papers at annual meetings of the Transcultural Nursing Society in Kuopio, Finland (Coler, Ferreira and Nobrega), the International Family Nursing Conference in Valdivia, Chile (Coler), a PAHO invitational meeting of psychiatric nurses in San Juan, Puerto Rico (Coler). A manuscript has been submitted to the Journal of Transcultural Nursing. New items have appeared with a picture of the team in Enfermería, the official journal of the College of Nursing in Chile (1997) and in a Newsletter of the Australian Centre for the Development of Psychiatric Nursing Excellence (1997). Nurses in Columbia and Newfoundland have asked to be included in the pilot-testing project.

10.4 SUMMARY

In summary, three generic post-basic education modules have been developed by means of a paradigm and framework by 10 experts in mental health nursing, representing nine countries. These modules will be adapted according to the culture and educational system of each. Because not all countries have university-based basic level nursing education, the phrase, *post-basic* instead of graduate or postgraduate education was selected. It will be these experts who will decide how the modules will be taught (i.e., as a workshop, as freestanding courses, as part of an already developed curriculum, or through computer-based learning programs).

Because the goal of the meeting was only the development of the skeleton and the generic content of the modules; because the culturally specific content and level of post-basic education will be country specific; the project may be visualized as a non-traditional educational enterprise which addresses universally defined nursing problems. The requests from the other countries is seen as a bonus for enriching still further the curriculum content

and strategies developed to date by the BIGmhn, and the international data base of mental health nursing.

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11. THE COMMUNITY MENTAL HEALTH SERVICE IN JAMAICA

By Hemsley C. Stewart

11.1THE EVOLUTION OF COMMUNITY PSYCHIATRY IN JAMAICA

The early 1960s saw the evolution of Jamaica's model of community psychiatric care, as strategies were required for maintaining the many patients discharged from Bellevue Hospital to the community.

The Social Work Department at Bellevue pioneered the trend by establishing six psychiatric counseling centers in 1963. The centers later became full-scale clinics based at Parish Hospitals.

"Up to early 1966, Bellevue Hospital was the central venue for the care of the mentally ill in Jamaica. In 1958, a World Health Organization (WHO) Psychiatric Consultant, Dr. Roberts recommended to the Government of Jamaica that psychiatric facilities be established on an island-wide basis to reduce the emphasis placed on Bellevue Hospital as the sole facility for the care of the mentally ill (Roberts 1958). His recommendations were confirmed and restated by another WHO, Psychiatric Consultant, Or Richman (Richman, 1965), and by West Indian Psychiatrist, Or Beaubrun (Beaubrun, 1966). Beaubrun further suggested that the major focus should lie on the establishment of general hospital psychiatric units throughout the island" (Hickling, 1976).

The strategies proposed by these psychiatrists were for the decentralization and diversification of mental health/psychiatric care throughout the Island.

This was in keeping with the trend toward deinstitutionalization community care and rehabilitation which was taking place in other parts of the world at that time.

From these strategies the Community Psychiatric Nursing Service evolved and was implemented in 1966 with the training of the first group of Mental Health Officers (MHOs). The officers were Registered Mental Health Nurses who were given additional training. On completion of training, four officers were assigned with responsibility for eight parishes. They were required to:

1. provide follow-up care for patients in these communities who were discharged from Bellevue Hospital; and

2. establish and manage psychiatric clinics in specified areas.

The demand for the service grew to such an extent that the short-term objective of placing one officer in each Parish was set. Toward this end, four additional officers were trained in 1971 bringing the total of assigned officers to eight.

In 1972, a policy decision from the Ministry of Health and Environmental Control directed that psychiatric patients be treated at local parish hospitals and clinics. This decision paved the way for a pilot Community Psychiatric Service in the Eastern Parishes of the Island by the University of the West Indies in cooperation with the Government Health Services.

11.2THE DEVELOPMENT OF THE COMMUNITY PSYCHIATRIC NURSING SERVICE

By 1973 the Community Psychiatric Program was extended to the entire Island with the establishment of community follow-up services in 17 out-patient clinics and the implementation of in-patient psychiatric services in 17 General Hospitals (Hickling, 1976). These services were maintained by five visiting psychiatrists, the eight resident mental health officers, and the staff on the medical wards of the general hospitals where acutely ill psychiatric patients were admitted.

In 1974, The Mental Hospital Law was amended to enable MHOs to enter private premises, and with the help of the police remove persons assessed to be mentally ill, to treatment facilities. A later Ministry of Health decision was made for the officers, with the help of the police, to remove suspected mentally ill persons from the streets.

Due to the increased workload created by the extended functions of the MHOs plus the continuously increasing demand for the service islandwide, another six psychiatric nurses (without additional training) were assigned to the community service in 1975. In 1976, these six nurses together with seven others participated in a three-month Community Mental Health Course. The curriculum was now broader in scope and included psychology, psychiatry, community organization, community psychiatry and social case work.

11.3THE EFFECTS OF THE SERVICE

The initial effects of the Community Psychiatric Service is highlighted by Hickling, (1976) who wrote that the introduction of the service in 1972 made a dramatic impact in the admission rate of the Mental Hospital.

In 1973, admissions decreased by 32 per cent below the 1972 figures, from 2,368 to 1,589. "By December 1974, the admission rate was reduced by a further 19 per cent to make an overall reduction of 51 per cent over the two-year period, January 1972 to December 1974" (Hickling, 1976).

