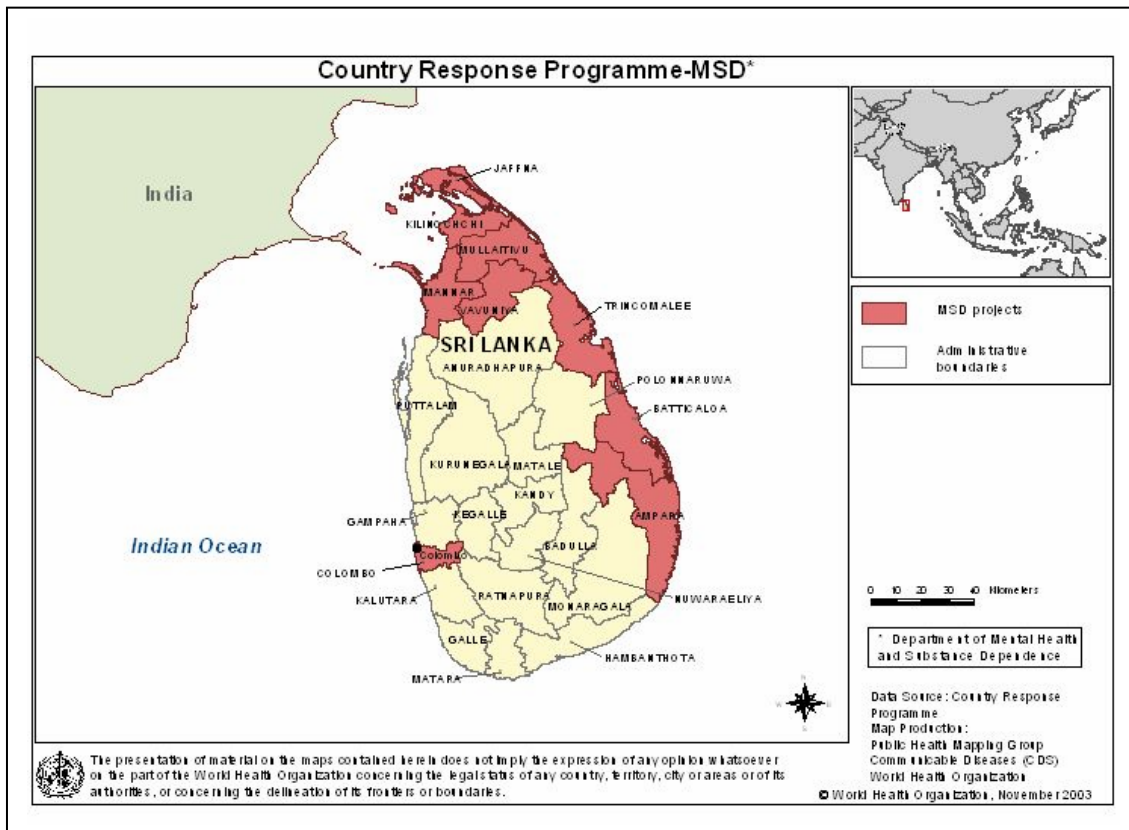


SRI LANKA: technical advice



Provision of Technical Advice to Sri Lanka

A country visit was undertaken for the purpose of a mental health needs assessment in Northeast Sri Lanka. Consequently, a comprehensive five-year mental health plan was developed in close collaboration with local mental health expertise.

Country Visit

Participants in the one-week mission were:

Ministry of Health (including the Director of Mental Health Services)

Ministry of Rehabilitation, Resettlement, and Refugees

WHO Sri Lanka

WHO Geneva

We gratefully acknowledge Dr M. Ganesan (Ministry of Health, Batticaloa) and Dr Daya Somasundaram (District Hospital Tellipallai, Jaffna) for their excellent input and constructive feedback during the development of this plan.

Background to technical advice

The WHO Department of Mental Health and Substance Abuse visited Sri Lanka at the request of Professor Jayalath Jayawardena, MP, Minister of Rehabilitation, Resettlement & Refugees. Dr Jayawardena had prior discussions concerning the visit with the Department of Mental Health and Substance Abuse in Geneva in 2002 and 2003. The Minister's specific request was to conduct a mental health needs assessment in Northeast Sri Lanka.

In June 2003 a needs assessment mission in Northeast Sri Lanka was undertaken (Jaffna, Batticaloa, Killinochi, Vavunia). The mission involved technical staff from WHO Geneva, WHO Sri Lanka, the Ministry of Rehabilitation, Resettlement and Refugees, and the Ministry of Health.

