

# Deinstitutionalization and attitudes toward mental illness in Jamaica: a qualitative study

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## ABSTRACT

**Objective.** *To consider whether or not deinstitutionalization and the integration of community mental health care with primary health care services have reduced stigma toward mental illness in Jamaica.*

**Methods.** *A qualitative study of 20 focus groups, with a total of 159 participants grouped by shared sociodemographic traits. Results were analyzed using ATLAS.ti software.*

**Results.** *Participant narratives showed that stigma had transitioned from negative to positive, from avoidance and fear of violent behavior during the period of deinstitutionalization to feelings of compassion and kindness as community mental health services were integrated with Jamaica's primary health care system. The Bellevue Mental Hospital and homelessness were identified as major causes of stigma.*

**Conclusions.** *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.*

## Key words

Attitude to health; mental disorders; community mental health services; deinstitutionalization; Jamaica.

Since gaining independence from the United Kingdom in 1962, Jamaica has made significant public policy changes to its mental health services (1–3). These changes have developed a robust community mental health service (4–5), major deinstitutionalization of the single mental hospital built by the British in 1862 (6), and the radical restructuring of

the country's mental health legislation (7). There have also been significant efforts to educate the general public about mental illness and its treatment through popular media (8) and innovative socio-drama and cultural therapy programs (9–11). Significant changes have occurred in mental health care in the Caribbean since early reports (12–15).

The objective of this qualitative study was to assess the attitudes toward and stigma associated with mental illness in Jamaica and to determine if these were related to the major changes in public policy—particularly, deinstitutionalization and integration community mental

health services with primary health care services—that the country has undergone during the last five decades.

## METHODS

This was a qualitative focus-group study conducted in Jamaica, designed and implemented in 2005–2006 by collaborators from the University of the West Indies (Mona, Jamaica), McGill University (Montreal, Canada), Smith College (Northampton, Massachusetts, United States), and Meharry Medical School (Nashville, Tennessee, United States). The study was approved by the

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**TABLE 1. Demographic composition of 20 focus groups held to determine how deinstitutionalization has impacted attitudes toward mental illness in Jamaica, 2005–2006**

Group	Status of respondent	Gender	Socioeconomic class	Age range in years
1	Mental health patient	Female	NA <sup>a</sup>	≥ 18
2	Mental health patient	Male	NA	≥ 18
3	Mental health patient's relative	Male	NA	≥ 18
4	Mental health patient's caregiver	Female	NA	≥ 18
5	Urban resident	Female	Upper	≥ 18
6	Urban resident	Male	Upper	≥ 18
7	Urban resident	Male	Middle	≥ 18
8	Urban resident	Female	Middle	≥ 18
9	Urban resident	Male	Lower	≥ 18
10	Urban resident	Female	Lower	≥ 18
11	Urban resident	Female	NA	≥ 40
12	Urban resident	Male	NA	≥ 40
13	Rural resident	Male	Upper	≥ 18
14	Rural resident	Female	Upper	≥ 18
15	Rural resident	Male	Middle	≥ 18
16	Rural resident	Female	Middle	≥ 18
17	Rural resident	Male	Lower	≥ 18
18	Rural resident	Female	Lower	≥ 18
19	Rural resident	Male or female	Mixed	≥ 40
20	Urban or rural resident	Male or female	Mixed	≥ 18

<sup>a</sup> Not applicable.

institutional review boards of the University of the West Indies, Smith College, and Meharry Medical College; approval from McGill was not requested.

A total of 20 focus groups (nine groups of males, nine groups of females, and two groups of mixed gender made up of 7–8 participants each) were conducted at outpatient mental health care facilities in Kingston, Jamaica, and at community sites around the island (Table 1). A total of 159 participants were recruited from community organizations by a trained recruiter employing an eligibility-screening questionnaire. Participants were recruited based on occupation (16), and placed into focus groups based on

shared sociodemographic variables (17, 18). All participants were volunteers; they received refreshments and a small travel stipend of US\$ 7. The focus-group discussions were conducted using a standard guide of seven questions (Table 2). The duration of each discussion was approximately 2 hours.

