

# COMMUNITY PSYCHIATRY AND THE PAN AMERICAN HEALTH ORGANIZATION: THE JAMAICAN EXPERIENCE<sup>1</sup>

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This report is dedicated to the memory of Dr. K. C. Royes, Jamaican psychiatrist, scholar, and gentleman, without whose foresight and self-sacrifice the changes related below would have taken years longer to achieve. He died most tragically in 1975 while working with the authors and the Jamaican authorities on consolidation of the new mental health services.

*Jamaica's mental health program, carried out with the assistance of consultants from the Pan American Health Organization, has focused on getting away from custodial care, redistributing services as much as possible in general hospitals throughout the country, and involving an enlightened community. Staffing has been accomplished in large part through brief basic or supplementary training of existing health professionals.*

## Background of the Program

The gradual realization that custodial care in isolation from the community and from other health facilities is a poor form of psychiatric attention has led in the Caribbean area to an increasing interest in alternative approaches. The Pan American Health Organization has helped to generate such thinking and has given some assistance in bringing about the necessary changes. For example, in Montserrat, where at one

time psychotic patients were jailed and then transferred to the Mental Hospital in Antigua, they are now mostly treated in the general hospital and followed up in community clinics. This has been achieved in the absence of a psychiatrist by progressive health professionals with lay support and PAHO consultation. Similarly, Barbados has developed an elaborate system of community care based on a district psychiatric nursing service. There is also a rapidly expanding sheltered workshop which has had much public backing. The Bahamas, Dominica, Grenada, Jamaica, Trinidad and Tobago, and other places in the Caribbean area have likewise begun to introduce the community approach.

The present report will deal with the specific case of Jamaica. The third largest island in the Caribbean Sea, it lies 90 miles south of Cuba and is 148 miles long by 50 at

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its widest point. The country has a population of almost 2 million, more than a third of whom live in or near Kingston, the capital. The majority of the people are of African or Afro-European descent, and English is the language spoken. Its independence gained in 1962, Jamaica is governed by a parliamentary democracy patterned along English lines, and suffrage is universal. The crude death rate was 7.6 per 1,000 population in 1971, and life expectancy is estimated at 70 years. The health services are quite sophisticated.

In 1958 the Jamaican authorities requested advisory services from PAHO in connection with a proposed review of the situation of psychiatric care and the development of corresponding recommendations. At the time, all such care was provided by Bellevue Mental Hospital in Kingston, a custodial institution with 2,700 patients.

A PAHO consultant came briefly and recommended decentralization, together with the development of in- and outpatient services at the rural hospitals (1). He also suggested that further technical assistance be requested in order to elaborate a full plan. Accordingly, a second consultant came for a short period in 1962 and returned for several months in 1964 to work on an intensive study of the existing situation and the development of a detailed program. The resulting proposal (2) amounted to no less than a revolution in the existing system for care of the mentally ill. The plan was accepted in principle by the Government, and it received further impetus through the formation of a Department of Psychiatry at the University of the West Indies in 1964. The decision was taken to house the Department in University College Hospital, a teaching general hospital, where it was given six beds initially.

The major aim of the plan was to bring quality psychiatric care within ready reach of the entire population. This was to be achieved through: (1) the provision of education in the principles of mental health

and ill health for all medical personnel, for key nonmedical personnel, and for the lay public; (2) the redistribution of psychiatric services; (3) the building of needed new facilities; (4) the development of a new administrative structure; and (5) the drafting of a new law on mental health. It was suggested that a psychiatrist and a psychiatric nurse be provided by the Pan American Health Organization to assist in the implementation of this plan. The two posts were in fact created in 1968 and have been filled almost continuously since then.

The progress achieved in each of these five main areas is briefly reviewed below.

### **Education in the Principles of Mental Health**

#### *Demonstration Unit*

On arrival of the PAHO consultants in Kingston, a demonstration unit was set up in one of the better admission wards of Bellevue Mental Hospital. Its purpose was twofold. In the first place, it was to be used to train doctors and nurses from country hospitals and from the public health service. Here they were to learn the techniques of basic psychiatry which had not been a part of their previous training so that, with some consultation and guidance, they would be able to care for the mentally ill in their areas. Secondly, it was to provide in-service training for Bellevue staff in modern techniques of psychiatric care. The ward was run as an open-door therapeutic community, with smaller group therapy, individual therapy for some patients, a busy activity program, individual nursing care plans, and much staff interaction and teaching.

