Research

Working towards a paradigm shift in mental health: stakeholder perspectives on improving healthcare access for people with serious mental illnesses and chronic physical illnesses in Jamaica

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Abstract

The Jamaican public health system has incorporated mental health services into community-based primary care to improve healthcare access for people with serious mental illnesses (PWSMI), especially given global concerns about the high rate of comorbidity of chronic physical illnesses (CPI) among this population. Although it has been over twenty years since this strategy was implemented, there is a dearth of research into the views and experiences of stakeholders relating to this health system response. The current study sought to explore stakeholders' perspectives and recommendations for improving the Jamaican public health system's response to healthcare access for PWSMI & CPI. A constructivist grounded theory approach was used to collect and analyse data from fifty-seven participants across six participant groups: health policymakers, primary care physicians, psychiatrists, mental health nurses, PWSMI & CPI and, their caregivers. The findings of the study identified one overarching category, "a paradigm shift in mental health" supported by six subthemes: (1) prioritise mental health, (2) reduce stigma and discrimination, (3) fill gaps in policies and practice, (4) address workforce issues, (5) improve health infrastructure and operations, and (6) respond to social needs. Findings highlighted a need for strategies that address social determinants of health inequalities such as stigma and discrimination as well as poverty to improve healthcare access. The paradigm shift in mental health will require greater financial and human resource investment in responding to these comorbid conditions and increased involvement of PWSMI and other stakeholders in strategies aimed at improving healthcare access and outcomes.

Keywords Serious mental illness · Chronic physical illness · Health system · Recommendations · Healthcare access · Jamaica

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1 Introduction

Latin America and the Caribbean consist of thirty-three countries spanning the regions of Central and South America, and the Caribbean [1] Estimates from the region indicate one in four persons experience mental illness in their lifetime [2], with mental disorders accounting for an average of 1815.05 per 100,000 population of disability-adjusted life years in 2019 [3]. Regional estimates for serious mental illnesses such as schizophrenia and bipolar disorder range from 1.1 to 2.5% of years lived with disability, resulting in considerable impact on individuals, families, and health systems [4]. People with serious mental illnesses (PWSMI) in the region have an estimated reduced life expectancy of 30 years with worsened outcomes reported in lower-income countries [5]. These outcomes have mainly been linked to the high prevalence of chronic physical illnesses (CPI) such as cardiometabolic diseases, respiratory diseases, cancers, and other non-communicable among members of this population [6, 7].

Despite these estimates, only eight of the thirty-three countries in the region have enacted legislation and national policies related to mental health [5]. Mental health service accessibility and responses are limited due to significantly lower investment in healthcare compared to other regions [2, 3]. Moreover, weak political will, minimal legislation for human rights, limited implementation of policy, budgetary constraints, and fragmented healthcare systems are key factors limiting healthcare access for PWSMI [2, 3, 8–10]. Levesque et al. [11] proposed that healthcare access is determined by dimensions related to health service accessibility, and individual abilities and characteristics. Dimensions of health service accessibility relate to aspects of the health infrastructure and include approachability, acceptability, availability and accommodation, affordability, and appropriateness of care [11]. The dimensions related to individual characteristics involve an individual's ability to perceive, seek, reach, pay, and engage with healthcare to meet their health needs [11].

Jamaica represents one of the few Latin American and Caribbean countries identified in the literature as making significant progress towards improving healthcare access for PWSMI & CPI despite resource limitations [8, 9, 12]. The public health system in Jamaica has transitioned towards deinstitutionalisation, systematically phasing itself out of a centralised institutional model of care for PWSMI to a community-based mental health service [12, 13]. The process consisted of a collaborative effort between the Ministry of Health & Wellness, the University of the West Indies, and the Pan-American Health Organisation [13]. The transformation included the reformation and amendment of mental health policy and legislation; the establishment of a mental health unit led by a director in the Ministry of Health & Wellness; a gradual phasing out of the country's only mental health hospital and subsequent increasing capacity of the community-based primary mental healthcare services; increased availability and affordability of psychotropic drugs through the establishment of the National Health Fund in 2003 (which provides free or heavily subsidised medication); inclusion of psychiatric and community mental health nurses in primary care health centres; and training of primary care staff in mental health education [8, 9, 14]. The latter represents an ongoing program facilitated under the auspices of the World Health Organization's Mental Health Gap Action Program (mhGAP) [4]. The shift to community-based primary healthcare for PWSMI was a deliberate attempt to cater to both the mental and physical healthcare needs of this population [8, 9, 13].

