Psychiatry in the Commonwealth Caribbean

A brief historical overview

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Treatment of the mentally ill by the Aboriginal Awaraks of Jamaica and the other Caribbean islands was first described by a Spanish monk in 1540[1]: 'Lunatics' who were called 'mind riven' were treated in the community with salvent herbs, which were blended with food and left to hang on fruit trees for those who wandered, and by the administration of unguents and lavings while singing. This record indicates that the mentally ill were treated by the indigenous Indians without restraints, and with rudimentary attempts at pharmacology and cultural therapies. But this enlightened but primitive mental health system was destroyed with the advent of the Spanish conquerors who, according to Las Casas, "in about eight to forty years have unjustly put to death about twelve million Indians without distinction of quality, sex or age".

During the Spanish colonial period (1500–1650) the mental health system of the indigenous Indians were promptly replaced by the prevailing psychiatric practices of Europe. In Jamaica especially, designated buildings adjacent to the monastery in the main town of Santiago de la Vega were used for the mentally ill.[2] Clearly this was the beginning of custodial institutionalisation in the West Indies. It is important to note that the population of the islands, decimated by genocides, was small, and the need for psychiatric facilities minimal.

Most of the islands were captured by the British in the mid 17th century. This period heralded the onset of the slave trade, during which millions of Africans were brought to the Caribbean as part of the enormously remunerative 'triangular trade' between Europe, Africa, and the Americas. The population increased one hundred-fold. The need for mental health services increased to match the dramatic rise in population. But the services did not grow correspondingly.

There was a high incidence of mental illness during this period. Suicide was common as a reaction to slavery, Africans showing a stubborn refusal to accept the status of slaves. Hanging and dirt eating were the most common forms, while mass suicides of groups of 25 or more were "awefully prevalent". Cases of outright insanity caused by the impact of the slave ships have also been reported. Facilities for such mental illness were virtually non-existent in that period. The rudimentary hospitals or 'hothouses' on some slave plantations were used for solitary confinement. The high numbers of 'weakly' or invalid slaves were an indication of the cruel treatment and extremely severe labour to which the Africans were subjected.

Mental health facilities provided by the British at this time simply continued the tradition of violence and restraint which had started with the Spanish colonialists. Certainly, any form of violent behaviour (psychiatric or otherwise) was treated with the legal penalty of death, usually in a barbarous manner such as slow burning.

Not that there was a shortage of trained doctors during that period; there were 300 in Jamaica in 1833. The profession was respected and the practitioners proved helpful, reliable, competent and often ingenious. Brathwaite[3] reports that doctors looked after the local white population and the slaves on the plantations but strict medical attention to all patients, particularly the slaves, was impossible. Perhaps the most significant mental treatment facility for the mass of the population was provided by the black slave preachers, doctors and obeah men. These practitioners were almost entirely independent of white control and contributed enormously to the physical and psychological wellbeing of the slaves. Slave doctors were usually confined to the plantation while obeah men and women had influence throughout society. Indeed, so influential were the latter that the British authorities introduced draconian legislation banning the use of obeah across the Caribbean.[1,3]

Liberalisation of the colonial system occurred during the 19th century in response to slave rebellion across the Caribbean and changing economic prospects of the triangular trade. The emancipation of slaves in 1834 was accompanied by an increasing administrative response to health needs, although the services lagged behind those in Britain itself. The turn of the century saw the construction of eight hospitals in Jamaica,[3] each of which contained an annexe for the treatment of the mentally ill, usually by confinement, and immersion in a rush tank for the unruly.[2] The slave hospitals on the plantations were

https://doi.org/10.1192/pb.12.10.434 Published online by Cambridge University Press

closed during this period and, in Jamaica, the annexe of the Kingston Public Hospital was enlarged and officially designated the Lunatic Asylum for all mentally ill persons from the population of close to 400,000.

The Act of Emancipation did not, however, improve the economic situation of most of the population and wave after wave of violent revolt continued. The British response increased militarisation, and increased custodial institutionalisation for the apprehended offenders. Secure prisons were built and, by 1844, insane persons charged with offences were being confined in them. By the mid 19th century, the available space for the confinement of insane persons became hopelessly inadequate and led to the creation of larger and more secure lunatic asylums. For example, an asylum was constructed in Antigua to serve all the Leeward Islands which included the British Virgin Islands, St Kitts, Nevis, Anguilla, Barbuda, Montserrat and Dominica. In Grenada, an asylum was established in 1879 in an old Fort built by the French 100 years previously, and served the Windward Islands. The creation of these asylums and the supporting legislation occurred across the Caribbean between 1860 and 1895. Restraint was the main therapeutic tool and continued until the mid-20th century. In some territories, an attempt at vocational therapy was instituted but this was short lived.

Private practitioners provided mental treatment to those who could pay, but by far the largest segment of the population received care from black preachers and the ubiquitous obeah men and women who had survived the attempts of the British to destroy them. This pattern of community mental health care has continued in every Caribbean island.