It was not possible to implement the first aspect because staff shortages prevented the Ministry of Health from releasing rural health professionals to undergo the special training planned. This problem was partially overcome by running a series of seminars in the rural hospitals over the next

four years. As for the second part, the unit did serve a useful in-service training function for the hospital. It was also much used in the teaching of clergy, probation officers, nurses, psychiatric residents, and many lay groups. Perhaps its most important function was that it showed a wide variety of people that a psychiatric ward could be a place filled with enthusiasm, hope, trust, and creativity and that intensive care usually led to rapid recovery. It was continued for three and a half years.

### *Introduction of Psychiatry into the Health Sciences Curricula*

In 1965 a six-week clerkship in psychiatry was introduced in the medical school program and a series of lectures on basic psychology and psychopathology were included in the preclinical curriculum.

In 1969 all nursing students began to have a course in psychiatry as part of their training. Over the ensuing years many short courses in basic psychiatry have also been provided for senior nurses throughout the country. This has been done usually by attaching psychiatry onto whatever in-service training programs were already planned or in progress—for example, courses in personnel management and administration. Similarly, midwives in training also received orientation in the subject. These efforts have done much to enhance the acceptance of psychiatric care in rural hospitals and in the community. By now all the general hospitals in the country (21 in total) have nurses on their staff who have had some psychiatric training, and several of them have young doctors also with such preparation.

In 1969 the first five mental health officers were trained and placed in rural parishes. Drawn from the ranks of the nurses in the mental hospital, they were all trained psychiatric nurses to begin with (holding the degree of R.M.N.—Registered Mental Nurse) and some of them were also

generally trained (R.N.—Registered Nurse). Their additional program consisted of a three-month course in community psychiatry, with emphasis on increased understanding of the social factors leading to psychiatric illness and the methods and resources available for mitigating these factors. Their task was to promote early case-finding and treatment in their parish and to assist in the follow-up of patients discharged from Bellevue Hospital. At first they operated in a vacuum with very little support, since there were few doctors with the knowledge or interest to practice in- or outpatient care of the psychiatrically ill and too few psychiatrists to permit the scheduling of regular consultations in rural areas. They were pioneers in a very real sense. Over the last six years their number has increased. This corps now forms the backbone of the new regional services and is constantly gaining support and recognition, both professional and from the general public.

In 1972 the Department of Psychiatry began its graduate program with one candidate. With supplementary courses offered through a one-year exchange program with the Department of Psychiatry at Edinburgh University, it has been possible to train seven Caribbean psychiatrists up to the specialist level and another four doctors have received a one-year course in psychiatry.

### *Education for Nonmedical Personnel and the Lay Public*

It cannot be said that any programmed plan of mental health education has been drawn up to focus on key nonmedical groups such as police, clergy, lawyers, politicians, or teachers. Still, in a variety of ways these groups have gradually become more involved. Right now the police have recognized the need for some training in the psychology and management of the emotionally disturbed, and a course in these

topics is to become part of the police training program. Likewise, many useful seminars have been run for teachers, would-be school counselors, clergy, probation officers, and university lecturers.

The gradual change in attitude of the lay public is very evident. The populace is much more accepting of the partially recovered mentally ill patient and is learning how to support and encourage him. This new outlook would seem to stem largely from the program's efforts to treat some mentally ill patients in local health facilities.

### Redistribution of Psychiatric Services

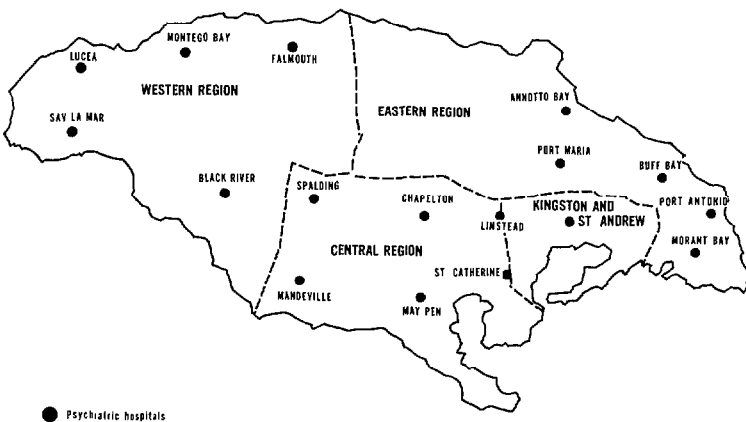
The first move in the direction of redistributing the services was the placement of five mental health officers in different parishes in 1969. Their assignment permitted increased patient care in all phases of treatment within their respective areas.