The state of mental health

A 1994 community survey of the effects of war in the North found 25% depression, 27% anxiety disorder and 14% post-traumatic stress disorder. These rates were higher in a study of outpatient attendees at a general hospital in Jaffna. Schizophrenia has been, is, and will continue to be the major mental health problem for the mental health services, because it is common (affecting up to an estimated 1% of the population), highly disabling, striking at a young, productive age and running a chronic course. There is some evidence that schizophrenia may have a relatively high incidence among Tamils (Somasundaram et al., 1993)⁴. Around

⁴ Somasundaram DJ, Yoganathan S, Ganesvaran T. Schizophrenia in northern Sri Lanka. *Ceylon Medical Journal* 1993 Sep;38(3):131-5.

the world, the prevalence of schizophrenia is between 0.5% and 1%.

The suicide rate in Sri Lanka ranks among the ten highest in the world, and the most recent official figures of 1991 put it at 31 per 100,000. The rates for men however are more than double that of women (44.6 compared to 16.8). Both the actual suicide rates as well as those for attempted suicide in Northeast Sri Lanka may be particularly high, especially among displaced persons as in Vavuniya, where an epidemic rate of 103/100,000 was observed⁵.

Mental health services

In the Northeast as in other parts of Sri Lanka, many administrators and health staff consider mental health to be a separate and unimportant area. However, the WHO Global Burden of Disease 2000 study suggests that mental and neurological disorders account for more than 12% of loss of disability-adjusted life years across the globe.

Several meetings with top-level policy makers to highlight the urgent need to establish mental health in the Northeast have taken place involving the Ministry of Health.



Inpatient accommodation

⁵ *Lancet*, 2002 Apr 27;359:1517-1518.

Although the Ministry of Health is known to have given mental health top priority in the Northeast, concrete steps still have to be taken to implement these priorities. The circumstances in the Northeast (i.e. a post-conflict area) would need to be recognized to make a special case temporarily.

Because of 20 years of violence, service development for persons with severe mental disorders has been severely impaired or destroyed, resulting in the under-provision and fragmentation of mental health services.



War-torn hospital

In June 2003, there were only two Tamil psychiatrists who, with limited resources, were providing community mental health care in and near the districts of the two largest cities in the Northeast (Batticaloa and Jaffna). In addition, a variety of NGOs run programmes targeted at trauma-related mental and social problems in a variety of locations. Different mental health stakeholders in the Northeast advocate for different mental health activities. In the absence of a comprehensive mental health plan, new activities appear to develop in an uncoordinated fashion, with the implementation of lower order activities before higher order needs are met.

In seven of the nine districts there is no acute inpatient care. There is some

follow-up care (through outreach clinics) for patients with severe mental disorder in some divisions, but not in divisions far away from both Jaffna and Batticaloa. Although there have been some efforts to train family health workers (i.e. primary care staff), the majority of primary care staff are still not sufficiently competent to reliably identify mental problems, manage common mental disorders, refer patients when necessary, and provide follow-up mental health care for those with severe problems.

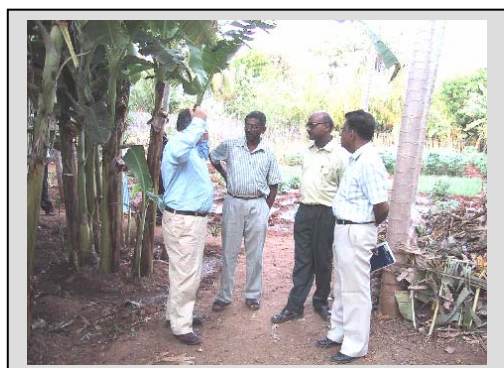
The lack of services in parts of the province is coupled with a concentration of staff (and beds) in a few cities and a lack of staff in more rural districts. In these districts, the government has created limited posts and only small numbers of health staff are expected to seek work. Although good acute inpatient care exists in two districts, the Northeast does not have any appropriate inpatient facilities of intermediate duration (up to six months) to provide psychosocial rehabilitation for those who do not recover sufficiently during acute inpatient care.



Mental health unit

Without such facilities, chronic patients with schizophrenia do not receive the care they require. They are at risk of neglect or becoming long-term residents in the Colombo-based custodial psychiatric hospitals, where

treatment is inadequate and patients tend to deteriorate in the absence of psychosocial rehabilitation or family social support.