All five focus-group leaders were post-graduate psychology students trained in focus-group mediation. They led the informed-consent procedures and conducted the focus-group sessions. Trained court stenographers recorded and transcribed all the sessions. The first author coded the transcripts using ATLAS.ti (Version 5.0) qualitative data analysis

software (19). The authors also read the transcripts together and agreed upon the emergent themes, as well as the ATLAS.ti data classifications, using methods previously described (20).

## RESULTS

The ATLAS.ti analysis produced 141 major, coded responses from the participants of the 20 focus group. The large number of responses reflected the difficulty that participants experienced as they approached the topic of mental illness in the context of changing public policy regarding mental health care. The responses were grouped into nine major categories (Table 3).

### Psychiatric hospitalization and stigma

In 1862, the “Lunatic Asylum” was built in Jamaica; it was renamed “Bellevue Hospital” in 1947. Bellevue Mental Hospital served as the sole long-stay facility and primary source of inpatient mental health care for several decades, until deinstitutionalization was enforced in 1972.

Participant responses indicated that Bellevue Mental Hospital represents a negative model of mental health care and illness and is the basis on which much stigma was founded. In addition, participants associated being committed to this custodial institution with irrevocable madness (Box 1).

The deinstitutionalization process shifted treatment away from custodial institutionalization in the long-stay hospital. Two 20-bed facilities were developed within the major hospitals in Kingston and Montego Bay. Although some

**TABLE 2. Prompt questions for focus groups held to determine how deinstitutionalization has impacted attitudes toward mental illness in Jamaica, 2005–2006**

Questions
1. What does the word “stigma” mean?
2. Who does stigma apply to? Why and describe these people?
3. Have you ever stigmatized anyone?
4. What do you think about people with mental illness?
5. Do you think mental illness is the mentally ill person's fault?
6. What do you know about the mental health care system?
7. If you had a mental illness would you be worried about being looked down on, discriminated against, or unfairly restricted because of the illness?

**TABLE 3. Major discussion themes for focus groups held to determine how deinstitutionalization has impacted attitudes toward mental illness in Jamaica, 2005–2006**

Themes
1. Definition of stigma
2. Responses toward mental illness and the mentally ill
3. Caregiver coping strategies
4. Causes of mental illness
5. The mental institution as a cause of stigma
6. The mental institution as a change agent
7. Public education and understanding mental illness as it relates to stigma (linked to institutionalization)
8. “Living while mad”; consequences of being mentally ill
9. Responses to the vignette

participants were not familiar with these “new” facilities, one participant described them as comparable to Bellevue Mental Hospital: “. . . there are three main institutions, there is of course, Bellevue, Ward 21 [The psychiatric unit in the University Hospital of the West Indies in Kingston] and 10th Floor, Cornwall Regional [in Montego Bay]. . . .”

It seems that despite the shift to short-stay care, Jamaicans have for some time negatively associated mental health care with institutionalization. The implication is that Bellevue Mental Hospital parented the stigma of custodial care, and it has been replicated despite the smaller size and different location of other facilities in the country. Furthermore, this stigma appears to be entrenched, and attached to any individual receiving treatment at these facilities (Box 2).

Since 1974, there has been no physical institution in existence in Jamaica where a mentally ill person could be incarcerated for more than 3–4 weeks. In fact, under Jamaica’s 1998 Mental Health Law, a patient cannot be detained involuntarily for longer than 28 days (7). However, despite this transition and the ability to seek outpatient treatment from hospital facilities, the study participants made a major distinction between degrees of mental illness based upon whether treatment was received in a custodial facility or at a walk-in clinic. If care was sought at a walk-in clinic, the mental illness was viewed as treatable (Box 3).