The reduced admission rate was accompanied by a corresponding reduction in the resident population of the hospital. In 1973, the end of year population decreased by 13 per cent below the 1972 figures, from 2,914 to 2,514. By December 1974, the population was further reduced to 2,337, representing an overall reduction of 19 per cent over the two-year period (Hickling, 1976). By 1976, the population had fallen to well below 2000 patients. During the 1990s the population has been consistently maintained at approximately 1200 or below.

11.4TRAINING OF MENTAL HEALTH OFFICERS

Since 1982, the training program to prepare registered nurses to be Mental Health Officers has been upgraded and extended to six months. In addition to preparing nurses for leadership positions in the Community Mental Health/Psychiatric Services, it also prepares them to function in in-patient and rehabilitation services.

The Courses include psychology, sociology, epidemiology, community organization, community mental health, psychiatry, community psychiatry rehabilitation, psychiatric nursing, community psychiatric nursing and rehabilitation nursing. In addition, participants are introduced to research methods, principles and techniques of teaching and public speaking, to prepare them for their expanding role in the community.

Lecturers for the courses are drawn from related disciplines as well as members of the psychiatric team. Special emphasis is now being placed on preparing participants for the additional responsibilities involved with counseling the increasing numbers of substance abusers, HIV positive and AIDS clients.

Additional training is provided on the job when the nurse is selected to be a Mental Health Officer. Before appointment to the post each officer is required to participate in the four months nursing administration course to acquire the necessary management skills required for performing management functions.

In 1997, a Mental Health Nurse Practitioner Course was started to further prepare the nurse for treating the mentally ill in hospital and the community. The plan is to upgrade the current Mental Health Officers to Mental Health Nurse Practitioners before training new Mental Health Nurse Practitioners.

11.5THE ACTIVITIES OF MENTAL HEALTH OFFICERS

There are currently 25 Mental Health Officers including one Coordinator and five

Supervisors. They manage 79 clinics at hospitals and health centers island-wide, in addition to the management of patients admitted to the wards of parish hospitals. Each officer has an average caseload of 400-500 patients and make 250 patients interactions per month.

The officers contribute to the promotion of mental health and the prevention of mental illness as they liaise with guidance counselors in the schools, serving as consultants and lecturing to students. Similar services are provided for other community organizations such as the churches, youth groups and service clubs.

There are four full-time psychiatrists (including a director) and others who function on a part-time basis providing service throughout the Island.

11.6 CONCLUSION

The Mental Health Officers continue to be the mainstay of the Community Psychiatric Program in Jamaica as the program contributes to:

1) Treatment and maintenance of the patient in his community.

2) Prevention of institutionalization by preventing admission to the mental hospital.

3) Reduction of the length of stay in hospital when hospitalization becomes necessary.

4) Prevention of the stigma attached to hospitalization at the mental hospital.

5) Reduction in the cost of hospitalization.

6) Maintenance of the family unit during the patients illness.

7) Provision of social support by the patient's family and friends.

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12. NOTES FOR A CONCEPTUAL CRITIQUE OF MENTAL HEALTH NURSING[2]

By Silvina Malvárez

12.1THE IMPACT OF WORLD CHANGES ON MENTAL HEALTH

If we refer ourselves to mental illnesses as conventionally classified, the World Health Organization holds that there are 40 million persons in the world who suffer from grave mental illnesses, another 250 to 300 million have less serious illnesses, but still are disabled and an undetermined suffer from unexplainable psychological factors associated with the subtle processes of an organic nature. There are strong reasons to believe that these will worsen if public and preventive measures are not used.

Harvard University, at the same time, points out that 8% of the total world's illnesses are mental illnesses and that this index increases 15-16% if self inflicted wounds are included. Thus, 34% of the illnesses are associated with human behavior. The main categories are associated with depression, violence, degenerative diseases of old age, alcoholism, substance abuse, epilepsy, and others. Suicide is found in numerous countries among the top ten causes of death (Department of Social Medicine, Harvard University, 1995).

On the other hand, the epidemiology of mental illness and psychiatry in the Region of the Americas indicates that 30% and 40% of persons suffer some type of mental problem during their lives. Research done in various countries demonstrates an incidence of 19% to 34%. Thus around 17 million children 4 – 16 years are probably affected by mental problems (OPS/OMS). The Harvard Report also reports that in less developed countries these indicators increase and for Latin America and the Caribbean it is possible to expect that 88 million of the persons have mental illnesses that need consideration.

But the health statistics do not account for the new problems of mental health that have not been classified or deeply studied. However, current practice concepts and models of intervention have not been useful to understand these new problems.

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[2] A bridged version. Full text available in Spanish version of this document.

Many mental health problems have been unconventionally classified. These include: all types of violence, especially among adolescents and children, stress resulting from social tension, new forms of depression associated with unemployment, changes in social class, destruction of familiarity, feelings of insecurity and defenselessness, self medication and with pharmacist supervision. Other unconventionally classified mental health problems include: isolation, loneliness, individualism, uncertainty, and paralysis in relation to the future, effects of political repression, and the violation of human rights, problems of identity resulting from migration, transculturation, increase of discrimination, and marginality, abandonment of children and elderly, consequences of teen pregnancy. Additional psychiatric problems that are unconventionally include profound chronic mental illness, as well as the isolation and abandonment resulting from deinstitutionalization (Malvárez, 1977).