While Jamaica has progressed by implementing strategies to improve healthcare access for PWSMI & CPI, limited investment of human and financial resources has slowed the progress towards a fully integrated health service for this population [4]. The transition to deinstitutionalisation is underfunded and there are a disproportionate number of mental health services within community primary care where approximately only one-third offer and provide mental healthcare, despite receiving 80% of mental health visits related to serious mental illness [4]. In addition, deinstitutionalisation has resulted in a rise in homelessness among PWSMI, along with dehumanisation, stigmatisation, and discrimination [14]. Nevertheless, these issues are not unique to Jamaica, and despite global efforts to improve healthcare access for PWSMI, mental health treatment gaps have persisted over the last 30 years notwithstanding rising evidence of the high prevalence of CPI among PWSMI [10, 15].

Given the high rates of morbidity and mortality among PWSMI, strategies to effectively manage serious mental illnesses and CPI need to be sustainable, and culturally appropriate to improve the health system response [15, 16]. The World Health Organisation has called for more country-level research that involves different stakeholders (and in particular, service users) to provide comprehensive, context-specific data that can be used to improve the understanding of the needs of PWSMI & CPI and develop meaningful interventions that will address those needs [15]. Research of this nature allows health policymakers and clinicians to provide meaningful insights related to the needs and capacities of the health system [15]. While PWSMI & CPI and their caregivers can provide important

insights into the lived experience of mental distress as well as the structural determinants that affect their overall health and well-being [17, 18, 19]. As there is a paucity of research in the Jamaican context, the current study aimed to explore stakeholders' perspectives and recommendations for improving Jamaica's public health system response to healthcare access for PWSMI & CPI.

2 Methods

2.1 Study design

This study utilised a qualitative constructivist grounded theory method [20, 21] and is part of a larger study exploring enablers and barriers to healthcare access for PWSMI [22]. This method suited the study objectives as it facilitated a holistic and comprehensive exploration of participants' perspectives, which allowed for the generation of a context-specific model of recommendations [21, 23].

2.2 Setting

Jamaica is a Caribbean Island nation and is classified as an upper-middle-income country, with an estimated population of 2.82 million people [24]. It is estimated that 40 psychiatrists, 100 mental health nurses, 400 community psychiatric aides (nurse assistants), and 108 clinical psychologists (most at the master level) work within the private and public health system serving the population [25]. Public primary healthcare is provided through community health centres distributed across the island and includes mental health clinics operated by psychiatrists and/or mental health nurses with the support of psychiatric aides [8, 13]. Primary care physicians operate curative clinics with the support of registered nurses and respond to physical health problems. Hospitals are located throughout the island and provide secondary and tertiary healthcare [8, 13]. Within the local health system context, service users are called patients, and this paper adopts this language, reflective of the local context.

2.3 Participants

Participants (n = 57; 44 females and 13 males) were recruited into six groups: four health policymakers (HPM), nine primary care physicians (PCP), eleven psychiatrists (Psych), five mental health nurses (MHN), twenty-three PWSMI & CPI, and five caregivers. Inclusion criteria for health professionals (groups 1–4) were: employed in their current role for at least a year, or in the case of Psych completing their final year of residency in psychiatry. For the PWSMI & CPI group, the inclusion criteria were persons 18 years or older with a pre-existing diagnosis of serious mental illness (with no reports of a psychiatric crisis in the past week) and a CPI diagnosis. Those included in the caregiver group needed to be 18 years or older and identify as the caregiver for a family member with co-morbid serious mental illness and CPI.

2.4 Data collection

Several strategies were used to recruit participants. Relevant directors of health in the area of non-communicable diseases and mental health in the Ministry of Health & Wellness (N = 5) were recruited via direct email invitation to participate in the study. Clinicians (PCP, Psych, MHN) were recruited through an expression of interest flyer advertised in medical associations or via snowball sampling. Participants who were PWSMI & CPI and their caregivers were recruited via an expression of interest flyer advertised in a mental health support group, or via direct sensitisation to the study and invitation to participate presented to those attending 18 mental health clinics island-wide where data was collected for the broader study.

Semi-structured interviews were conducted with participants once written informed consent was obtained to allow for detailed exploration of the topic [26]. Interview guides were developed for each participant group. The development of the interview guides was informed by the literature, feedback from all members of the research team (which consisted of Jamaican and non-Jamaica researchers), and feedback from the research project stakeholder reference group (which consisted of six members representative of the study population). All interview guides included standard questions related to the strengths and weaknesses of the public health system response to PWSMI & CPI. Questions also provided opportunities for participants to discuss recommendations for improvement. Interviews were conducted by

the lead author during the COVID-19 pandemic (March–November 2020) and per the government-enforced restrictions, interviews were conducted via telephone or video conferencing and lasted between 30 and 60 min.

