According to the World Health Organization (WHO), the prevalence of mental disorders through life is over 25% worldwide [1], and on the other hand, psychiatric services are undergoing major changes in practice, education and research in a climate of burgeoning health-care costs, and changing priorities and service directions [2]. On the other hand, the primary Community Mental Health Center (CMHC), which was planned to be established in 1963 and was supposed to prepare a minimum range of services for inpatient, outpatient, partial hospitalization, emergency services, community consultation, and education to a defined catchment area of 75000 to 200000 people, has been accomplished differently in various parts of the world. CMHC included a psychiatrist (including child psychiatrist, if available), a clinical psychologist, a psychiatric social worker, and a psychiatric nurse, an occupational and recreational therapist [3]. The main purpose of the formation of CMHC was to provide comprehensive services to prevent, diagnose, treat, and rehabilitate psychiatric patients with no dependence on psychiatric hospitals [2], and to make the main task of community psychiatry, namely deinstitutionalization doctrine, possible, alongside reduction of insane criminals or senseless homeless people. The major concepts in this approach include: providing local services that are easily accessible in a catchment area, comprehensive services, continued care, effective intersectional connection, and emphasis on prevention besides treatment [4]. On the other hand, Primary Health Care (PHC) is generally the first point of contact for persons seeking to access health care and workers of PHC play an essential role in the healthcare model [5].

WHO defined PHC in the Declaration of Alma-Ata as necessary health care based on pragmatic, methodically sound and publicly acceptable techniques and skills, which have been made generally available to persons and relatives in the community through their complete partaking and at a cost that the community and country can afford, independently, to maintain at every stage of
their development [6]. Specifically, the Alma-Ata Declaration has outlined eight essential components of PHC, including: 1) Health education about prevalent health complications and the techniques of preventing and controlling them; 2) Nutritive promotion including food supply; 3) Supply of suitable safe water and hygiene; 4) Maternal and child health care; 5) Vaccination against major infective ailments; 6) Prevention and control of locally endemic illnesses; 7) Proper treatment of common maladies and harms; and 8) Provision of necessary medications [7]. Health systems which are focused on PHC are expected to have better health consequences and more public satisfaction at lower expenses and proper access, and PHC has frequently been considered as the primary point of contact for persons who need to access health care, particularly for the susceptible groups [7]. The appropriate delivery of PHC relies on physicians, nurses, midwives, adjuvant workers, as well as traditional practitioners, who have been aptly taught to work as a team and to respond to the expressed health requests of the community [8]. The countrywide network of rural and urban health centers of PHC are linked with the state treatment centers by means of a coordinated referral system.

Thus far, such a nationwide set-up was almost effective with respect to planned responsibilities and tasks, which were largely with reference to communicable and non-communicable physical ailments. Among them, communicable diseases were the most threatening problem in, particularly, developing countries, and PHC was an effective strategy for controlling contagious illnesses. In recent years, a new agenda is developing that desires to incorporate community psychiatry into PHC, for enhancement of public mental health and modification of related shortages. Certainly, this new strategy necessitates extra personnel, like psychiatrists, clinical psychologists and psychiatric nurses, if standard care, public education and clinical research and reappraisal are among the established objectives of the new model. On the other hand, if more comprehensive care, like rehabilitation of chronic psychiatric patients is planned [9], then social worker, occupational therapist, social skill trainer, behavioral family therapist, case manager, and vocational therapist, in addition to conveniences for enactment of residential care, crisis intervention, sheltered workplace or semi-competitive workstation, outreach teams, and so on, for independent or supervised living of chronic psychiatric patients in the milieu of society and implementation of deinstitutionalization policy may demand extra facilities, budget, personnel, and coordination, which can be out of capabilities of the present PHC network.

As is known, about 75% non-compliance in the first two years of treatment and around 10 - 90% joblessness among schizophrenic patients shows that coping with severe and chronic mental patients demands a specific mindset, which can be different with monitoring and treatment of, for instance, infectious diseases. In the field of psychiatry, while primary prevention is not as possible as contagious illnesses and secondary prevention is not as short as many of the physical diseases, tertiary prevention is quantitatively and qualitatively dissimilar to somatic ailments. For example, while disability and incapacitation in movement disorders can be restricted to certain actions or occupations, the said problem in psychiatric patients is usually more comprehensive and includes many personal, familial, social, and career dysfunctions. So, while physical rehabilitation focuses on specific somatic disabilities, psychiatric rehabilitation has a variety of short - term and long - term goals for a mixture of incapacities. Similarly, the stigma of physical disability is limited to disabled organs and related incapacitation, while the stigma of psychiatric disorder affects the entire personality, which may extend a bit to other family members, too [10].