The International Committee of Population Crisis stated that in 1991, 500 million persons worldwide lived under conditions of extreme suffering (9%). Another 3.5 million persons lived in conditions of grave infirmity (66%); 650 million with a level of moderate suffering, (11), and 800 million are exposed to a low level of suffering (13%). (International Committee of Population Crisis, 1991).

In this changing end of the century and millennium, mental health has been considered by the majority of the world's countries one of the principal problems of mankind. This is not only because of its place in the quality of social life, but also because of its strategic position in the socioeconomic development of nations, not only due to the gravity of the damages that are a consequence of world changes but also because of the world's achievements.

We must consider three or four questions whose awareness is determined by the wisdom and ethic that supports and focuses attention on mental health.

1) The world has vigorously changed according to Shimon Peres, "the 21st century is not the continuation of history, but the future that will allow us to get ahead of danger and direct our destiny as humanity." Revolutions have occurred without arms, frontiers have diluted and increased inequality, there are new hopes and dangers. Mental health could be both.

2) The problems with mental health are increasing in the world and in the region. This is a result of changes, political models, concepts, and practices that insist in simple interpretations and answers and are not pertinent, in spite of

strong strategies and transformations in the field that have been generated.

3) Nurses have a particular responsibility in relation to mental health and a special social place to occupy.

We need to understand the historical world and regional changes. We must also consider relevant and major problems and develop complex theories to understand mental health. In addition, we should continue to change nursing in such a way that through its effective and competent interventions it supports advancement and preservation of mental health in society.

The answer to the serious problems of mental health continues to be the traditional model. It is centered in psychiatric hospital with institutionalization, custodial, and pharmacological treatment, which isolate and excludes subjects. At the same time, the politics of health lack the components of mental health and few attempts are made to include mental health because of laws that institutionalize the status quo.

The education and training of mental health personnel finds itself associated with influential factors that are not possible to ignore. These conventional factors in theory as well as in methods and organization contribute, sustain, and deepen physical-natural, biological models or psychological explanations while overlooking psychological suffering.

12.2REVOLUTIONS AT THE END OF THE CENTURY

Since the fall of the Berlin wall, and perhaps a little earlier, the world has endured multiple changes that undoubtedly affect health and the quality of life of communities. Dr. Ruben Ferro Argentinean physician and thinker has labeled these new changes with the title of “new revolutionary symbols.” These changes could be classified in the following categories (Malvárez, S. 1997):

- *Acceleration of History* with its multiple effects on daily life, on social and individual memory, and in the subjectivity of individuals.

- *Cultural revolution* determined and expressed by massive migration, changes in the family structure, increase of conflicts among ethnic minorities, political, cultural, and religious transculturation and globalization of images, symbols, necessities, and social models, changes in social values with a tendency toward individualism without

solidarity, loss of protective factors, strong mystical and religious tendencies that substitutes for the spirit, but do not transcend nor satisfy through their rational explanations life's problems.

- *Scientific technological revolution* explosive development of science and technology, substitution of man by machine, development of experiments that go beyond the limits of imagination and put in peril etiquette, explosive development of transportation and communication, crisis of scientific paradigms, disciplinary and transdisciplinary disengagement of new types of knowledge: the informatic description of emotional intelligence.

- *Economic* revolution Economic revolution in the political framework of the free market, privatization of state functions, and progressive disengagement of social responsibilities (healthy security, education, etc) changes in social values toward the commercialism of daily relationships, progressive increase of self destruction, principally associated with the alteration of the environment, increase of poverty among the majority, increase of social inequality, suppression of means of employment.

These are only some of the world's changes that definitely influence mental health and the quality of social life that generate problems of mental health for which conventional categories of analysis cannot be determined. Consequently, neither the social answers are available for these concerns. Over all, problems conventionally classified have also increased.

12.3IMPACT OF WORLD CHANGES ON MENTAL HEALTH

If we refer to conventionally classified mental illnesses, the WHO admits that there are 40 million persons in the world who suffer from profound mental illnesses, another 250 – 300 million who have a less serious mental illness, but still are disabled with a large proportion suffering from an undetermined mental illness.

This indicates that the model for conceptualizing, analyzing, and proposing programs of action in mental health in the Region is moving toward models of more complex, integrated, and multifaceted explanations, which helps to develop hope for better methods with results. Nevertheless, even with this direction, actions develop very slowly and often with more reformation than transformation with which it is possible to prevent failures.

It is, therefore, necessary that conventional psychiatric models and even some that are considered “alternative” models be revised and evaluated with the intent of adapting these models to changing epidemiologic situations, at the risk of not recognizing the new problems related to quality of life and mental suffering.

It seems that change would occur through the process of transformation. This would result from the analysis and the rationale of the problems of mental health in the world, the dimensions that are considered by the analysis, society, concepts, practices, and attention to mental health, as well as the participants in these decisions and their social consequences.

The introduction of social science to the understanding of health and mental health has permitted us to understanding the complexity of social processes. These are combined to determine health problems, helping us to understand, as affirmed by Bertrand Russell, that energy is the principal physical category, while power is the principal category of the social sciences. From this perspective health is considered a historical process that is not only socially constituted, but also determined and shaped by the effects of power (Malvárez, 1997).

Basic conceptions that we adopt to understand mental processes and their determinants constitute the cement upon which is built not only political action and technical health, but also social action to influence culture.