The country was divided into three broad regions (Figure 1). In July 1973 the first regional psychiatrist was appointed. With the assistance of three mental health officers, he was responsible for covering the Eastern Region of the country (population

350,000). After three months of his weekly in-patient consultations at all the hospitals in the area, the Region's admission rate to Bellevue Mental Hospital was cut to half of what it had been before (3). A second psychiatrist was located in Mandeville to cover the Central Region of the country in November 1973. A third one was placed in Montego Bay to cover the Western Region (350,000 population) in January 1974. These psychiatrists, with the assistance of mental health officers and the local health personnel, have developed in- and out-patient consultation on a weekly or fortnightly basis in almost every hospital in the country and are now attempting to involve district medical officers and their health clinics. As a result of these changes, the overall rate of admissions to Bellevue Mental Hospital has declined by 50 per cent.

It is anticipated that the number of regional psychiatrists will eventually be increased to one per parish, or one per 100,000 population, with a corresponding increase in the number of mental health officers. The service will become more comprehensive and will be totally integrated into the public health service.

Figure 1. Psychiatric regions of Jamaica and location of hospitals with psychiatric services.



### Building of New Facilities

The following steps toward the provision of new or improved facilities have been taken or are on the drawing board:

- Establishment of a rehabilitation service for long-stay institutionalized patients at Bellevue Mental Hospital—work started (4, 5);

- Conversion of Bellevue into a 500-bed acute psychiatric treatment center for the metropolitan area with certain specialized programs—plan being drawn up;

- Inclusion of a 30-bed psychiatric unit in a new wing of the Government General Hospital in Kingston—plans completed;

- Provision of 50 psychiatric beds at the new Regional Hospital in Montego Bay—25 already open;

- Installation of 20-bed acute psychiatric units at the general hospitals in the regional towns of Mandeville and Port Antonio—plans underway; and

- Building of 100- to 200-bed rehabilitation units for subacute patients at regional centers outside Kingston—namely, in Montego Bay, Mandeville, and Port Antonio—coordination and negotiations underway with the National Rehabilitation Services.

The ultimate aim is that each region will be able to look after its psychiatrically ill with the exception of those requiring highly specialized service, e.g. adolescents, drug abusers, etc.

It should be kept in mind that the effectiveness of these facilities will depend on having well-trained staff to man them.

### Development of a New Administrative Structure

Plans have been made for the appointment of a Principal Medical Officer (Mental Health)—that is, a Director of Government Psychiatric Services in the Department of Health, who will be responsible for overall planning and coordination of the

program. This person will have line supervision over the Senior Medical Officer at Bellevue Medical Hospital and the regional psychiatrists and technical supervision of a newly created Senior Nursing Officer (Psychiatry), who in turn will be in charge of all psychiatric nurses and the mental health officers.

### Drafting of a New Mental Health Law

After long delay, the nineteenth-century Jamaican Mental Hospital Law is being rewritten in the form of contemporary mental health legislation. Several English-speaking Caribbean countries already have modern mental health laws.

### Discussion

A description has been given of the initiation of community psychiatry in Jamaica. Certain questions are raised immediately.

*Should an attempt be made to launch a community program at a time when the mental hospital program is suffering from a shortage of well-trained staff?*

The answer would seem to be definitely in the affirmative. Custodial hospital programs are a way of hiding from the public what it does not want to see. Driving through Kingston these days, one sees well-fed but obviously psychotic individuals wandering around. If the mental hospital were performing a traditional custodial role, they would in all likelihood be housed in a locked ward with scant staff. As it is, mentally ill patients are now mixed in with other patients in many general hospital wards, and with efficient treatment they are often recovering and revealing themselves as healthy, concerned people. Jamaica is a small country and a chatty one; word of these events spreads quickly in the local communities, with remarkable effect in

increasing empathy and understanding of the mentally abnormal.

*Can such a program progress in a developing country in the absence of locally trained staff?*

The answer to this question is clearly *No*. At present the Jamaican program is seriously stalled by the lack of locally trained psychiatrists, social workers, psychiatrically trained nurses, occupational therapists, psychologists, and mental health officers. Attempts to import such people from developed countries are bound to be of limited success. Apart from the problem of salaries and working conditions, cultural differences may keep arriving professionals from contributing fully for at least a year, and language differences can prolong this adaptation even more. The obvious way to continue and expand the program in Jamaica while waiting for additional trained professionals is to increase the psychiatric potential of existing health personnel and to train mental health officers in larger numbers. The rural health personnel are gradually becoming more involved in psychiatric care through the efforts of the regional psychiatrists and the mental health officers. It is felt that this trend will be greatly accelerated when the district public health physicians have all had training in community psychiatry. In the last three years all candidates for the Diploma in Public Health at the University of the West Indies have studied a course on this subject, and some of these graduates have already moved into rural positions. As for the mental health officers, a training course for another group is scheduled.