2.5 Ethical considerations

Three bodies provided ethical approval for the study, namely, the Ministry of Health and Wellness Jamaica's Medico-legal Ethics Committee (2019/49), Curtin University Human Research Ethics Committee (HRE 2020–0022), and the University of the West Indies, Faculty of Medical Sciences Ethics Committee (#ECP 101, 19/20). This study was conducted following the guidelines and regulations provided by the Ministry of Health and Wellness Jamaica's Medico-legal Ethics Committee using the ethically approved study protocol.

2.6 Data analysis

Interviews were transcribed verbatim from audio recordings in keeping with a constructivist grounded theory approach [20, 21]. NVivo version 14 software [27] was used to facilitate data coding. Initial codes were generated using line-by-line coding with multiple reviews of each transcript facilitating constant case comparison and negative case analysis. Field notes and memos were written throughout data collection and analysis which assisted in the review, definition, and refinement of categories and sub-categories [20, 21]. The research team engaged in frequent reflexive discussions to ensure findings were rooted in the data and two co-authors independently reviewed emergent codes and categories for accuracy in the representation of the data [28].

3 Results

All participants highlighted that the approach of the public health system in providing free healthcare and community-based primary healthcare inclusive of mental health services was extremely valuable in facilitating and promoting healthcare access for PWSMI & CPI. However, participants also noted how high rates of stigma and discrimination, gaps in policies and guidelines, sub-optimal clinical practices, poor accountability channels, poor physical infrastructure, as well as deficiencies in human resources within the public health system negatively impacted healthcare access to PWSMI & CPI. Participants echoed the need for a paradigm shift in mental health, involving a reframing of health service delivery to standardised comprehensive and holistic care, screening, and management inclusive of mental health: *"It is a paradigm shift that is needed. [Health services] that are very comprehensive. It covers everything... mental, substance [use], psycho-sexual... don't skip out anything because you're treating the whole person" (HPM #3)*. To achieve this type of paradigm shift, participants noted that several aspects of the current public health system approach needed modification. Six subthemes were: (1) prioritise mental health, (2) reduce stigma and discrimination, (3) fill gaps in policies and practice, (4) address workforce issues, (5) improve health infrastructure and operations, and (6) respond to social needs. Figure 1 provides a visual representation of categories and sub-categories of recommendations made by participants who are stakeholders in the health system.

3.1 Prioritise mental health

Some health professionals believed that for changes to be meaningful and lasting, mental health needed to be established as a priority area for the Ministry of Health & Wellness. A few participants reported improved recognition by the government of mental health as a priority: *"The current Minister of Health [administration] has basically done a lot for mental health that has not been done for mental health in my previous 16–17 years" (MHN #1)*. However, others felt more needed to be done to ensure that the Ministry of Health & Wellness priorities and directives were upheld across health authorities Island-wide. These participants believed that the establishment of mental health as a priority area would facilitate more attention, funding and resources being available to services accessed by PWSMI & CPI.

3.2 Reduce stigma and discrimination

Participants from all groups believed stigma and discrimination directed at PWSMI & CPI was evident at a societal and healthcare level. The labelling of people with mental health illnesses as 'mad' fuelled societal stigma and discrimination
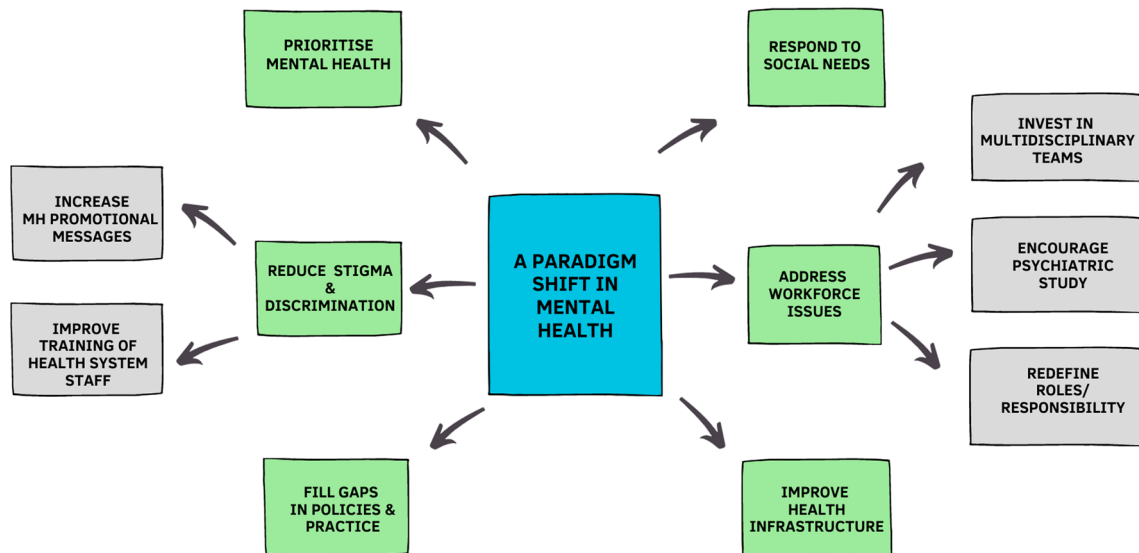
Fig. 1 Stakeholder recommendations for improving health system response to PWSMI & CPI