The conclusion that can be drawn from these participant responses is that custodial facilities, such as the Bellevue Mental Hospital and the two much smaller custodial admission facilities, were the primary determinants of stigma in Jamaica.

### Dehumanization and the process of homelessness

As was the case in the United States, deinstitutionalization and the development of community mental health services concurred with a significant increase in the number of homeless, mentally-ill persons living on the streets of Jamaica’s cities and towns. In general, increased homelessness was due to a lack of services, facilities, and housing required for the newly-released mentally ill, as well as new patients in need of care (21, 22).

Deinstitutionalization and homelessness took what was once a hidden social

#### Box 1. Bellevue Mental Hospital and stigma

“. . . if we didn’t have Bellevue as our standard for what mental health care facility is like, we would have a different view, but our experience and our standards are such that it reinforces the notion that these people are not worth an investment, they are different and they are less than . . . .”

“. . . Well, some people would say that from dem mad [and admit to Bellevue] dem can’t come back good again. They don’t see Bellevue as a hospital; they don’t see anybody coming out with a positive side. Him go Bellevue, that’s it, him a madman . . . .”

“Most people who go to Bellevue don’t come back out normal.”

“. . . The next time his son had to go to Bellevue, the man nearly had a break down, I see that big man cried like a baby, so you see the depth of the stigma of Bellevue . . . .”

#### Box 2. Stigma attached to the institutions

“. . . Madness resides in institutions . . . they [people in these institutions] are seen as being mad, that is what people think immediately . . . Stigma applies to persons who have been [admitted] to Bellevue [Mental Hospital] or Ward 21 [Psychiatric ward of the University Hospital of the West Indies] . . . .”

“There is a long time association, when you say Ward 21 everybody understands that the ward is for mad people and it is a long time association, you don’t have to say much more.”

“. . . You know some people when they reach 10th Floor, that is the time the family just reject them right away and not even help them, dem nuh try to work with them and talk with them and help them, and from them say 10th Floor, dem say a mad smaddy<sup>a</sup> that and that throw them off . . . .”

“. . . I do believe that there is a huge stigma attached to Bellevue and it would make a big difference to how he is viewed . . . It might be a totally different response you might get coming back from Bellevue than going to St. Ann’s Bay Hospital and being treated and sent back home. Going to St. Ann’s Bay Hospital and being treated and sent back home could be viewed as an episode, going to Bellevue he is a mad man . . . .”

<sup>a</sup> Smaddy = Someone/person

#### Box 3. Comparison of institutional care and health care centers

“To my level of understanding, being at Ward 21 or Bellevue versus a health center would show that you are more mentally ill.”

“You see when a person come from health center, him all right, him walk up and down, but when the person come from Bellevue yuh nuh know what can trigger them and dem mash up everything.”

issue and made it a visible social problem, evident to the general public (22). As a result, the public’s interaction with mentally ill persons increased significantly. The concept of dehumanization of homeless persons with mental illness emerged as a major component of stigma in the discussions among focus group participants. For these participants, home-

lessness seemed to equate to madness, and the association of homelessness with dirtiness was regarded as a major cause of stigmatization (Box 4).

There was a sense of repugnance expressed by some of the participants when discussing their encounters with homeless mentally-ill persons. Although participants did not perceive these persons

**Box 4. Homelessness, “madness,” and stigma**

“... We don't really understand this thing [mental illness], and of course that is where a lot of the fear come from. Once you understand something we don't fear it as much... the better you understand it the less you fear it... I think that the majority of people, when we look and see dirty people on the road, even if they are not mad we assume that they are mad. We associate madness with homelessness and dirty, and I think probably that is one of the reasons why there is stigma...”

**Box 5. Response to ‘madness’**

“... I was going down in a taxi one afternoon after leaving work, and as I reach at Strand Street one spit into mi face and mi say, driver, look here! And mi scream out. And when mi look, one [mad person] hawk and spit, and when you look [the spittle] it yellow, you know, Mi say, if mi could cut off mi face mi would a cut it off...”