12.4THE CHALLENGE

“What challenges shall we have in the future if we not only try to extend service coverage, but fundamentally transform the attention of psychiatry and even promote mental health?” It was thus that Dr. Ramon Granados Torano, Consultant for OPS/OMS expressed himself in a meeting of mental health nurses in Tegucigalpa, 1996.

The experiences that several countries of the region focus upon, and various countries of the world, and the initiative of OPS for the reconstruction of psychiatric attention supposes that many groups have taken on the challenge. In the middle of the process have found innumerable contradictions that are necessary to discuss. The challenge is clearly not about a small focus on the same problems, of reforming the same thinking, of reordering the same knowledge, of falsely redescribing the same programs and services.

The challenge is found jointly in the challenge of psychiatric values, the challenge of the culture of individualism, isolation, exclusion, marginalization, the challenge of political and economic power that sustain the conditions for mental illness. The challenge is about the dominant health knowledge and practice and the models that produce and reproduce knowledge that perpetuate unicausality and dependence. The principal challenge in reality is oneself, social actor, member of a health culture and profession that assumes the proper way to think of mental health.

Nevertheless, it is necessary to convert social and individual assumptions in order to comprehend and expand the complex understanding of the problems of mental health. Initially such a conversion assumes in its earliest conceptualization an integral discussion of the following points:

- the political and ethnic base of the concepts and practices concerning mental health
- the theoretical epistemological support of mental health models of note.

12.5TOWARD A SOCIAL CONCEPT OF MENTAL HEALTH

Consider some principal concepts that contribute to the understanding of mental health, from a social perspective which serves as a social foundation for nursing in mental health.

12.5.1 Concerning health as a social question

Health is a social question. Health being social, it is also political. The social concept of health is supported by two fundamental assumptions: about society and social processes.

12.5.2 Concerning Society

Society is not completely uniform, homogeneous, or harmonious (and where the disharmonies represent social dysfunction) but is characterized by the inequality of different categories. Social groups with quality of life, interests, ideas, capacities, and distinct powers exist. Their differences produce contradictions and conflicts, which are structures of the dynamics of society.

Social processes are historic, complex, discontinuous, uncertain, ambiguous, conflictive, and determine health. These

processes can be classified as historical-cultural, socio-economic, legal-political, scientific, technical, and economic-administrative.

12.5.3 Concerning Health

In this framework, health is a historical-social process, culturally determined, related to the style and quality of life of communities, and their economic political conditions of accessibility to the different types of wealth (cultural, economic, political, geographic, spiritual) in each place and time. Such processes are not only expressed in the distinct problems of illness or risk, but also in the different daily lives which are related to society.

Consequently, the state of health of a subject, group, or specific community, simply is an artificial reflection of historical processes. These reflections are realized by observers who intend to understand the process. Secondly, health is also a social expression determined by conditions of power that when fully understood, simultaneously represent both cause and state of health (Malvárez, 1997).

12.5.4 Concerning Mental Health

Historically defined by the absence of illness, mental health constitutes a theoretical-political area being developed, of which little is known, and assumes, as much for development of new concepts, like the invention and evaluation of new models of social, political, technical, administrative action, adapting to the realities of Latin-American countries. The field of mental health is trying to make itself complex and transdisciplinary with subjective knowledge of the uniqueness of the individual and the group, in the midst of conflict from the daily life of institutions and society. The mental health field is trying to broaden its vision through life in society while noting the interrelationships between health and illness.

From a *qualitative point of view relative to the state of mental life*, mental health can conceive of itself as a historically and socially determined process which integrates conflicting elements, composed of culture and of groups, with foreseeable and unforeseeable crisis, subjective and objective records, in which persons and groups actively participate in appropriate changes (de Galli, 1985). Mental health constitutes one of the elements of the integral health of the individual, along with physical and social health.

From an *etiological point of view*, mental health can be defined as a life process. It is determined and conditioned by a relationship of other natural, historical-political-cultural, socio-economic, scientific-technical processes, and of the organization of health services. All of these processes are interrelated and mobilized by a relationship to power.

Through its *political perspective*, mental health is understood as a social question determined by political forces. Mental health is expressed through relationships between the State and Society. It is an inalienable human right and is a concrete part of the concepts and processes of citizenship, liberty, democracy, and solidarity. Mental health is a result of a judicial legal system that promotes, supports, and defends it, from discrimination, exclusion, and the violation of human rights and from socio-political health determinants and guarantees its social development.

From a *scientific-technological* point of view, mental health corresponds to a mixing of disciplines and diverse practices related to all areas of knowledge and human activity. It is not, therefore, possible or convenient to diminish its potential. As an interdisciplinary field, it includes: the conceptual and practical problems of mental health, its changes and of mental illness, its ways of organization and regulation, and the effects of different powers over itself. As such, mental health conceptually and operationally exceeds a closed vision of health, despite a strong alliance with it.

The *care of mental health is* a joint effort based on a variety of cultural and scientific knowledge. Such care has the objective of promoting, protecting, re-establishing, and rehabilitating the mental health of individuals and groups (Galli,1985).

The integral attention of mental health includes a joint effort of health, socio-cultural, scientific-technical, economic-political, legislative, ethical, esthetic, and organizational measures, that have a comprehensive vision of a subject's life and that of a dynamic society. Such attention should be focused toward the establishment of networks of services that are characterized by the diversification and quality of health care and includes the distinct sectors of the community. Community mental health services should be built in centers that cultivate health, life, and citizenship.

