Decolonization of Psychiatric Public Policy in Jamaica

FW Hickling[1], RC Gibson[2]

ABSTRACT

Involuntary commitment and custodialization were the principal tenets of British colonial public policy provisions for the management of the violent, disturbed mentally ill in Jamaica and the West Indies. Over the fifty years following Jamaica's political independence from Britain, a community engagement mental health programme has developed through a decolonization process that has negated involuntary certification, incarceration and custodialization, has promoted family therapy and short stay treatment in conventional primary and secondary care health facilities, and has promoted reliance on traditional and cultural therapies that have been extremely successful in the treatment of mental illness and the reduction of stigma in Jamaica. Collaborations involving The University of the West Indies, the Jamaican Ministry of Health and the Pan American Health Organization have been seminal in the development of the decolonizing of public policy initiatives, negating the effects of involuntary certification that had been imposed on the population by slavery and colonization. This collaboration also catalysed the psychiatric training of medical, nursing and mental health practitioners and the execution of community mental health policy in Jamaica.

Keywords: Community mental health, involuntary certification, mental health integration into primary healthcare

Descolonización de las Políticas Públicas en Materia de Psiquiatría en Jamaica

FW Hickling[1], RC Gibson[2]

RESUMEN

El compromiso involuntario y la custodialización eran los principios principales de las disposiciones de las políticas públicas coloniales británicas, para el manejo de los enfermos perturbados de sus facultades mentales y violentos en Jamaica y West Indies. Durante los más de cincuenta años que siguieron a la independencia política de Jamaica de Gran Bretaña, se ha venido desarrollando un programa de salud mental basado en el compromiso a través de un proceso de descolonización que ha invalidado la certificación involuntaria, el encarcelamiento y la custodialización, promoviendo en su lugar la terapia familiar y el tratamiento de estancias cortas en centros de salud de atención primaria y secundaria convencional. Asimismo, ha promovido la confianza en las terapias tradicionales y culturales que han sido sumamente exitosas en el tratamiento de las enfermedades mentales, y la reducción del estigma en Jamaica. Colaboraciones que incluyen a la Universidad de West Indies, el Ministerio de Salud de Jamaica, y la Organización Panamericana de la Salud han desempeñado un papel seminal en el desarrollo de iniciativas en materia de políticas públicas descolonizadoras, que anulan los efectos de la certificación involuntaria impuestas históricamente a la población por la esclavitud y la colonización. Estas colaboraciones también catalizaron el entrenamiento psiquiátrico de médicos, enfermeras, y profesionales de la salud mental, así como la ejecución de políticas comunitarias para el cuidado de la salud mental en Jamaica.

Palabras claves: Salud mental comunitaria, certificación involuntaria, integración de la salud mental en la atención primaria de la salud

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From: [1]Caribbean Institute of Mental Health and Substance Abuse (CARIMENSA), The University of the West Indies, Kingston 7, Jamaica and [2]Department of Community Health and Psychiatry, Faculty of Medical sciences, The University of the West Indies, Kingston 7, Jamaica.

Correspondence: Professor FW Hickling, Caribbean Institute of Mental Health and Substance Abuse (CARIMENSA), The University of the West Indies, Kingston 7, Jamaica. E-mail: frederick.hickling@uwimona.edu.jm

INTRODUCTION

During the closing decades of the twentieth century, there emerged a profound challenge to the entrenched colonial system of management of mental illness in Jamaica. This has catalysed an explanatory scholarship with the objective of understanding the aetiology of madness as well as the treatment systems that were imposed by the British during the period of slavery and colonialism. This article will document the psychiatric and mental health services present in Jamaica during the pre-colonial period, practice and policy during the period of slavery and British colonialism (*c* 1500–1962) and the overwhelming metamorphosis of the psychiatric system that emerged in Jamaica in the decades following independence in 1962.