towards patients. Participants stated that policymakers, clinicians, administrative staff, and security personnel were responsible for perpetuating these attitudes. It was argued that there was a need for strategies that changed the mindset of health staff:

> "The main thing is from top to bottom. From doctors down to porters, administrators, parish managers, go right down[to staff of lower levels], change the mindset. Do not look at mental illness as how everybody sees mental illness, as a "Madman". See the person as the person they are and not as what they are diagnosed" (MHN#1).

Participants outlined two key strategies for reducing stigma and discrimination; (a) improve the training for health system staff and (b) increase health and mental health promotion messages.

3.2.1 Improve the training of health system staff

Participants argued there was a need for better mental health training for health system staff, this is illustrated in Fig. 2. A few health professionals suggested that the World Health Organisation's mhGAP was a tool that could be used more

Fig. 2 Recommendations for the improvement of training for health system staff
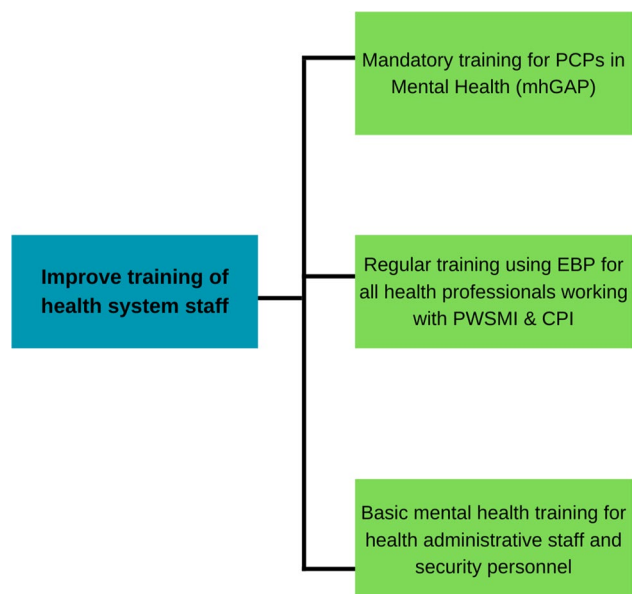
broadly to upskill primary care physicians and nurses to recognise and initiate treatment for some mental illnesses. They recommended that greater emphasis be placed on implementing the: "*mhGAP as a compulsory module for all doctors [PCPs]*" (*HPM #2*). Others suggested training around the screening and management of mental illnesses become mandated as a part of continued medical education that all PCP complete to remain registered. Another suggestion involved: *"[foster] greater participation of the clinician [PCP] in the management of clients with mental illnesses" (PCP #1)* as this would improve the comfort, confidence, and capacity of PCP to manage these patients.

Some participants felt that all health professionals working with PWSMI & CPI should be involved in systematic and continuous training related to evidence-based practice. They considered that ongoing training would serve to: "*break down institutional stigma and will help us with detecting early signs of illness and knowing what are the things that we need to be looking out for" (Psych #4).*

Additionally, across participant groups, administrative staff and security personnel were identified as needing mental health training as the first point of contact with health services for PWSMI & CPI. The type of interaction that PWSMI & CPI experienced with these personnel served to facilitate or obstruct their healthcare access. Some PWSMI & CPI and their caregivers described instances in which security personnel or administrative staff outrightly denied them access to health services or openly shamed or embarrassed them which resulted in them leaving and not re-engaging with health services. Participants believed that mental health sensitisation training would increase these staff members' understanding and skills and lead to improvements in their responses to PWSMI & CPI.

3.2.2 Increase health and mental health promotional messages

Most participants highlighted that stigma and discrimination existed beyond health services and was widespread in Jamaican society. The high levels of stigma and discrimination were seen as obstructive to PWSMI & CPI ability to access healthcare due to fear of family and community members finding out about their mental illness and withdrawing their social support. Hence, participants argued the need for more consistent health promotion messages addressing mental health stigma and discrimination: "*We can stop stigmatization by having more education for people to know more about it. Just like they do about diabetes." (PWSMI & CPI #19).* Health promotion initiatives should be geared toward building awareness and understanding of mental health and mental illness and help improve social attitudes towards PWSMI & CPI that hinder their ability to access healthcare.