In the framework of the enlightened state, attention to mental health implies participation of all the actors involved in the process, that is, users, lenders, and institutions.

In this sense, the ruling organizations should be reviewed, in order to search for service systems that provide an integrated answer to mental health problems. Such a system should predominantly include community services, that are focused on the promotion of mental health and crisis intervention in different environments (family, school, recreation, hospital, cultural, religious, etc). Such services should also be involved in identification and attention to at risk groups. General hospitals could be the focal point that oversee community possibilities, while psychiatric hospitals change to a more progressive focus (Malvárez, 1996).

The *formation and capacity of mental health personnel* constitutes a structural element of the service model. Such capacity should be oriented, not only to the critical analysis of the predominant psychiatric mode, but also to the transformation of legal-political concepts, practices, and services in mental health. Such an orientation will generate social, ethical, and responsible answers.

12.6PLACE AND IMPORTANCE OF NURSING TO MENTAL HEALTH

12.6.1 Brief synthesis of the situation in Latin America

Nursing in the field of mental health, does not differ from the general model of the profession, expressing the appropriate predominate signs of psychiatry in each state or country.

Nursing consequently predominates a custodial or assistant role in the framework of thee great psychiatric hospitals, influenced by the force of this conceptual system, although in many places, nurses are beginning to establish part of the interdisciplinary preventive teams that communities propose, and even promoting attention to mental health.

Nevertheless, even in this field, the concepts and practices of health professionals are more frequently discussed. Nurses do not try to assume the mental health problems of the community like responsible professionals.

In line with the previous explanations, it can be concluded that nursing has paralleled social-political and scientific-technological movements historically and at present. Nursing has also occupied a passive-independent place and consolidated the distinct psychiatric models.

Since the decade of the 80's, in some countries of the region, mental health movements and psychiatric reform have accompanied the process of democracy. This new tendency, as we have proposed, is based on the concept of mental health as a result of history, culture, lifestyles, life conditions politics, and society. This new tendency proposes attention to decentralization, interdisciplinary and cross sectional community views. This tendency links mental health with the concepts of citizenship and production of life that promotes creativity, solidarity, and individuality. This tendency determines the initiation of the transformation of concepts and practices in mental health, in the organization of services and in the formation and personnel capacity in the specialty.

Accompanying the process of transformation, nurses in various countries have notably made roads in political decisions, in diagnostic practices and therapies, in determining the organization of services and in the investigation of mental health. In these same contexts many nurses have redirected their organizational programs, their plans of study, and pedagogical models for the formation of mental health personnel. They have not only influenced the general formation of nurses, but also the contents of the education.

These experiences have had a general factor in common that seems necessary to resurface the participation of nurses in interdisciplinary decisions, development and intervention in mental health. The interdisciplinary field has determined that the nurses be expected to have multiple knowledge and capacity, and that they also be incorporated in the same professional level of other more developed mental health disciplines. Nurses have thus been able to offer important contributions to the investigations, decisions, formation, planning, and intervention in mental health.

The above mentioned experiences are beginning in the majority of countries, to encounter many obstacles, with the major challenge of opposing the conventional strongly held model, coexisting often with the same model, and presenting the appropriate contradictions of this coexistence.

The attention of mental health constitutes a vast space where nurses have many opportunities to contribute to the improvement of the quality of life of Latin American communities. To make the best use of these opportunities is a challenge that nurses cannot overlook, risking the social-technical abandonment of the principal problems of society.

Such opportunities are present today like a virtual space that is necessary to recognize in order to construct professional

nursing in light of mental health. Good reasons exist to assume that this professional group can and is taking a position of respect (Malvárez, 1994):

- The first of these reasons is the size of professional nursing group that in the majority of the countries of the region represents a prominent proportion of all health professionals (in the world, nurses make up a group of 5 million persons). The size of the proportion of the nursing sector allows one to think that if their practice sees the growth of services in the future, an enormous community group will benefit from them.

- In another sense, the size of professional nursing group represents a disdainful quality evolving in relation to the forces of society, with little say in the political decisions of all fields, especially health.

- The second reason is constituted by the diversity of knowledge and capacities that characterize its formation and is especially oriented and sensitive to the understanding of human affect, making nursing strategic and of much importance to health.

- The third reason refers to the sum and type of care and the wide range of situations concerning health and illness to which nurses attend, without knowledge and capacity. Nurses are directed toward a sense of inclusion and consideration of mental health problems of communities. It is possible to anticipate great impact.

- The fourth reason is that the condition of humanitarian work for which nurses receive special social recognition, is not casual, and through it resides a great potential for community receptivity, by virtue of the social, comprehensive character and social-affective qualities that rationalizes nursing actions.

- The final reason is that nurses, through service as well as teaching, have historically characterized themselves through alternative models of health organizations, even when they have failed in strategic beginning analysis.

12.7 TOWARD THE CONSTRUCTION OF A NEW PROFILE OF THE NURSE IN MENTAL HEALTH

12.7.1 Obstacles and the bases for the transformation

There are three orders of obstacles whose nature is precisely to threaten the risk of perpetuating the reiteration of failures or at least ineffective strategies:

- theoretical – epistemological obstacles;
- ethical-political obstacles;
- administrative obstacles.