“... One time one mad man bounced into me walking downtown... An mi run go get some Det-tol [detergent] and wash myself down. If I see one naked, me gone! Even though you know you can't catch it [the madness] by going beside them, some people just don't want dem beside dem; so dem scorn them...”

“... Some people watch dem [mad people] like thief, because dem jus feel like dem ah go thief something or worse. If dem have a little pickeny [child] wid dem in de place, dem feel like dem [the mad man] ah go molest de child...”

**Box 6. Recognition of community mental health services**

“... You have the Field Officers [Mental Health Officers], who are the mental health persons. One of them came with the ambulance to my nephew, when he would not come to clinic. He take the ambulance with a police and they go and give him the injection. First time you did not have it like that, so I think it is much improved and you can live with it now. I think it is very good now... it is a different level, the society is changing in its view towards these issues but generally the stigma still applies, maybe it is not as strong as before because it is happening in so many people's families that they are more accepting of these things...”

“... I know that they [Mental Health Officers] go around, maybe it's only St. Ann but I know that they have the mobile team that go around and try to take off some of them off the street...”

“... I think that mental health now has really improved now because when I started working at this hospital whenever there is a person who is mentally ill they would tie them up and bring them to the hospital so that they can get injection and quite awhile I have not seen anybody come here like that. I think that they are doing a good work. People are becoming more tolerant...”

as being contagious, their response to them was of extreme disgust and avoidance. Added to this was a powerful and prevailing prejudice that the mentally ill are perverse, unpredictable, and could harm those around them (Box 5). Despite recognizing this as a deeply dehumanizing view and acknowledging their desire to avoid mentally ill persons, the stigma was still apparent.

**Community care as a negation of stigma**

Juxtaposed with these expressions of stigma and revulsion toward the homeless mentally-ill was a paradoxical cultural expression of affirmation for the community mental health care services now implemented in Jamaica. The nationwide, community care public policy has

become public knowledge and the care services being established in parishes across the island are making a significant impact on the Jamaican population. Positive personal experiences with the community mental health services seem to have had a transforming effect on the negative stigma that some previously associated with mental illness and treatment (Box 6). Despite recognizing that the stigma still exists, there seems to be a positive shift in the overall view of mental health care and a reduction in stigma, which is likely due to the widespread nature of mental illness and an increased awareness of the services being offered.

**A transition in public perception and care**

A remarkable finding of this study was the powerful, insightful expressions of care and kindness toward people with mental illness that were reiterated by many of the focus-group participants. These expressions overpowered the fear of violence and other behaviors associated with the mentally ill. This transition seemed to be related to the experiences that participants had in dealing with mentally ill persons in the community since the advent of community-based mental health services in Jamaica.

One of the participants, a working class woman from Montego Bay, gave an account of the stigma-transforming effect that she experienced with a homeless mentally-ill man living in her community (Box 7). This woman's story takes place in the context of a Jamaican tradition whereby a deceased family member's possessions are divided up and given to close friends and family. This is called the “dead lef” [the possessions “left” to family and friends].

The story's significance is two-fold. First, it reveals a transformation of attitude toward the mentally ill man, which occurred when the woman extended her care to this “mad man” by providing him with some of her brother's “dead lef.” This indicates that through consistent exposure to the mentally ill, a positive change in perception occurred within the community. The community members drew the “mad man” into their circle through a continued display of care and inclusion, which in a very real way negated their perception of him being “mad.” This act of social support may be a reflection of the public education programs that have been