3.3 Fill gaps in health policies and clinical practice

Health professional participants indicated that gaps in policies and guidelines related to the care of PWSMI & CPI resulted in varied clinical practices. This negatively affected the healthcare access experienced by PWSMI & CPI. For instance, both PCP and Psych said there was a lack of policies and guidelines related to the co-management of PWSMI & CPI, leading to role ambiguity and confusion. Mental health nurses also felt there was some ambiguity about their role in writing re-fill prescriptions for psychotropic medication and saw the need for clear guidelines related to this. One HPM indicated there were plans to address these gaps: "*We also wanted to have a protocol to effectively manage physical and mental disorders. Those Protocols are still not fully developed, but that's part of the plan." (HPM #4).*

Participants noted the importance of policy that provides clear guidelines that improve dialogue between clinical teams: "*Better dialogue, better communication... being able to have better collaboration with Primary Health Care Providers would make a big difference."(Psych #6).* They also felt that there was a need for the development of policies and regulations that would streamline expectations for clinical practice related to the screening and management of mental illness, substance misuse, and co-occurring CPI. This would improve PWSMI & CPI access to appropriate care that meets their health needs.

3.4 Address workforce issues

Across all participant groups, workforce challenges were reported which limited the public health system response to PWSMI & CPI. These issues included high turnover of clinicians, the constant rotation of clinicians across different clinics, low staff-to-patient ratios, and limited speciality staff such as psychiatrists, especially in rural areas:

> "*Staff is always an issue—lack of staff. So, we don't have the adequate numbers that we should have of psychiatrists, mental health nurse practitioners, mental health officers, nursing aides, even social workers." (Psych #2).*

The outcomes of these staffing issues included: extended wait times for patients; limited time spent in consultation with patients; reduced opportunities for therapeutic alliance; and compromised continuity of care. Participants suggested several strategies to address these staffing concerns such as: (a) encouraging psychiatric study, (b) redefining roles and responsibilities and, (c) investing in multidisciplinary teams.

3.4.1 Encouraging psychiatric study

A few participants suggested that stigma and discrimination associated with mental health made psychiatry a less attractive profession which is considered less legitimate than other areas of medicine. To combat this, participants suggested implementing recruitment and retention incentives: *"look for incentives for persons who are in mental health, just to give people that comfort or that sense of security that this is a field that I can go into." (Psych #3)*. This would foster interest in the discipline that could help to increase the specialist workforce and improve access to appropriate care for PWSMI & CPI.

3.4.2 Redefine roles and responsibilities

Health professionals suggested that one strategy to address staffing issues was to redefine roles and responsibilities and consider how tasks could be shared or shifted within clinical teams:

"I think there has to be that reviewing of the roles and responsibilities of the different players… we as mental health practitioners who are very few and much stretched would become like supervisors, to offer the guidance to primary care practitioners… we have started training of primary care physicians, but I also think we may need to re-look at the community mental health service and how it is now operating and what it is that we really want to offer in terms of a service." (Psych #11).

A few health professionals indicated that this might also include expanding the roles and responsibilities of other health workers (e.g., community health aides) not currently aligned directly to the care of PWSMI & CPI to improve healthcare access and outcomes for these patients. These health workers can assist with the follow-up and monitoring of patients, and provide tangible ongoing support.

"Community health aides are so dispersed in the community… they can [visit] the elderly, persons with low socioeconomic status and those with mental illness. They're supposed to be aware of who has these chronic illnesses… [and can] make sure that they get their medication that morning, in the evening. Are they getting a meal? Did they shower? What's going on in the home[?]" (Psych #7).

A redefinition of roles and responsibilities was seen as a practical and immediately available strategy to enhance service delivery to PWSMI & CPI.

3.4.3 Invest in multi-disciplinary teams

Some participants indicated that the public health system's heavy focus on the bio-medical treatment of PWSMI & CPI results in an overreliance on medication and subsequent neglect of social determinants influencing both mental and physical health and well-being of patients. Most health professionals noted that antipsychotic medications heighten the risk of CPI and reported their observations of these impacts in the patient population. They believed that greater incorporation of other health professionals (such as psychologists, social workers, and occupational therapists) in the care of PWSMI & CPI would reduce the workload on clinical teams, improve the accessibility of appropriate care to patients, and result in overall better health outcomes for PWSMI & CPI:

"This (including allied health professionals) would definitely help with the overall management of these patients and actually improve their prognosis. Cut down on some of these stressors that they're having, helping them to develop better problem-solving skills and just fitting in so many different ways." (Psych #6).