The second have to do with a value system and the relationship of power that destroys and diminishes the field of health and of which nurses constitute a necessary part.

The third are related to the technical-administrative organizational processes of health and mental health services that operate and express politics and crystallize the history and whose nature and dynamics are understood.

The first are associated with the conceptual models that sustain the knowledge and practices of mental health, jointly with culture decide politics, and finally determine the formation of services. Such conceptual models of mental health are derived from the dominant paradigms in science, culture, education, administration, public health, and medicine, and its reflection is necessary to explain mental health knowledge and nursing.

From the social perspective of mental health, it is necessary that nurses study with depth the manner in which persons take care of each other and how through that process influence social dynamics in its distinct dimensions in order to provide for that care. A great contribution to the development of this idea has been Manfred Max Neef (1993) with his theory of the Development of a human scale, in which he proposes a new definition and classification of human necessities and of satisfying or destructive social processes that are realized or imposed. The care of mental health provided by nurses from a social perspective, jointly with the promotion of life, constitutes at least two of the principal missions of nursing that need to be considered and reinvented.

12.8 COMPONENTS OF A MENTAL HEALTH NURSING FRAMEWORK (MALVÁREZ, 1994)

The need for mental health by the communities of Latin America and society demand from nursing a new framework. Without it risks remaining at the edge, uninvolved, and possibly be brutally modified by changes instead of leading those changes from within. This framework can be made though participation and in response to local requirements and possibilities. As a function of the mission of nursing in society, in the field of mental health, this framework should be defined by social responsibility, action, and knowledge.

12.8.1 Concerning Social Responsibility

- Responsibility for the mental health needs of communities with a social and epidemiologic vision.
- Responsibility in the scientific evaluation of diagnostic measures and nursing therapeutics in mental health
- Responsibility in. the transformation of autocratic and dependent socio-cultural models, toward attainment of liberty, autonomy, citizenship, and production of life that affects mental health.
- Responsibility in the transformation of biological-curative health models and improvement of attention to general health.
- Responsibility in participant solution of the problems of mental health.
- Responsibility in the transformation of psychiatric institutions.
- Responsibility for politics and society and mental health.

12.8.2 Concerning the field of action

At the level of government

- Participation in the formulation of social politics and health and in the management of the application of laws in mental health.

- Participation in the formulation of politics that will develop mental health.

- Articulating mental health with education, justice, social well being, security, work, social communication and other sectors with politics, and general health plans.

At the community level

- Identify the mental health necessities of the community, of the groups and risk factors in mental health.

- Development and implementation of participant programs that promote and protect mental health.

- Intervene in situations of risk and crisis.

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13. DISTANCE EDUCATION AS A MANPOWER DEVELOPMENT STRATEGY

By Marlene Farrell

The profession of nursing is constantly challenged to meet evolving health care needs, while at the same time maintaining the standards and integrity of the profession. These needs arise from the requirements of society --nationally, regionally, and globally. As countries report on their nursing situations, almost invariably, the need for improving the level of preparation of various categories of nursing personnel surfaces.

As the profession moves into the 21st century, a major role transition for nursing is occurring worldwide. This transition arises from a view of the future where the nursing role will be interdependent, focused more on health care, with clearly specified independent functions and more flexible boundaries. The responsibility of the nurse will change from that of solely providing care and safety for patients in an institutional setting to that of developing health prescriptions in community-based institutions as well as in tertiary care environments. In the past, the major function of the nurse has been providing patient care under the direction of the physician, controlled by institutional policies set by others. In the future, nurses will not only provide direct care but will be involved in legislation, definition of standards, and policy determination as part of an interactive, multidisciplinary team. The focus of care provided will include prevention of illness as well as health maintenance and restoration.

For many countries, professional education and advancement for the nursing work force has been hindered by the scarcity of health manpower resources. And, this situation may be aggravated further by a lack of qualified nurse educators and infrastructure, such as basic utilities, libraries, and communication and transportation systems.

Across the continent countries are embracing distance education as a means of upgrading large cadres of nursing care providers--from aide to auxiliary, general or technical to professional, baccalaureate to master's and master's to doctorate--in a timely manner without disrupting their usual employment. Nursing, like many other disciplines, must move from the concepts of the industrial age to the new age of information, and efforts directed toward professional development must be responsive to the

challenges of the information age. While many changes have occurred in educational frameworks worldwide, continuing education is essential.

Distance education is based on the belief that when students have access to a program of planned instruction where the course materials are systematically designed and provide direction to additional resources, students can proceed in a self-directed manner and be successful in meeting the specified outcomes for each course. Distance education for nursing has been a part of higher education for nearly half a century, beginning with the University of South Africa (UNISA) in 1951 and followed in 1961 by the Open University of the United Kingdom (British Open University). Since the 1970's, the number of universities dedicated to distance education around the world has grown to nearly 30. including Athabasca University, Canada; National University of Education, Spain; University Established at a Distance, Costa Rica; and National Open University, Venezuela among others.

