Suman Fernando on community approaches to 'third world' mental health service development

Whose reality counts now?

In Britain many people complain about the quality of support for people with mental health problems. Yet the situation is often much worse in other parts of the world, and especially in low-income countries.

Although families and communities that are intact generally provide care for people in trouble, every society – or rather individuals in them – sometimes need help from 'outside' the family or community setting, however cohesive or supportive these may be. Moreover, many places in the 'third world' are affected by conflict and natural disasters, resulting in social disruption, and family and community support is then impractical. In this situation, a person who is overwhelmed by serious behavioural or emotional expression (panic states, over-activity, aggressiveness etc.) is likely to end up incarcerated in an old-fashioned, punitive asylum or even restrained in their own homes. Not a humane outcome by any standards. So mental health services are desperately required and western help is often needed to develop them. But there are complex problems involved here.

For one thing, mental health is not just a technical matter but is tied up with ways of life, values and worldviews that may vary significantly across cultures; also issues around mental health are as much (or more) social and spiritual as medical. And, more specifically, notions of 'madness' and 'psychopathology' – and indeed many of the so-called diagnoses of illness – on which mental health systems in the West are based, reflect western ways of thinking embodied in psychiatry and western psychology; and these often conflict with the worldviews of many communities in Asia and Africa. So just applying psychiatry developed in the West is fraught or worse.

Another problem is that poor countries that lack proper systems of mental health care also lack social care networks – some even lack a safety net for the starving poor. In such circumstances it is unrealistic to separate mental health care from social care and poverty reduction. A service for 'mental health' must inevitably cover what in rich countries would be regarded as social, educational and even financial problems.

What is happening today in some third world (poor) countries that are trying to develop mental health systems is worrying. Too often, unmodified biomedical psychiatry is being pushed on to these countries, despite it clashing with the cultures and mores of the communities themselves. In a sense, the old colonial attitudes prevail – unwittingly maybe – and this is compounded by local administrators and politicians giving undue credence to anything from Europe that can be sold as 'scientific'.

Yet there are innovative services being developed by local agencies.[1] One way forward is using community development methods such as Participatory Rural Appraisal (PRA).[2] A programme in Sri Lanka is investigating the feasibility of using PRA for mental health service development in conjunction with the concept of 'wellbeing', rather than the western concept of 'health' that is 'mental' (implying *ipso facto* that it is not social or spiritual). Field studies in the tsunami-affected areas of south Sri Lanka and among people displaced by armed conflict[3] suggest that this approach may be productive.

The model for mental health service development proposed by the Sri Lanka team is composed of three overlapping stages: (i) dialogue and consultation with communities using PRA; (ii) capacity building with local mental health workers, at which point outside help in an advisory capacity is brought on board; and (iii) integration of the system into social welfare and health structures. The advantage of this model is that local communities are involved in defining their needs, planning ways to meet them and being involved in bringing about change, while the way is open for outsiders with other approaches to contribute as partners as appropriate. In the present political climate, the alternative to a community development approach may be that western biomedical psychiatry gets imposed willy-nilly – and *that* would not serve at all well the people of the country.

1. Fernando, S. (2006) 'Working with communities', *Openmind* 139.
2. Chambers, R. (1997) *Whose Reality Counts? Putting the First Last*, London: ITDG Publishing.
3. Weerackody, C. and Fernando, S. (2008) 'Field report: perceptions of social stratification and wellbeing in refugee communities in north-western Sri Lanka', *International Journal of Migration, Health and Social Care* 4(2): 47–56.