3.5 Improve health infrastructure and operations

Participants spoke of their concerns about the poor physical infrastructure in many community health centres. They identified issues related to the small size of some facilities, poor ventilation, few interviewing rooms, inadequate bathroom

facilities, and limited availability of basic equipment such as scales and blood pressure machines. These conditions were uncomfortable for patients and health professionals. They also compromised clinicians' ability to deliver appropriate care: "*It is a general lack of resources and facility space that greatly hinders the delivery of healthcare to this target population.*" (PCP #1).

Health professionals also indicated that the lack of a centralised electronic records management system throughout the public health service was a major weakness as they often struggled with the illegible writing of clinicians in patient files and lacked ease of access to patient records especially when patients visited hospitals or clinics:

"I think things need to be digitally done to help with the documentation and being able to find records easily of patients. The public health system really should move to that and reduce the waiting time and the workload on the administrative staff, and the bad writing of doctors." (PCP # 7).

Figure 3 highlights the ways participants believed the health infrastructure could be improved. Participants believed improvements to physical infrastructure and a centralised electronic patient records system would improve access and appropriate care for PWSMI & CPI. It was argued that a centralised electronic patient record system would facilitate better monitoring, and follow-up of patients by providing clear records of their diagnoses, treatment plans, referrals, and medication as well as serve to improve collaborative care. *"I think if we had electronic support, it would be easier to trace patients' medications and follow up for ease of care." (Psych #1).* Participants also believed changes such as making special provisions for older adults, having a visiting laboratory technician at rural health centres, increasing home visits by mental health teams and PCP, and greater availability of modern classes of psychotropic drugs with less negative side effects could greatly improve PWSMI & CPI's access healthcare.

3.6 Respond to social needs

Participants across all groups expressed concern about the lack of social services built into healthcare provision for PWSMI & CPI. They acknowledged that poverty was a substantial concern for this patient population. The role that financial and other social support provided by family and community members played in enabling healthcare access for PWSMI & CPI was highlighted. Participants also identified difficulties faced by PWSMI & CPI who lacked social support in accessing healthcare. Consequently, they discussed the need for strategies that extended beyond the immediate healthcare needs of patients to address social needs. Although some aspects of this would be based in the health sector, participants saw this as a multisectoral initiative that would involve a broader systems approach that involves non-health sector stakeholders and include greater collaboration with PWSMI & CPI, family members, friends, and community members that could help improve the access to healthcare and quality of life of PWSMI & CPI:

Fig. 3 Recommendations for improving health infrastructure
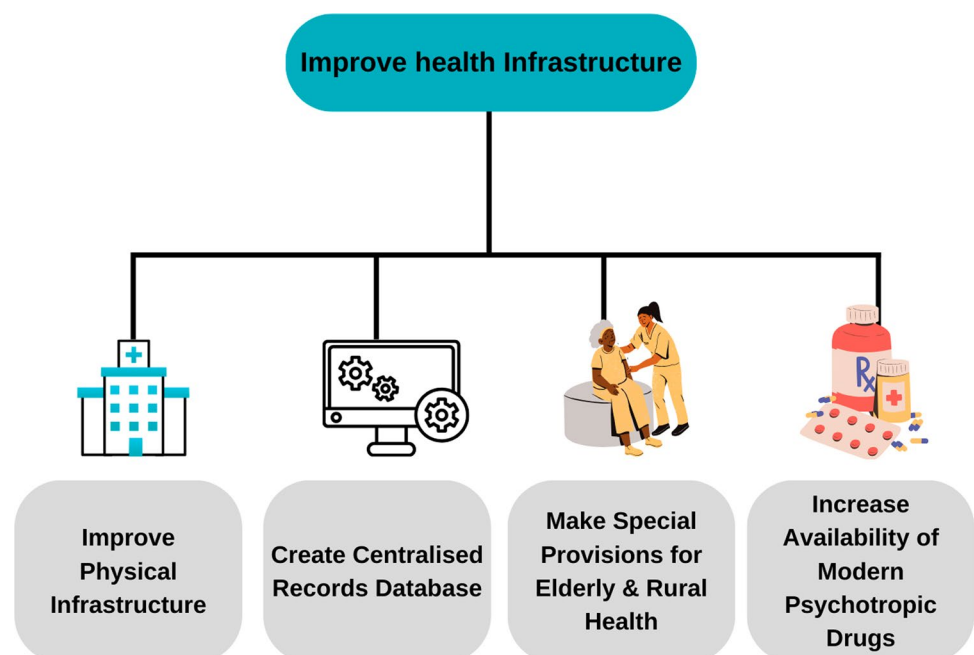
"It also calls for us to do a lot more thinking outside the box, in terms of getting help for these individuals… collaboration with persons outside of health. So, the social welfare systems, NGOs, persons interested in helping other individuals, churches, so we have to use these opportunities to get assistance for the clients." (Psych #11).