Distance education has been broadly defined by Moore as a strategy in which the teacher or institution providing instruction is separated either in time or place, or both, from the learners. The spirit and potential of distance education can best be realized by programs that are specifically designed and implemented based on the needs of the identified population of learners for whom the program is intended. The focus of the program is student learning rather than presentation of knowledge. The curriculum is competency-based, prior learning is assessed and validated, and skills to promote each student's success are developed. The role of the teacher is that of facilitator and collaborator in the learning process rather than giver of information. Services to support the educational and administrative processes are usually decentralized. These programs typically are described as correspondence, open learning/open university, semi-present, independent study/assessment, and more recently, the electronic classroom. A common denominator is all these approaches to distance education is innovation in delivery of instruction and in teaching-learning methodologies, and little or no classroom time.

Adult learning principles are important to the planning and delivery of distance education programs. The central theme is that the student is an active participant rather than a passive recipient in the teaching-learning process. The emphasis is on thinking rather than memorizing, and collaborative work between teacher and student and student with student. The teacher role is one of facilitation--a collegial relationship that encourages self-initiated networking so that students may have access to a wide variety of learning resources.

Self-development is another important consideration in distance education programs. The process of self-development begins when the student constructs and analyzes a personal portfolio and then devises a plan for developing knowledge and skill toward achieving an individualized program of study. The development of self continues as the student self-selects learning activities, pursues complex tasks and projects as an individual or group member, and participates in measuring his or her own attainment of the learning objectives through self-evaluation. Since adult learner centered programs are competency-based, the student faces only self-competition against a pre-established set of criteria with a specified minimum acceptable performance level.

Finally, because the program capitalizes on the assets the working adult brings to the educational setting, the workplace becomes a laboratory. The student in the employee role sees the immediate application of new knowledge to real problems encountered at work or in other settings or other roles. The personal satisfaction and the external recognition that come when new knowledge is used in problem identification and problem solving through effective change agentry boosts the confidence of the individual.

Today a variety of distance education programs are available to nurses in the United States, some serving a broad geographic area, others a more local community. The origin of the nursing degree program through distance education goes back more than 20 years and is linked to the generosity of the W.K. Kellogg Foundation. In 1973, a credit-by-assessment model, first for the associate degree and later the baccalaureate, began through the New York Regents External Degree through the University of the State of New York. In 1981, through the leadership of California State University, a statewide RN to BSN model, which included teacher-facilitated seminars for all courses and a credit-by-assessment option for many courses in the nursing major, was initiated. These innovative distance education programs overcame the initial skepticism and achieved accreditation by the National League for Nursing. They continue to serve as models for other states, other institutions, and other countries. The California program, now housed at California State University, Dominguez Hills (CSUDH), added a stateside distance education master's degree in 1985. In 1994, through the addition of electronic communications, the statewide model became a national model. Nurses who have access to a television/VCR or cablevision, plus a computer with a modem, can now enroll in CSUDH nursing courses anywhere in the United States. There are some students enrolled who live in the Caribbean, the South Pacific islands and in Europe. Mostly, these are nurses in the military who have been transferred to these locations. The national model is currently being extended to include the master's

degree program. The master's degree in nursing will be offered on line probably beginning fall semester 1998.

The Center for International Nursing Education at CSUDH is currently serving as a resource to existing and emerging distance education projects that have been funded by the W.K. Kellogg Foundation in Latin America and Africa. On the South American continent a variety of distance education programs is encountered. Consultants found that in Latin America, the term distance education often meant that students would never come on a campus or interact directly with a teacher. The term "semi-presencial" was coined to distinguish distance education in nursing from those that use solely a correspondence or independent study model.

For example, in the Southern Cone region of South America, nursing schools in Uruguay, Argentina, and Chile have initiated distance education programs. The Universidad de la República in Montevideo has experience with a BSN completion program. Argentina's nurses can complete a program of studies for the licenciatura through the Universidad Nacional de Rosario and soon will be able to earn the master's degree in nursing administration. In the Patagonia region of the country there is a completion program for the licenciatura in two states, Chubut and Rio Negro. Through the Pontífica Universidad Católica in Santiago, Chile, nurses from service can develop their knowledge of leadership and primary health care through a distance education certificate program.

Nurses in Cali, Colombia and nearby cities have had an exceptional opportunity. During the early 1980s the entire population of technical nurses there who desired upgrading earned the licenciatura in nursing through a distance education program offered by the School of Nursing at the Universidad del Valle. As the demand for that program was met, a distance education master's degree program was implemented and is actually more popular than the on-campus program. A new project of the School of Nursing is a distance education program to upgrade auxiliary nurses to the licenciatura. At the Universidad Nacional de Colombia in Bogota and master's degree program using some distance education methodology and other innovation educational strategies is underway.

At the Universidad de Zulia in Maracaibo, Venezuela, the School of Nursing implemented a distance education program to upgrade technical nurses to the licenciatura. While nursing faculty developed the learning materials, students from the School of Education participated in the instructional design process.

Brazil has two distance education programs funded by the Kellogg Foundation. In Minas Gerais there is an ongoing effort to upgrade

attendants to the auxiliary level. A new program is a decentralized master's degree program. In the southern part of Brazil, the School of Nursing at the Universidade Federal do Santa Catarina in Florianopolis has a unique project involving six universities and the states of Rio Grande do Sul, Parana and Santa Catarina. It is offering its master's degree on the campuses of the other universities to help build capacity, and will then serve as a resource when the other schools are ready to offer their own master's programs. The multi-university project has subsequently added a new component--a specialization program through distance education.

A proposal has been submitted to the W.K. Kellogg Foundation for develop a regional distance education program for the Central American region. The countries participating will be Guatemala, Honduras, El Salvador, Nicaragua, Costa Rica, Panama and the Dominican Republic.