Similar transformatory changes in psychiatric systems have also taken place in the other territories of the Anglophone Caribbean during the post independence period. This era has seen the establishment by The University of the West Indies (UWI) of undergraduate and postgraduate psychiatry training programmes that have profoundly influenced the training of medical doctors and nurses in the region. The UWI also pioneered the master's and doctoral degrees in clinical psychology and the development of a master's degree programme in cultural therapy to meet the needs of the people of the Caribbean. These transformatory changes are worthy of detailed description and analysis in their own right, but this article will focus instead on the decolonization of psychiatric public policy that has taken place in Jamaica over the last fifty years of political independence from Great Britain, as well as the role that the UWI has played in the profound metamorphosis inherent in this decolonization process.

The Emergence of the Lunatic Asylum

The treatment of the mentally ill by the indigenous Tainos of Jamaica as described by the Spanish Monk, De Las Casas (1542), involved the use of unguents and salvent herbs blended with foods which they hung from fruit trees for those they called 'mind-riven' who were allowed to wander at large. The Spanish colonizers attributed the excellent results achieved by these indigenous treatments as sorcery (1). By the time the British captured the island of Jamaica from the Spanish in 1655, the majority of the indigenous population had been eradicated by genocidal violence or lethal infectious diseases imported by the Spanish colonizers (2). The next 150 years saw the massive introduction of African slaves *via* the triangular trade, and history records the viciousness with which the slave masters treated their slaves. The mortality rate of African slaves was the highest in the first century of slavery, and it was not unusual for reports of horrendous murders of African slaves inflicted as punishments by their masters (3). During slavery, the health of slaves was the responsibility of the slave owners. It is likely that violent mentally ill slaves in this period would be 'put down' by their owners. The comment by Halliday (4) that "*. . . mental illness was rare in Africans and slaves of the West Indies* . . ." is therefore not surprising. In the first half of the eighteenth century some slaves who were deemed to be mentally ill were incarcerated in plantation dungeons or 'hot houses' (1). Jamaica's first Lunatic Asylum was part of the Kingston Public Hospital, established in 1776. Involuntary commitment and custodialization were the principal tenets for the public policy provisions for the management of the violent, disturbed mentally ill in Jamaica and the West Indies. "*. . . The conclusion is inescapable that measures to remove, sequestrate and care for the insane were central elements in Britain's 'civilizing mission'. . . .*" (5). It is important also to note that prior to emancipation, public institutions accommodated only Whites and free Black people.

The Most Cruel and Revolting Crimes

The establishment of the asylum at the Kingston Public Hospital signalled a period in colonial history where the responsibility for the care of the mentally ill slaves was shifting from the slave owner to the colonial Government as the prelude to abolition and emancipation. The state did not take responsibility for the care of ordinary Black people until post emancipation and the new mental hospital (1860) was built partly to accommodate the increase in numbers with the addition of ex-slaves to the patient pool (6). Hickling and Gibson (7) suggest that the establishment of the asylum in Jamaica represented a shift towards more humane treatment for the mentally ill that was mirroring a shift that was taking place simultaneously in the United Kingdom (UK). Smith (5) suggests that the first successful abandonment of the use of instruments of mechanical restraint – chains, leg locks and hand cuffs – in England took place around the time of the abolition of slavery in the West Indies, and the reduction in the use of the instruments of torture of African slaves. Morrissey (6) suggests that this period of convergence may have been catalysed by the mental illness of King George III in England. However, these enlightened forms of treatment were slow in reaching the Lunatic Asylum in Jamaica. The conditions for the mentally ill incarcerated in the asylum in Kingston were appalling. The situation of overcrowding and ill treatment that existed in that institution was recorded by the warden of the time to be "*a chamber of horrors*" (8) and the physical abuses commonly inflicted on the patients of that institution, described by Henry Taylor, the head of the West Indian Department at the Colonial Office in 1961 as "*the most cruel and revolting crimes*" (9). Agitation by Jamaican Dr Lewis Bowerbank and his colleagues eventually succeeded in the establishment of a new Lunatic Asylum in Rae Town in Kingston (7). Between 1863 and 1886, the English physician Thomas Allen attempted to establish the rudiments of '*moral treatment*' that married custodialization and involuntary commitment with vocational therapy. This experiment was short lived, however, and by the end of the nineteenth century, the conditions of overcrowding and despair had returned to the Lunatic Asylum and remained so

until the transformation that would take place at that institution in the decade following political independence in 1962.