So, on a social basis, the stigma of insanity is very different from the stigma of paralysis or
 crippling. Neutralization of psychiatric stigma, as well, is unlike deactivation of stigma due to physical illnesses. Nevertheless, in recent years, in opposite to the last decades and academic lectures, the slogan or philosophy of independence of psychiatric patients, which is defined as personal monetary and societal sovereignty, seems to be weakened a bit due to a number of reasons including: neoliberal economic policies, which is absolutely a profit-based stratagem, lack of enough evidence in support of profits of psychiatric rehabilitation or shortage of experiences that could be comparable to outcomes of community support program of university of Wisconsin, which had accomplished under the title of “Program of Assertive Community Treatment (PACT)” for maintaining severely psychiatrically disabled persons in the community at a good quality of life by assertive outreach and training in community living. PACT was a community-based, comprehensive treatment service for chronically mentally ill persons that had demonstrable success in reducing rehospitalization and improving the quality of life of participating patients [11].

Also, administrative failure in provision of expert personnel, deficient financial plans, lack of proper strategy, lack of motivation or coordination among administrators, shortage of fellowship program in public psychiatry and its alumnae as the apt arrangers and planners of psychiatric services, cultural issues, and lastly piecemeal knowledge or compromised insight concerning philosophies of community, social or public psychiatry and psychiatric rehabilitation, can be accounted as additional reasons for inactivity or failure of community psychiatry and psychiatric rehabilitation. Disregard to compassionate suggestion of WHO, it seems that the said reasons, whether justifiable or objectionable, solvable or unsolvable, during the last decades after the introduction of neuroleptics, have bypassed, passively, and bit by bit, the contemporary integrated psychiatric rehabilitation model, which was the final agenda, after passing the medical model, therapeutic community model, and social learning model of therapeutic (healing) paradigms in the preceding epochs. While integration of community psychiatry into PHC seems to be an imaginable and effective program, its range of effectiveness doesn’t look to be, appositely, inclusive.

Although public psychiatry and psychiatric rehabilitation are usually assumed to be integrated or inseparable portions, the second fragment cannot be accomplished automatically because its implementation depends on the structure, orientation and strategies of the first portion. Public psychiatry, which still has conceptual mix-up with preventive, broad-based, social or community psychiatry, is not equal to psychiatric rehabilitation per se and demands supplementary investment, employees and motivations, in addition to current daily services and management. Philosophically, for employment of psychiatric rehabilitation, the professional staff must turn from expert “definer of need” and/or “assessor of services”, into a resource which the disabled persons may or may not use, according to their selections. Moreover, disabled people are, first of all, part of the community and de-medicalization of social work with disables is mandatory. Also, social perspective and participation should be promoted and prevailed and service providing should be founded on “human rights”, rather than “pity”. Furthermore, more “positive use of language”, as a communicative tool, is recommended and “help” is for all people, not only for people with impairment. Besides, “community involvement”, rather than only a case-work team, is a prerequisite. So, dealing with “disables” is a specialized responsibility, which requires “commitment”, “skills”, “assessment”, “negotiation”, “advocacy”, “counseling” and so on, and is not a “secondary or subordinate” activity (should not be “underestimated”).

Also, “empowerment” must be the “final objective” of the rehabilitative team [9]. According to the WHO, the development of mental health programs worldwide should
adhere to the following principles: 1) providing treatment in primary care; 2) making psychotropic medications available; 3) giving care in the community; 4) educating the public; 5) involving communities, families, and consumers; 6) establishing national policies and legislation; 7) developing human resources; 8) linking with other relevant sectors; 9) monitoring community mental health; and 10) supporting more research [12]. Therefore, as stated by some scholars, maybe it is necessary to integrate the mental health system into the PHC due to the high prevalence of mental disorders, the importance of the work of GPs in the primary care system, and the fact that around thirty percent of patients who see a medical doctor suffer from depressive and anxiety illnesses. Accordingly, the main purpose of this integration is to emphasize prevention together with treatment, continued care, screening, and timely and appropriate referral [13]. Likewise, consistent with some successful samples, this tight cooperation between PHC and specialized teams, as a collaborative care model, will provide the optimal use of all services through a synchronized scheme [14]. Hence, supposedly, the designated collaborative care model takes methods to diagnose and treat widespread psychiatric complaints through the institution of partnership components for the CMHC. Such a CMHC partnership unit includes a general physician and a case manager who deals with the diagnosis and treatment of depression and anxiety illnesses in their clienteles under the supervision of CMHC [15].

