



special articles

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SAEED FAROOQ AND FAREED A. MINHAS

Community psychiatry in developing countries – a misnomer?

There has been a rush towards community psychiatry in the developed world in the past few decades (Tyrer, 1998a). In developing countries the concept has been equally popular and various programmes have been described (Burns, 1998; Goldberg, 1992; Issac, 1996). The term 'community psychiatry' originates from a peculiar historical background, is based on certain principles and is shaped by the existing pattern of mental health services in many Western countries. Although the term is vague, its application is especially problematic in developing countries. In this article an attempt will be made to highlight the origins of the term community psychiatry and its application in developing countries.

The literature both in psychiatry and social sciences is replete with the controversies about definition of the word 'community'. To some it rings a public health note, to others it may suggest a neighbourhood, a district or perhaps an ethnic grouping. The term community psychiatry can be understood in the historical perspective of modern psychiatry in Europe and America. In the second half of this century 'community' replaced the 'institution' because the latter came to be seen as authoritarian, inefficient and in many ways anti-therapeutic. The institution was a place with almost impenetrable barriers to the outside world, having all sorts of institutional rituals and requiring huge expenditure, perhaps without demonstrable efficacy. The community, on the other hand, was considered an ideal place for the treatment of those suffering from mental illness. It must also be realised that community psychiatry was not merely a product of movement against the psychiatric institutions. The prevalent political and social ideologies at that time also played a significant role in highlighting a role of the community in treatment of psychiatric disorders.

Keeping aside the conceptual issues, in practice the word is commonly used to denote a geographical and administrative area, a relatively well-integrated neighbourhood or perhaps anything outside the hospital (overlooking, of course, the fact that the hospital is also located in the community!). In modern psychiatric practice, community psychiatry usually refers to providing psychiatric services for a well-defined catchment area, demarcated geographically and administratively, such as a

borough, district or county. Although the actual practice differs widely in different countries, certain principles can be identified in shaping these services. These 'principles' of community psychiatry, proposed by Caplan and Caplan (1967), have proved useful and valid to varying degree in defining the subject. These principles include:

- (a) responsibility to a population, usually a catchment area defined geographically
- (b) treatments close to the patient's home
- (c) multi-disciplinary team approach
- (d) continuity of care
- (e) consumer participation
- (f) comprehensive services.

The situation in developing countries

Anyone who is familiar with the history of psychiatry and existing mental health services in developing countries can realise that community psychiatry does not exist in any of the meanings we have discussed so far. The term is applied and used in a totally different way.

In almost all developing countries institutions never existed at a scale to be replaced by the 'community'. Neither did these countries face the social and political changes necessitating a rush towards community. In many countries a few mental health hospitals were built by the colonial powers, mainly in big cities, but the number of beds in these hospitals had no comparison with those in the developed nations. For example, Pakistan, with a population of over 40 million, had only three mental health hospitals in the early 1950s (Shafique, 1995). In developing countries almost all the care was provided by the family without any involvement of psychiatric services. The situation still persists. For enormous rural populations (up to 70% of the total population of most developing countries) modern psychiatry does not seem to exist. Patel and Winston (1994), for instance, point out that in Zimbabwe up to 80% of the rural population consult traditional healers and the few psychiatrists in the country are primarily concerned with hospital-based care of severely disturbed patients. In fact, it can be argued that in the majority of developing



countries mental health care is being provided by the community in the true sense of community care. On the contrary, in places like the UK, although former psychiatric patients are now 'in the community', 'care by the community' may often be little more than rhetoric (Jones, 1993).

In some developing countries like India and Pakistan a model of community psychiatry has been established and found quite effective in providing services for the large populations (Goldberg, 1987, 1992). The approach essentially consists of incorporating psychiatry into primary care. The objective is to provide mental health care facilities to the grossly underserved populations mainly in rural areas. The emphasis is on creating awareness in the community about mental health, training primary health care workers in recognition and early management of common psychiatric disorders and the integration of mental health services with other disciplines in primary care. These services target high priority conditions like epilepsy, psychoses, neuroses and drug-induced problems identified by various cadres of general health workers with back-up services by trained psychiatrists. It appears that this model of community psychiatry may be the only viable option for a large number of developing countries. It must, however, be realised that this concept of community psychiatry is totally different from the prevalent concept of community psychiatry in Western countries as we discussed earlier. There is no statutory responsibility to a catchment area, continuity of care is not possible and the main objective is to provide minimum essential services to a large population with the help of allied health professionals working in other disciplines. This approach can best be regarded as primary care psychiatry, but not community psychiatry.

We believe there is another compelling reason to give up the term, at least in developing countries. Community psychiatry has recently been criticised on both sides of the Atlantic. Torrey (1995) describes deinstitutionalisation of those suffering from severe mental illness in America as the largest failed social experiment of the 20th century. In Britain the unprecedented degree of criticism faced by the existing mental health services can be gauged by the articles appearing in their defence in the British literature, partially in reaction to the Government's announcement that community care has failed (Tyler, 1998b; Burns & Priebe, 1999) and increasingly restricted measures are proposed, such as supervised discharge, etc. There are even pleas to abandon the term community psychiatry because "what started as an ideal has become an excuse for buck passing, asset stripping and skimping on provisions" (Robertson, 1994). However, the concept of so-called community psychiatry as it is practised in the developing world seems to be quite effective and appropriate for the populations it is supposed to serve (Goldberg, 1987, 1992). We are afraid that once the winds of change blow in the West, as they seem to be at present, these might take away a useful idea that is still being implemented in some parts of the developing world and has still a long way to go.

A solution: primary care psychiatry?

The practice of psychiatry in the developing world may be well served by abandoning the term community psychiatry altogether. It could be replaced by the term 'primary care psychiatry'. Over the past two decades primary care psychiatry has evolved as a field in its own right in many countries with different systems of medical care (Fuhrer, 1992). In developing countries, where the number of specialist mental health professionals is very small in comparison to the actual demand, the provision of mental health services would remain a dream unless psychiatry was firmly rooted in primary health care (World Health Organization, 1975). By adopting this term, psychiatry in developing countries is likely to be owned in primary care.

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- *Saeed Farooq Assistant Professor and Head of Department of Psychiatry, Postgraduate Medical Institute, Gout: Lady Reading Hospital, Peshawar, Pakistan; e-mail: Psych@psh.paknet.com.pk, Fareed A. Minhas Associate Professor, Institute of Psychiatry, Rawalpindi General Hospital, Muree Road, Rawalpindi, Pakistan
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