Political Independence, Asylum Deinstitutionalization and Community Mental Health

The pioneers of the post independence revolution in Jamaican psychiatry were Grenadian-born psychiatrist Michael Beaubrun and his Jamaican counterpart, Ken Royes. In the decades before political independence from Britain in 1962, they had both worked in state mental hospitals of the Caribbean, Beaubrun in Trinidad and Tobago (St Ann's Hospital) and Royes in Jamaica (Bellevue Hospital). Both Beaubrun and Royes were leading proponents of the community mental health philosophy and the antithetical rehabilitative deinstitutional public policy. Beaubrun created the training nexus for medical practitioners in the Caribbean by establishing the undergraduate and postgraduate psychiatry training programmes in the Faculty of Medical Sciences of The University of the West Indies at Mona, Jamaica (10). These programmes have been responsible for the psychiatric training of hundreds of Jamaican and Caribbean physicians and nurses and more than thirty psychiatrists who have helped drive the metamorphosis of psychiatric policy and practice in Jamaica in the post-colonial period.

The name of the Lunatic Asylum in Jamaica was changed in 1947 to the Bellevue Mental Hospital (BMH). Soon, thereafter, Ken Royes joined a long tradition of Jamaican psychiatrists in the twentieth century as the Physician Superintendent of the asylum (1948–64), and in collaboration with colleagues from the Pan American Health Organization, catalysed the transformation from custodialization of the severely mentally ill to rehabilitation and community treatment. Important elements of this transformation were the implementation of Maxwell Jones' (11) concept of the therapeutic community, the establishment of vocational therapy and a thrust towards community and family reintegration of patients from the asylum (12).

Cultural Therapy

A major element of the transformation of the Bellevue Mental Hospital and its conversion from a custodial into a rehabilitative hospital was the development of a cultural therapy process, which culminated in the formation of the Cultural Therapy Centre in 1978 (13). This centre was established on the grounds of the mental hospital with close access to the adjacent community. It was manned by an operational clinical team and was attached to a fully equipped open-air performance and entertainment garden theatre capable of seating one thousand five hundred patrons, and supported a ten-piece popular musical band. In addition to patients and staff of the BMH, the Cultural Therapy Centre also accommodated drop-in mentally ill homeless persons. The therapeutic methodology used at the centre consisted of sociodrama and a novel psychotherapeutic approach called psychohistoriography. The sociodrama process involved a combination of cultural and creative artistic expressions of the patients and staff with a psychotherapeutic analysis and a political process that was designed to implode the ideological struggles within the institution, thus resulting in new levels of productivity and social relationships. Out of monthly large group meetings that had been instituted between patients and staff, the process of psychohistoriography was created. Psychohistoriography is a fusion of historiography, dialectics and psychotherapy involving the examination of the psychological implications of a timeline of historical anecdotes and phenomena. A number of pageants were produced out of the cultural therapy process and these were performed to thousands of persons across Jamaica. They reflected very closely the anecdotal material and the themes and trends thrown up by the psychohistoriographic process around the large group meetings (13). The notion of culture as the driving energy of social therapy and change underpins the practice of cultural therapy and also captures the philosophy of Freire (14), who demanded the social and ideological transformation of the oppressed and disenfranchised peoples of the world, based on the needs of their own cultural expressions.

Community Mental Health Services

In the early 1970s, some of the initial psychiatrists trained in Beaubrun's fledgling UWI psychiatric residency programme, in conjunction with enterprising nurses from the Bellevue Mental Hospital, brought other revolutionary changes to the mental health services in Jamaica with the establishment of a community mental health and deinstitutionalization programme. The programme saw the integration of psychiatric services with general primary and secondary healthcare services, the establishment of a cadre of specialist community psychiatry nurses known as mental health officers, the implementation of new mental health legislation in 1974 and the reduction of the 3000 patient mental hospital population to 1200 persons by 1990 (15). The first steps towards the integration of mental health and primary care services took place in the parish of St Thomas at the outpatient clinic at the Princess Margaret Hospital. The pilot project, pioneered by Frank Ottey (16) and those early mental health officers (17), helped to establish the model on which the islandwide service was established. The initial implementation of the community mental health service in 1974 precipitated an immediate reduction in admissions to the mental hospital by 52% in the first two years (18). Eventually, primary care mental health services were established in nearly 400 clinics islandwide.