4 Discussion

This study sought to explore stakeholders' perspectives and recommendations for improving the public health system response to PWSMI & CPI. Participants acknowledged the benefits of Jamaica's free public healthcare system in facilitating healthcare access for PWSMI & CPI. Extensive research indicates that policies such as free healthcare and community-based healthcare services have a positive impact on healthcare access and serve to reduce health disparities among vulnerable populations such as PWSMI & CPI [15, 29–31]. Moreover, the approach reflects steps towards sustainable development goal 3.8 to "achieve universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all." [32, para. 3].

Despite these advances in healthcare, stigma, and discrimination continue to be major obstacles in providing quality healthcare to PWSMI & CPI in Jamaica and play a major role in the lack of momentum toward the improvement of mental health services seen in other countries [29, 33]. Stigma and discrimination shape negative social attitudes towards PWSMI, the health system process, clinician practices and engagement with PWSMI [33]. This results in delayed help-seeking for PWSMI and poorer quality of care being provided to them when they seek healthcare [7, 33]. Participants in this study called for a paradigm shift, echoing the repeated calls by the World Health Organisation and others to improve the quality of care and access to services for this vulnerable population [15, 34, 35].

The Jamaican health system has recently taken active steps to address these concerns. This includes updating the National Mental Health Policy and a National Strategic Plan that is underway, along with the establishment of a task force on mental health and homelessness [4]. The recommendations of the task force have been incorporated into the Ministry of Health & Wellness plans to reform the primary healthcare system [36]. These included initiatives to reduce stigma, increase integration of mental health services in primary care, improve emergency responses, psychiatric homecare, and transportation to healthcare facilities for underserved PWSMI [4]. The plan for the reform of primary care services in Jamaica also identifies mental health as a priority and outlines strategies to improve health infrastructure and workforce gaps over the next ten years, which were central recommendations made by study participants [36]. The investment of resources to improve physical infrastructure, including the use of electronic medical records would permit greater levels of availability and accommodation for collaborative care; accentuate screening and management practices; and facilitate research, therapeutic alliance, and continuity of care for all patients [37, 38].

Participants also proposed a redefinition of roles and responsibilities to address staff shortages that limit the health system response to PWSMI & CPI. These approaches are reflected in international literature and involve; incorporating peers, community health workers, and nurses in coordinating care roles, delivering psychosocial interventions to patients and caregivers, and educating and mobilizing communities around mental health [39–41]. Task-shifting and task-sharing approaches have yielded great benefits, particularly in low-resource settings [42, 43]. These strategies could serve to improve healthcare access for PWSMI & CPI in the Jamaican context by increasing the training and responsibilities of community health aides and psychiatric aides.

Improved training of health system staff was also viewed as necessary to reduce stigma and discrimination and increase healthcare access for PWSMI & CPI. The Medical Council of Jamaica [44] recently mandated that all medical doctors will need to complete continuing medical education units in mental health and wellness to renew their licensure as of January 2024. They note that this decision recognises the need for doctors to improve their competence and confidence in addressing mental health concerns [44]. This move represents a step in the right direction and will facilitate better access to appropriate care for PWSMI & CPI. However, action also needs to be directed toward non-medical, administrative staff, and security personnel. These members of staff often act as gatekeepers to health services and can negatively influence healthcare accessibility [45]. There is also a need to address the stigmatisation of psychiatry highlighted by some clinicians. This represents a type of occupational stigma, signified by the negative labelling of a profession that can result in undesirable consequences for those who practice it [46]. It is argued that occupational stigma occurs among psychiatrists and mental health professionals due to their association with PWSMI who represent a highly stigmatised group [47, 48]. Thus, addressing stigma and discrimination also extends to identifying strategies that address occupational stigma and incentivises the pursuit of mental health professions to increase the specialist task force and consequently appropriate healthcare access for PWSMI & CPI.

Furthermore, a greater investment in multi-disciplinary teams was seen as a needed strategy to address some of the inadequacies of the current bio-medical approach. This recommendation is in keeping with extensive literature that highlights that the bio-medical approach to treatment does not consider the complex interplay of social, environmental, and psychological factors that shape health experiences, access, or outcomes for PWSMI & CPI [17, 49, 50]. The inclusion of allied health professionals has been identified as best practice for the treatment of PWSMI & CPI as these professionals provide non-pharmacological treatment and engage in psychological and social interventions that can enhance healthcare appropriateness and outcome for PWSMI & CPI [4, 51].