Rehabilitation unit-gardening

Overall, the mental health problems that need to be addressed by services include both (a) mental health problems found in normal times, and (b) common mental disorders and other mental health problems due to the adverse effects of conflict. The burden of these problems is both on the mental health system and on the general health system, where most people tend to seek help for mental health problems (typically presented in the form of somatic complaints).

In the aftermath of the conflict, an increasing number of patients who suffer from disabling mental health problems need and seek treatment. The rehabilitation, development and reconstruction of the Northeast needs to include a social and mental health component in an integrated approach to improve the mental health of a people affected by war.



Hospital visit



Mental health workshop

Recommendations

In recognition of the fact that the services and people in Northeast Sri Lanka are seriously affected by the conflict, the following recommendations were put forward:

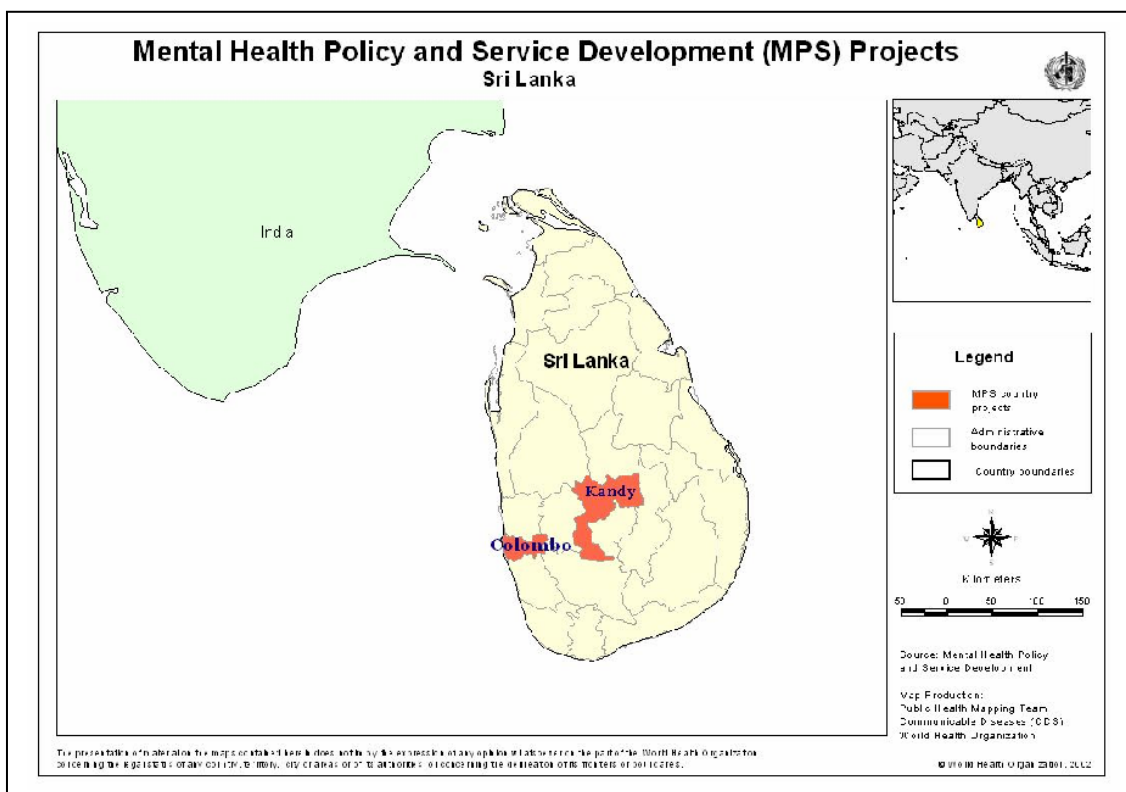
- Giving priority to the development of normal community-based mental health services in Northeast Sri Lanka. The normal mental health system can and should address both severe mental illness and common mental disorders and problems, including trauma-related mental problems.
- Increasing efforts to draw relevant mental health professionals to the Northeast, and to identify creative solutions to ensure that trained informal mental health human resources will not be lost.
- Ensuring that there are functioning acute inpatient psychiatry units in general hospitals in each district. This activity includes (a) either building or repairing/refurbishing units in seven districts and (b) hiring ward nurses and auxiliary staff where needed. (This activity also includes a telephone hotline at each unit).