Treatment of Psychosis in Open General Medical Wards

The integration of psychiatric services with general secondary healthcare services took the form of the inpatient management of acutely disturbed, usually psychotic, patients in the open general medical wards (OGMW) of general

hospitals (19). This represented a major departure from the practice of psychiatry on the world stage where persons with psychiatric disorders were, and still are, being treated in separate wards or institutions from patients with physical illnesses. The OGMW model, although initially spawned by Beaubrun (10) at the University Hospital of the West Indies (UHWI), was midwifed out of economic expedience when there were insufficient funds to establish deinstitutionalized discrete short-stay inpatient psychiatric wards in general hospitals throughout the country. The for-tuitous establishment of the OGMW model has yielded im-pressive results; by 2010, 44% of the annual admission of acute psychiatric patients was to these facilities (as opposed to institutional and other settings) and 67% of the admissions of all psychiatric admissions were to community hospital facilities (20). The OGMW model has also been associated with superior patient outcomes. Hickling *et al* (21) demonstrated that first-contact patients with schizophrenia in Jamaica admitted to and treated in OGMWs of general hospitals had swifter recovery, shorter stay in hospital, and less relapse than similar first-contact patients admitted to psychiatric units of general hospitals or to the mental hospital. Overall, the community mental health services established in post independence Jamaica have also shown superior patient outcomes with international comparisons. Hickling *et al* (19) showed that the relapse rate for patients with first-contact schizophrenia in Jamaica (13.7%) was much lower than the reported relapse rate for first-contact patients with schizophrenia in other developing countries (39%), and significantly lower than the reported relapse rate for first-contact patients with schizophrenia in first world countries (65%) like the UK (22).

Stigma and Victimization

Collis noted the high level of stigma towards mental illness in Jamaica and toward the Bellevue Mental Hospital (23). In a recent quantitative population survey of stigma in Jamaica, Gibson *et al* suggested that in the period of deinstitutionalization since the 1960s, there has been a beneficial effect on the stigma toward mental illness (24). Their study indicated that 79–82% of respondents in the national survey displayed attitudes of compassion, care, love and concern in comparison with the 37–43% who showed attitudes of anger, fear and disgust. Hickling *et al* (25) in a qualitative study on stigma to mental illness in Jamaica reported:

> ". . . *Participant narratives showed that stigma had transitioned from negative to positive . . . . The Bellevue Mental Hospital and homelessness were identified as major causes of stigma. Attitudes toward the mentally ill have improved and stigma has decreased since the increase of community involvement with the mentally ill. This reduction in stigma seems to be a result of the rigorous deinstitutionalization process and the development of a robust community mental health service in Jamaica . . .*"

In a recent article describing the dismantling of the archaic colonial custodial system of care at the mental hospital, Hickling explained how the deinstitutionalization processes revealed the interrelationship between the colonial victimization of Jamaicans with African belief systems such as the Rastafari, and the creation of mental health systems of incarceration designed to excise these belief systems from the mainstream of colonial society (26).

CONCLUSIONS

Collaborations involving the UWI, the Jamaican Ministry of Health and the Pan American Health Organization have been seminal in the development of the decolonizing public policy initiatives, the training of medical and mental health practitioners and the execution of community mental health policy in Jamaica. The transformation of the mental health services in Jamaica over the fifty years following political independence from Britain has spawned complex community mental health systems, integrated with the public health system, which have harnessed the energies of these therapeutic forces into processes that have sculpted contemporary conceptions of mental health, and which have powerfully negated the effects of involuntary certification that had been imposed by slavery and colonization on the life and behaviour of the Jamaican people.

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