The high rate of poverty or low socio-economic status among PWSMI & CPI were seen as leading contributors to the poor healthcare access experienced by this population. Participants recommended a multi-sectoral approach to address this issue. To improve the national response to non-communicable disease care in Jamaica, it is necessary to leverage multi-sectoral governance, and reposition these diseases (including mental illness), as issues of social concern, which are shaped by social determinants of health, and not merely individual choices [52]. By doing so, issues related to mental health and CPI can be recognised as issues of national and economic interest requiring cross-sector alliances to improve healthcare access and outcomes for this population and benefit society [52].

Although participants emphasised the need for a change in the way individuals think about mental health, they did not mention the importance of involving PWSMI in co-designing strategies, and interventions or using recovery-oriented approaches. The inclusion of the voice of PWSMI in shaping mental health policy and service delivery has become a hallmark of mental health services in many countries fuelled by recovery movements [35, 53]. Championed by people with mental illness, recovery-oriented approaches shift the health paradigm from focusing on diagnosis and symptoms towards holistic care that identifies, values, and builds strengths, and aids people in better managing their well-being, health, work, and social lives [53]. This can lead to healthier lifestyles, better health literacy, and greater social participation [54, 55]. By considering the social needs of people with mental illness and complex psychosocial issues, recovery-oriented approaches can promote inclusion and collaboration [55]. Therefore, there is merit in the exploration and piloting of these approaches for the Jamaican context.

The implementation of the stakeholder recommendations within the primary care context requires significant initial investment, but it holds the potential for substantial returns [52]. A recent study found that investment in improving clinical interventions for non-communicable diseases could save over 6,600 lives and reduce direct and indirect costs of US $640 million for Jamaica from 2017 to 2032 [52]. Similarly, improving treatment interventions for depression, anxiety, and psychosis could result in economic benefits that outweigh the cost, with a return on investment of US $5.50 for every USD 1.00 spent [4]. As a result, improving psycho-education, enhancing self-management skills, and building social support and welfare can enhance healthcare access for PWSMI & CPI, leading to better health outcomes, quality of life, and social participation of people in this population [51, 56, 57].

4.1 Limitations

The constructivist grounded theory approach encourages multiple interviews with participants, however in this study only a single interview was conducted with each participant which may have limited greater exploration of participant perspectives [28]. However, the wide cross-section of data collected and triangulated across key stakeholders in the health system, including patients and caregivers, was deemed appropriate to provide meaningful insight into views about the public health system response to PWSMI & CPI.

5 Conclusion

While the Jamaican public health system framework facilitates a level of healthcare access for PWSMI & CPI, issues related to stigma and discrimination, gaps in policies and guidelines, the dominance of the bio-medical approach, and low human and physical resources serve to limit healthcare access for this population. It is noteworthy that the public health system in Jamaica continues to take steps towards improving healthcare access for PWSMI & CPI. Nevertheless, there remains a need for a paradigm shift in mental health that will re-position and reframe mental health in a way that reduces stigma and discrimination and increases psychosocial support available to PWSMI & CPI. This approach should seek to encourage the inclusion of the voices of PWSMI & CPI and other key stakeholders and incorporate multisectoral partnerships. These measures will help to ensure that interventions and strategies geared at improving healthcare access and health outcomes for PWSMI & CPI are relevant, meaningful, and sustainable.

Author contributions All authors, except Gabrielle Mitchell, contributed to the conceptualisation of the paper. Supervision: Sharyn Burns, Robyn Martin, Ben Milbourn, and Wendel Abel. Formal Analysis: Patrice Whitehorne-Smith, Sharyn Burns, Ben Milbourn. Interpretation and Presentation of Findings: Patrice Whitehorne-Smith, Kunal Lalwani, Sharyn Burns, Robyn Martin, Ben Milbourn, Wendel Abel. Write-up and revisions: All authors contributed to the write-up and revision of the article.

Data availability We acknowledge that our dataset contains sensitive data that could be damaging to some study participants if shared publicly. For example, there are five health policymakers involved in mental health in Jamaica, three of whom took part in the study. Additionally, a third of the psychiatrists working in the public care system took part in the study. Even with de-identifiers, these individuals would be easily identifiable in the dataset, which can have implications for their profession. Where possible we have shared direct quotes and excerpts to validate the study findings. Furthermore, the data presented in this article constitutes work from an ongoing doctoral thesis. The data are embargoed until after the approval of the completed official thesis and all journal articles associated with the project have been published. After which it will be deposited to "espace" the Curtin University's institutional repository. At which point all reasonable requests for access to aspects of the study data can be made to the Curtin University Human Research Ethics Committee (email address: ROC-ethics@curtin.edu.au).

Declarations

Competing interests There are no conflicts of interest associated with any of the authors of this work as it relates to the research, authorship, and/or publication of this article.

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