**Box 7. Social inclusion**

“. . . One guy down fi mi side, him mad. Most of the time mi see him sit down round ah Credit Union. Mi brother whey dead the other day mi tek most of mi brother dressing clothes an give him, after everybody tek whey dem want. What lef, mi carry it go an mi call him over mi yard and mi give him [the mad man] . . . And if you see how him [the mad man] well dress, some people [in the community] say to him . . . ‘yuh enna name brand and sey yuh mad’, and music a play . . . Him [the mad man] come to me sey if mi nuh have nothing over deh to drink. And mi sey, like what? . . . Something hard man, mi want something hard [alcoholic]; yuh nuh hear music a play up de so . . .’ So one-day mi give him some rum cream [a local alcoholic drink] an mi sey yu can manage the rum cream? So mi give him the rum cream ina one cup and ice, and him dance and sing! An everybody [in the community] say ‘Leroy, yu nuh mad, man?’ Hear him: ‘*who, yu madda dan mi*’ [you are more insane than I am] and him [the mad man] talk nice, an him watch him clothes an him eat him food . . .”

**Box 8. Change in outlook—stigma versus community assistance**

“. . . As soon as a person develops mental illness the family forsake them. I think they need somebody who they can talk to; you can be kind to them and can lead them anywhere, just being kind . . .”

“. . . Some people will ‘illbuse’ them [the mentally ill] and hurt them, and some people will want to take care of them. So if everyone of us try to see their needs, then we can have a control over them . . .”

“. . . There was this young man who was mentally ill, and he came out [from hospital] and I said to my son who was building a house . . . ‘look, try him, see if he can work, and if he can work give him something to do; let him earn a money, let him become independent . . .’ and my son gave him a job to mix mortar, and he did a good job, and he was sober all that time . . .”

“. . . I think that support is part of what helps me and perhaps others to bounce back. One of the things that I know helped me personally is knowing that what was happening to me wasn’t peculiar to me . . .”

produced through Jamaica’s community mental health programs, which exhort local people to care for the mentally ill in their neighborhoods.

Second, this story cites a distinct example of homelessness and dirtiness being equated with mental illness, an association discussed previously. The woman described the effect that overcame other community members when they saw this “mad” man dressed in her brother’s “dead lef” finery. The response of the community members implies the contradiction of the well-dressed “mad” man; his well-kept appearance negating his expressed reality of madness. To community members, mental illness is reflected in a person’s attire, and a person dressed in fine clothes could not be mad (*ipso facto*). Thus, there was a paradoxical change in community members’ perception of madness with a change in clothing,

despite the constancy of the man’s mental illness.

It was surprising how many of the focus-group participants from whatever social class, gender, or age group were sympathetic to the concept of mental illness. It is evident from the responses that some of the participants had developed a relationship with mentally ill people. Participants identified kindness, compassion, and care as examples of “positive” emotions toward the mentally ill. In one of the focus groups, a male participant stated that even the acutely mentally-ill person needs to be treated with kindness: “. . . In that state he needs affection . . .”; and comments from other participants (highlighted in Box 8) indicate that kindness, rather than scorn or isolation, is more effective in managing mentally-ill persons in the community. Not only do these statements imply sym-

pathy toward the mentally ill, but they have important implications for continued public education. Community members seem to be willing to provide support for the mentally ill, but would benefit from education about various mental illnesses in order to increase their understanding and reduce negative attitudes and expectations.

**DISCUSSION**

This was a qualitative study that explored stigma and perceptions of mental illness in Jamaica. Prior to 1962 and independence from British colonialism, the only legal avenue for treatment of the severely mentally ill was incarceration at Bellevue Mental Hospital. Reports of the attitudes toward mental illness and its treatment at that time (12) indicate that stigma to mental illness was intense in Jamaica, and that Bellevue Mental Hospital was viewed with intense fear and derision. Since that time, major strides have been made in the deinstitutionalization of Bellevue Mental Hospital and the development of a community mental health service. The 159 focus-group participants and all of the moderators and researchers were from 18–65 years of age; therefore, only a few would remember the conditions and attitudes that existed prior to independence.