On the other hand, the most significant barriers to the implementation of the assumed doctrines worldwide, as stated by WHO, may include administrators' resistant to the changes or their disbelieving in the efficacy of mental health interventions, in addition to shortage of financial and human resources or other essential health priorities, which may compete with mental health care for subsidy. Moreover, primary care teams may feel overworked by their amount of work and refuse to accept the introduction of new policies and many mental health professionals may not want to work in public amenities or with primary care teams, and want to stay in hospitals [12]. Likewise, a recent study has revealed that in some of the developing countries the transition of PHC worker’s “knowledge” into “skill” and from “skill” into “ability” declined bit by bit and their capabilities in four areas, including nutritional promotion, endemic diseases prevention, safe water and sanitation, and essential provision of medications, were principally low. Consequently, the general ability perceived by PHC workers themselves looks relatively low and imbalanced [5]. While knowledge is the foundation, ability is destination. In addition, a small number of the PHC workers were found with high academic grade. As a result, higher education program is necessary for PHC workers [5]. Similarly, a new appraisal in China has revealed that both GPs and patients of PHC rated “coordination” as the lowest score, in comparison with other indicators like continuity, equity, quality of care, comprehensiveness and accessibility [16]. On the other hand, due to the increasing pressure on funds and the scarcity of PHC doctors and nurses in many countries, especially in developing nations, policy-makers must consider innovative and inventive opportunities to increase and improve the provision of PHC [17].

The results of these studies have revealed that PHC workers had a low to moderate perceived ability to carry PHC services, which may suggest that there is a huge gap between the necessities of PHC system and the tangible enactment of PHC workers. Also, as said by Gotovac et al. [18], though the workers of PHC play a vital role in evaluation and management of the inhabitants' health complications, there is a great lack of sufficient proper training for them. Similarly, a national survey in Canada has showed that there was a lack of skills, confidence, and suitable training in mental health care for PHC workers, and the suppliers themselves also distinguish the gap and express their interest in teaching programs for reinforcement of their capability [19]. Besides,
the under-developed economic status of many countries makes it difficult to find a fitting PHC. Then again, one of the preconditions of WHO for the development of PHC, was that 5% of gross national product should be devoted to the health budget; but, most healthcare budget is allotted to large urban-based hospitals, such as secondary and tertiary health care centers, and PHC services seem to be underappreciated by the administrations, resulting in unsatisfactory monetary subsidy and insufficient training for PHC workers [20]. So, though, in fact, psychiatric rehabilitation with its ideal objectives, has not or could not been implemented acceptably in many countries, and public psychiatry has notable deficiencies with respect to associated amenities, investment, personnel and creation of characteristic CMHCs, especially in developing or non-developed countries, based on the aforementioned problems and barriers, if such an integration between PHC and community psychiatry be accomplished carelessly and based on only some questionable pilot studies, the end-result would be nothing except than more confusion in the realm of community psychiatry.

But, if the proposed incorporation is defined as an enhancement of synchronization, interaction and referral between active PHCs and working CMHCs, then the outcome could be an extraordinary upgrading of public mental health. Studies which introduce, representationally, GPs as mental health experts and their secretaries as case managers, may reduce, unintentionally, the importance of psychiatry as a scientific field and case management as a key element in harmonization between society and chronic mental patients after discharge from psychiatric hospitals. No doubt, in non-developed or unindustrialized societies, which naturally lack the main components of modern public psychiatry, PHC could execute primary steps of diagnosis and treatment of many neuroses or even psychoses, but it would not be without serious complications, errors or side effects. Also, PHC doesn’t seem to be apt for enactment of rehabilitative schemes because it has not been scheduled for that reason. Moreover, a small number of educative conferences are not comparable to some years of training and reading. Similarly, the registration and telephone call of an office assistant is not equal to the wide-ranging tasks of a true case manager. On the other hand, if a system is not able to implement standard mental health services and duties, on a national scale, then it is not able, as well, to remove the said paucities before or after transferring them to PHC. Anyhow, without the presence of robust supervisory foundations, it seems unlikely that PHC be able to handle, simultaneously and satisfactorily, all communicable, non-communicable and psychiatric ailments.

References:

Integration between Community Psychiatry and Primary Health Care: A Reevaluation Concerning Survival of Psychiatric Rehabilitation


DOI: https://doi.org/10.1136/bmj.39469.432118.ad

DOI: https://doi.org/10.7326/0003-4819-159-7-201310010-00011


DOI: https://doi.org/10.1001/archpsyc.1980.01780170034003


DOI: https://doi.org/10.1016/j.genhosppsych.2013.07.009

DOI: https://doi.org/10.1176/ps.2009.60.1.74


DOI: https://doi.org/10.5694/j.1326-5377.2003.tb05033.x