*What role has the Pan American Health Organization played in this saga and what should it do in the future?*

Indeed, it has served a number of functions and these are worth looking at in some detail:

- *As creator of a new ideal of care:* The consultant sent by the Organization in 1958 provided the first broad directions for a contemporary system of psychiatric care in Jamaica.

- *As planner:* In 1965 the PAHO consultant left a detailed plan of operation with the Jamaican authorities. Unfortunately, only its short-term phase could be implemented. Until recently most health planning in the English-speaking Caribbean area—not just mental health planning—has been carried out according to a “response-to-crisis” pattern. This is now changing, but only gradually, to long-term planning based on a careful appraisal of the present situation and future needs. Meanwhile, it is still the short-term plan, with its obvious concrete gains, that is most likely to be carried through to an effective conclusion.

- *As teacher of medical personnel:* The PAHO consultant has a useful role to play as teacher of community psychiatry, social therapy, psychiatric research, group psychotherapy, psychodynamics, dynamically oriented nursing, child psychiatry, etc.

Jamaican and British training has had a heavy bias toward the organic, descriptive approach, in which the psychiatrist, viewed as the only real arbiter of psychiatric care, struggles with a virtually incapacitating workload. This system evidently has its shortcomings in meeting the needs of a developing country. The psychiatrist must be taught how to delegate responsibility and provide care by utilizing the skills of many less-trained individuals. In this regard the PAHO consultant can serve as instructor.

Finally, the Organization's consultant can help to promote research and the development of special areas such as child psychiatry and care of the mentally retarded.

- *As liaison between university and governmental services:* In most countries there is an area of difference between university medicine, with its emphasis on training, and governmental medicine, with its em-

phasis on service. It tends to become accentuated in a developing country where governmental health services are grossly overextended. In such circumstances the PAHO consultant can help to maintain a good level of cooperation between these two areas of endeavor.

- *As coordinator of plans and programs involving psychiatric nursing:* Despite the fact that usually about half the beds in a national health service are devoted to psychiatric care, psychiatric nursing does not figure importantly in national nursing plans and policies. A PAHO nursing consultant in mental health is in a unique position to ensure that the psychiatric aspects of nursing get a good hearing at the highest executive level and to promote the creation of a psychiatric nurse position at the level at which general health policies and programs are laid out.

- *As international "seal of approval":* Many psychiatric workers in developing countries are well trained and progressive but have great difficulty in getting their proposals implemented because of lack of local support. The PAHO consultant can often help to present these proposals with maximum enthusiasm and force.

- *As educator of key citizens and the general public:* A proportion of the consultant's time can usefully be spent in increasing the understanding of psychological processes and problems on the part of key lay personnel. This may take the form of organizing seminars for such groups as teachers, clergy, or police. Frequent use of the news media is

also helpful. With the growing public interest in this field, it becomes much easier to influence legislators to rewrite the laws and vote funds for necessary changes.

- *As provider of training fellowships:* The identification of key psychiatric personnel who with additional training can provide needed leadership, as well as the provision of that training, has been another valuable function of the Organization.

### Conclusion

Thus the nucleus of a community-based program of psychiatric care has been constructed in Jamaica and it has demonstrated its superiority beyond a shadow of doubt in terms of both quality of care and economy. Its development may be divided into three stages: the *stage of preparation*, during which medical personnel were taught psychiatric skills and the philosophy of community care was explained to them and to the public; the *stage of implementation*, in which regional services were set up and a major rehabilitation drive was launched in the national mental hospital; and now the *stage of consolidation and expansion*, which is just about to begin. Community psychiatry has definitely made its mark in Jamaica, and its absence would now be acutely felt.

The Sixteenth Report of the WHO Expert Committee on Mental Health, titled *Organization of Mental Health Services in Developing Countries (6)*, echoes and supports the substance of the observations reported herein.

### SUMMARY

The development of a modern psychiatric service in Jamaica and the role played by PAHO consultants in this development is described. Some fundamental points are raised:

- It is essential that a director of mental health services and a senior psychiatric nurse be given senior positions in the Ministry of Health so that the psychiatric services receive due attention and

are integrated closely with the other health services.

- The local training of psychiatric professionals of all categories is essential for such a service and should be given priority by the Government.

- The intelligent use of a large number of briefly trained individuals is the only way to

provide psychiatric coverage in a developing country.

- PAHO consultants assigned to work in a

developing country over an extended period can play a useful role in the introduction of contemporary psychiatric services.

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