The final example is from Mexico. The Universidad Autónoma de Nuevo León in Monterrey, México is currently offering a distance education program for completion of the licenciatura in collaboration with the University in Colima. The faculty has plans to develop a distance education master's degree program in the future.

It is certain that there are many other experiences with distance education in Latin America. It is also clear that the demand for nurses educated beyond a technical preparation continues to grow. Developed countries need to accelerate their efforts and developing countries need to be encouraged and supported as they respond to current and anticipated societal needs by using distance education strategies.

14. PANEL OF CLINICAL SPECIALISTS: MENTAL HEALTH AND PSYCHIATRIC NURSING

By Cecilia Del Valle, Ileana Miranda, Carmen Rivera, and Sylvia Rosada

The last part of the symposium was developed through a dialogue between clinical specialists who work in different scenarios of mental health and psychiatry in Puerto Rico. Mrs. Sylvia Rosado works with populations of women who are victims of sexual trauma that receive ambulatory services in the Hospital of Veterans. Mrs. Carmen Rivera provides supervision and rehabilitation of adult patients hospitalized for a long time in the State Psychiatric Hospital in order to return them to family and work life. Mrs. Ileana Miranda serves as therapist in a private agency of managed care that offers ambulatory psychiatric services to people in all stages of growth and development in the northwestern and center sections of the island. Miss Coral Andino is educator in the area of psychiatric nursing at the School of Nursing of the Inter-American University. Dr. Cecilia del Valle, is one of faculty of the School of Nursing of the Medical Center and teaches the course in psychiatric nursing and mental health.

Each panelist had the opportunity to share her experience including the roles and functions they carry out as clinical specialists, the services they offer, populations served and therapeutic modalities utilized. In the role of therapist they provide individual therapy, group therapy and family therapy, since having received training for this role during their education as clinical specialists. Mrs. Rivera and Ms. Andino were involved more in education both with patients and with adult students. While Ms. Rosado and Ms. Miranda carried out independent functions in their role of therapists. Both maintain a close collaboration with the interdisciplinary team to achieve an integrated and quality care. The teamwork is based on the belief that each member has a contribution to make to the holistic care of the patient child/adolescent, adult or older adult. They believe in the right of the patient to decide on his/her own care; continually promoting their participation in the care.

In addition to utilizing the traditional therapeutic modalities already mentioned, in practice other alternate therapies are being introduced, such as meditation, the creative visualization and the massages. These therapies have had very good acceptance especially with female victims of sexual trauma. The patient can receive the services during the hospitalization, which can vary from one to

four weeks or as ambulatory care. When the patient needs hospitalization, the admission can be either voluntary or involuntary. Involuntary hospitalization occurs for those situations in which the behavior of the patient endangers his/her life or that of another person or the community and in such situation is admitted through Law 116 of January 1980.

The clinical specialist in Puerto Rico has an academic preparation of master's degree in nursing and in this case the role is in the practice of mental health and psychiatry. The Clinical Specialist as a case manager functions in private agencies as well as for the state and federal government. The annual salary varies between $25,000 to $30,000.

The presentation was concluded recognizing that there exists a great deal of need in Puerto Rico to prepare nursing professionals in the area of mental health and psychiatry. This is due to the fact that in Puerto Rico the incidence of psychosocial problems such as violence, alcoholism, drug addiction, the partner and family abuse have been increasing, contributing to the development of emotional and mental disorders in populations of risk.

ANNEX A: AGENDA

PSYCHIATRIC MENTAL HEALTH NURSING
SYMPOSIUM AND MEETING OF THE EXPERTS
San Juan, Puerto Rico
8-10 February 1998

Location:

Club of the School of Medicine University of Puerto Rico, tel. (787) 758-2525; Lodging in Cardiovascular Center of Puerto Rico and Caribbean (in the same complex). They can receive faxes at School of Nursing (787) 281-0721, tel. (787) 758-2525 ext. 2100.

Sponsor:

- Pan American Health Organization (PAHO)
- Nursing School of the University of Puerto Rico
- Ministry of Health of Puerto Rico

Objectives

1. Provide an updated information on psychiatric and mental health nursing and prepare a videotape of selected presentations.
2. To review past and current technical cooperation in psychiatric/mental health nursing and make recommendations for future work by PAHO, in collaboration with other partners, to improve psychiatric and mental health services through nursing.
3. To prepare a scientific and technical document on nursing on psychiatric/mental health nursing that supports future technical cooperation of nursing in this area. The document will be in English/Spanish with articles in the language of the author, but with a summary in both languages.

PRELIMINARY AGENDA

Arrival 8 February

Individual meetings with Dr. Itzhak Levav and Dr. Sandra Land

7:00-9:00 p.m. Cocktail Center MEPSI, Faculty Lounge

9 February

8:00 a.m.-5:15 p.m. Symposium

The presentations will be in the language that the lecturer chooses (English or Spanish). It has not still been decided on simultaneous interpretation.

7:00 p.m.-9:00 p.m. Meeting of the experts

10 February

8:30 a.m. - 9:30 a.m. Symposium
9:30 a.m. - 5:30 p.m. Meeting of experts

ANNEX B: PARTICIPANTS LIST

Pan American Group of Nurses interested in Mental Health
San Juan, Puerto Rico
8-10 February 1998

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