The mental health systems continued more or less unchanged in the first half of the 20th century. By the 1930s two major factors had begun to influence the care of the mentally ill: first, was the rise of physical treatments and, second, the wave of workers' unrest which triggered the independence movement. Most of the lunatic asylums mentioned earlier had fallen into disrepair; sanitation and overcrowding were deplorable, supervision was lacking, and therapeutic programmes absent. The populations of the institutions had trebled or quadrupled, and the staffing was minimal and inadequately trained.[2]

In the mid-1930s the lunatic asylums were all redesignated as mental hospitals with names suggesting tranquillity: Seaview in Belize; Bellevue in Jamaica; Black Rock in Barbados; Richmond Hill in Grenada; and St Ann's in Trinidad. The 1940s saw the introduction of ECT, insulin coma and lobotomy, while the 1950s heralded the advent of the phenothiazines and occupational therapy. Still, conditions improved only marginally, and the populations of the hospitals continued to grow. These conditions and treatment services were in large part responsible for the growing stigma of mental illness around the Caribbean. There were few psychiatrists at the time although West Indian doctors were being trained in Britain in small numbers.

Most community mental treatment facilities were still in the hands of private practitioners, religious healers and obeah men, and most of the neurotic and personality problems of the population, which had further trebled by this time, were being administered to by these sources.

Compared to the previous five centuries, the post-independence period has been associated with a massive explosion in research, training and clinical services. Perhaps the most critical factor was the establishment of a Faculty of Medicine in the University of the West Indies in 1947, and the development of a Department of Psychiatry in 1965. The Department has provided psychiatric training for medical students, and continuing postgraduate training for psychiatrists, most of whom continue to work in the Caribbean, and are primarily responsible for the continuing improvement of the mental health services.

Mental health legislation

The Mental Hospital Laws produced by British colonial governments provided a model for custodial treatment. A new Mental Health Act based on the 1959 UK Act came into force in Trinidad and Tobago in 1975 and provides for the establishment of community psychiatric facilities, the redefinition of the procedures for compulsory admission of the mentally ill, and the provision of Mental Health Review Tribunals.[4] For the most part, mental health legislation still remains fixed to the older 'custodial' British laws, with Trinidad and Tobago being the only exceptions.

Community mental health

Spearheaded by the Pan American Health Organisation and the University of the West Indies, sectorisation of community services, the provision of general hospital psychiatric units, and out-patient services for the treatment of mental illness have been recommended for the Caribbean. The first general hospital unit was established at the University Hospital in Jamaica in 1965.[5] From my own study of this unit in 1975, I concluded that the predominantly physical methods of treatment had resulted in the improvement of most patients, but had also led to administrative problems concerning the provision of long-term out-patient care.

Sectorisation was initiated in Eastern Jamaica in 1972, serving a population of 370,000, and resulted in the reduction of hospital admissions by 50%.[6] The

sectorisation programme was established in Jamaica as Government Policy in 1974 and in Trinidad and Tobago in 1975.[4] The Jamaican programme of 17 general hospital psychiatric units and out-patient clinics was associated with a reduction of acute admissions to the mental hospital by 51% after two years. Similar programmes were established in Grenada[7], Antigua[8] and by 1983 similar services had been established in all the Caribbean Territories.

Other community mental health facilities

Several novel mental treatment facilities have been established in the community across the Caribbean during the last three decades. Alcoholics Anonymous (AA) has grown rapidly in Trinidad and Tobago with special adaptation to the village system; 115 AA groups and 12 Al-Anon Groups had been formed by 1980.[9] In Jamaica, Allen has developed novel 'holistic' clinics within the Baptist Church which have proliferated effectively throughout the Baptist community. GPs continue to serve in the front line in treatment of mild and moderate mental illness. There has been an expansion of private psychiatric services across the Caribbean, with psychiatrists treating the moderate and severe mentally ill in their offices, and in private general hospitals. Between 1975 and 1984, I began a weekly radio call-in programme in Jamaica, where listeners would write or call the 'radio psychiatrist' and explain their symptoms to him. I conducted a brief 'examination' and advised the caller on the nature of his condition, the possible causes and treatment, and sources for treatment. This popular programme had a marked effect in destigmatising psychiatry by providing psychiatric education. In a 1984 survey it was found that 95% of the respondents regarded the programme as valuable.

Deinstitutional and rehabilitation

Since the establishment of mental hospitals in the Caribbean there has been a steady increase in their populations. A rehabilitation initiative began in Jamaica[10] with the establishment of a pilot unit based on therapeutic community principles. Of the 247 admissions to this unit in its first five years (all long-stay patients) 80% were discharged to home, although there was still a 25% readmission rate.

Between 1976 and 1983 the principles developed in this pilot unit were extended and the traditional custodial nature of long-stay wards was changed into a graded system of minimum, moderate and maximum supervision units. By 1980 there were nearly 700 patients in some form of vocational activity ranging from agricultural work and carpentry to craft and light industrial work. Between 1974 at the commencement of the programme and 1983 the resident population of the hospital fell by 60%. The political implications of this programme have recently been discussed by Hickling.[11] Although there has been no similar deinstitutionalisation programme in the Caribbean, Jurgensen[8] has reported an interesting experiment in Antigua where the Mental Hospital has been closed and mental health services are now entirely located in the community.

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