In a recent study of deinstitutionalization-related articles published by Jamaica’s principal newspaper during a 26-month period (23), the authors reported results of public attitudes toward deinstitutionalization and community-based mental health services that were contrary to results from most high-income countries, the latter indicating negative media portrayals of mental illness and the mentally ill. The findings of the study proposed three positive rhetorical devices that were commonly employed by a Jamaican newspaper to promote deinstitutionalization and allay fears and concerns regarding community treatment of the mentally ill. These were “countering fear through expert knowledge,” “appeals to reason,” and “lay scientific education.” Whitley and Hickling (23) introduced an overall label for this process that they called “*psychological deinstitutionalization*.” This underscores the hypothesis derived from the present study: that over the course of 45 years, changes in Jamaica’s public policy regarding mental health services have had

a transforming effect on people's attitude toward mental illness and has redirected stigma from *negative to positive*.

Many of the focus-group participants had been exposed to mentally ill people in their families, in their communities, or in the news media. It was revealing that participants' reflections moved from the intense negative stigma reported by Collis (12) to reports which varied from very positive to very negative, and that most of their comments reflected conflicting ideas during the transformation. The discourse always moved from negative to positive, and reflected the cognitive and emotional struggle that participants experienced within a public policy environment that had moved mental illness out of the institution and into the community. Participants reflected the consciousness and responsibility engendered by the 45-year public policy deinstitutionalization process and the media thrust that had encouraged this process of psychological deinstitutionalization of the community.

First and foremost in Jamaica's "psychological deinstitutionalization" process was the struggle with the perception and the reality of the mentally ill being dangerous. The earlier work of Hickling (9) reported on cultural therapy processes, including the island-wide performance of plays and pageants by patients of the Bellevue Mental Hospital and the use of a weekly radio psychiatry program over a period of 10 years in the 1970s (8). These were the initial efforts to reduce stigma toward deinstitutionalization and the development of a nationwide, community-based mental health program in Jamaica. It has been suggested (24) that some study participants, those 40 years of age or older, may have positive memories of the radio psychiatry and cultural therapy programs and other efforts made during that period more than 30 years ago. That study concluded that, because the focus-group participants in this age group expressed empathy and positive attitudes toward individuals with mental illness, some earlier deinstitutionalization campaigns may have had a lasting, positive impact.

The findings of this study concur with the quantitative findings of a previous study (25) in Jamaica that suggested that since the 1960s, there has been a beneficial effect stigma toward mental illness produced by interaction between the

general population and the mentally ill. That study indicated that 79%–82% of respondents in the national survey displayed attitudes of compassion, care, love, and concern, compared to 37%–43% who showed attitudes of anger, fear, and disgust. This finding is in marked contrast to the significant body of literature from Western nations (26) that suggests a strong stigma associated with mental illness that has been increasingly recognized as a barrier to effective care and mental-health related service utilization, and may substantially reduce the quality of life for individuals with mental illness and their families (27).

Most of the study participants were attempting to reconcile an often mythical belief that the mentally ill are violent with a conscious experience and the reality of present-day Jamaican community mental health public policy, which negates these strongly-held myths. As a result, participants have restructured and resynthesized new models of care and kindness to deal with their mentally ill relatives, friends, and community members. The authors of the present study suggest that these findings were forged in the crucible of the extensive changes to mental health public policy, grounded in the social re-engineering of Jamaica's society as it moved out of European colonialism into the post-colonial era.

One of the profound consequences of the mental health public policy movement in Jamaica is that the acutely mentally ill are being treated in the open wards of general medical hospitals across the country (28). In fact, since 1972, patients with acute mental disorders have been treated in the open medical wards of general hospitals islandwide, with minimal negative sequelae, and with tremendous success, recovery, and follow up. This approach seems to be unique to Jamaica. Meta-analyses in the Cochrane Library have failed to replicate this finding worldwide (29, 30).

This novel work on community mental health and deinstitutionalization and its association with the transformation of attitudes and stigma among the Jamaican people suggest that changes in mental health delivery have taken a leading role in shaping stigma toward mental illness in Jamaica. These findings are in marked contrast to findings from North America (31) and the United Kingdom (32). Gen-

erally, these studies have reported an increase in negative stigma toward mental illness following deinstitutionalization, particularly an association between violence and mental disorders, such as schizophrenia, alcoholism, and drug dependence (32).

The present study suggests that in Jamaica, the custodial mental hospital represented a negative institutional construct that was the main source of the development of stigma toward mental illness, and this stigma was transferred to other hospital-based treatment facilities across the country. However, deinstitutionalization and integration of community mental health care with primary health care services have played a non-stigmatizing role, particularly through increased public interaction with the mentally ill and by building public awareness of community mental health services and their effectiveness.

## Limitations

Since this was a qualitative study that used focus-group discussions, a conclusive statement could not be made regarding an association between changes in public policy regarding mental health and the attitudes of the Jamaican population toward mental illness and its stigma. Several hypotheses about this relationship were formulated and could be used in future studies to design questionnaires that would quantitatively assess these suppositions.

The use of focus groups is commonly thought to limit the ability to generalize the study results to the larger population. However, the number of focus groups that were studied and the demographic breadth, across gender, age, socioeconomic status, and locations across the island, are thought to increase the researchers' ability to make hypotheses that are, for the most part, representative of the general public.

## Recommendations

Future research using quantitative measures within a population sample should explore the current study findings to clarify issues raised, including: knowledge about and attitudes toward the various mental health services (institutions, hospitals, community mental health services); knowledge about and

attitudes toward mental illness; and the rights of the mentally ill. These factors should be measured against specific demographic variables to identify whether there are differences in public perception based on gender, socioeconomic status, and/or previous contact with mentally ill persons, as well as the extent of the contact.

Future research should also be geared toward identifying the gaps between public knowledge of mental illness and its treatment, and the public education

programs that have been implemented in the past. It may also be important to identify the role that the news and entertainment media play in the development of current public opinion on mental illness, and to identify where these sources fall short. The ultimate goal of these research findings is to create and implement a health television and radio station in Jamaica that provides more effective public education.

Based on these preliminary findings, a growing public acceptance of commu-

nity mental health services is likely to necessitate a relative increase in services and facilities available to the general public. Services must be expanded to effectively manage the increasing number of cases of mentally ill persons requiring treatment—a situation that began with deinstitutionalization and is expected to grow—and to prevent anyone from falling through the cracks or becoming a “revolving door case” due to lack of follow-up and aftercare post-discharge.

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**Externamiento psiquiátrico  
y actitudes hacia las  
enfermedades mentales en  
Jamaica: estudio cualitativo**

**RESUMEN**

**Objetivo.** Evaluar si el externamiento psiquiátrico y la integración de los servicios comunitarios de salud mental con los servicios de atención primaria de salud han reducido el estigma respecto de las enfermedades mentales en Jamaica.

**Métodos.** Estudio cualitativo de 20 grupos de opinión con un total de 159 participantes agrupados según sus características sociodemográficas. Se analizaron los resultados con el software ATLAS.ti.

**Resultados.** Los relatos de los participantes revelaron que, cuando los servicios comunitarios de salud mental se integraron con el sistema de atención primaria de salud de Jamaica, el estigma había pasado de *negativo* a *positivo* y de la evitación y el temor a un comportamiento violento durante el período de externamiento a sentimientos de compasión y amabilidad. Las principales causas de estigma identificadas fueron el modelo de atención del hospital mental Bellevue y vivir en las calles.

**Conclusiones.** Las actitudes hacia los enfermos mentales han mejorado y el estigma ha disminuido desde que aumentó la relación de la comunidad con los pacientes. Esta reducción del estigma parece deberse al proceso riguroso de externamiento psiquiátrico y al desarrollo de un servicio comunitario de salud mental sólido en Jamaica.

**Palabras clave**

Actitud frente a la salud; trastornos mentales; servicios comunitarios de salud mental; desinstitutionalización; Jamaica.

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