- Organizing monthly follow-up outpatient clinics of severe mentally ill persons in each division of the Northeast.
- Organizing care in the community for those with common mental disorders and problems (incl. trauma-related problems), and heavy alcohol and drug use. This activity involves training and supervision by two groups of psychosocial trainers. The community resources to be trained include: primary health care-staff, teachers, village leaders, and traditional healers.

A detailed five-year mental health plan has been written with a budget to estimate the amount of external resources required to implement priority activities. It is envisioned that further fund raising for this plan will continue to be based on a rank order of priorities, which are therein defined.

WHO/Headquarters in collaboration with the WHO regional and country offices continues to commit itself to search for resources to implement the plan.

Sri Lanka



Project goal

To encourage a process of deinstitutionalization of psychiatric patients and promote reintegration in the community.

Project objectives

- **To reduce** the number of admissions and re-admissions to the Angoda/Mulleriyawa/Hendala Hospital complex.
- **To establish** a supportive infrastructure, including follow-up care, based on the existing primary health care infrastructure and with the involvement of NGOs active in the field of mental health and well-being.

Implementing institutions

- Ministry of Health, Colombo
- Angoda (Teaching) Mental Hospital, Colombo, Western Province
- Nivahana Society of Kandy (NGO), Central Province

Background

Sri Lanka is an island nation with a population of 18.5 million. The population is made up of mostly Sinhalese (74%), Sri Lankan Tamils, (12.6%) Indian Tamils (5.5%) and Muslims (7%), as well as other minorities such as Moors, Malays and Burghers. The country is divided into eight provinces. Each province has an elected Provincial Council. There are around 300 Local Councils across the island. For the last 20 years, there has been political unrest and an ongoing civil war in the north and east of the island between Tamil separatists and the Government. Therefore, there has been substantial migration of Tamils from the north and northeast to the south as well as from Sri Lanka itself.

Health Services

The Central Ministry of Health is responsible for funding public health services through provincial departments of health and divisional health services. Preventive health services are provided through primary care facilities, by public health midwives and nurses, and public health inspectors. The Central Ministry of Health remains responsible for human resource development, personnel posting and discipline, bulk purchasing of drugs and allocation of capital expenditure.

Each province has a department of health led by a Provincial Director of Health Services who reports to the Provincial Minister of Health and the Central Ministry. The Provincial Director is responsible for hospitals as well as primary and secondary health care facilities. The provincial Ministry of Health is responsible for policy-

making, planning, monitoring, coordination of provincial health activities, procurement of supplies and managerial and technical supervision of divisional health teams.

Each province consists of approximately three districts and 30 divisions. Each district has a Deputy Director of Health Services. At the divisional level, a group of Divisional Directors of Health Services (DDHS) has been created. These Directors have been appointed by the Central Ministry of Health. They are responsible for coordinating all curative and preventive health activities as well as for the management of facilities, including district hospitals. This has further helped to devolve power to divisional levels.

The state of mental health

Between 5% and 10% per cent of people in Sri Lanka are known to suffer from mental disorders that require clinical intervention. Nearly 70% of patients seen in clinical practice are diagnosed with psychosis or mood disorders. Among the most common conditions seen in clinical practice are psychosis, mood disorders, dementia, anxiety disorders, somatoform disorders, substance abuse, stress disorders, and adjustment disorders. Psychiatric practice tends to be based on the biomedical approach and relies mainly on the use of drugs and electro-convulsive therapy. Patients who need or seek other treatments are referred to non-medical mental health professionals (Paper given at WHO Expert Committee Meeting, SEARO, 2000).

An estimated 70,000 Sri Lankans suffer from schizophrenia. This figure

is expected to rise with the increase in the number of young adults. It is estimated that 5-10% of the population over 65 years of age suffers from dementia. The most recent figures show that the suicide rate in Sri Lanka is 44.6 for men and 16.8 for women. However these figures date back to 1991 (please see WHO website figures at:

http://www.who.int/mental_health/media/en/363.pdf

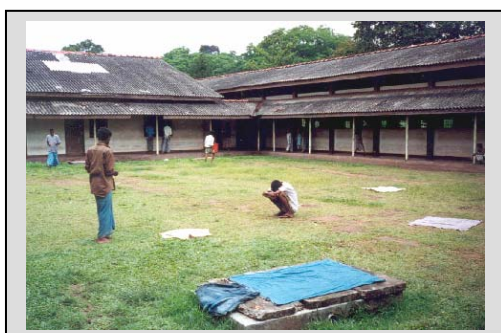
and

http://www.who.int/mental_health/prevention/suicide/suiciderates/en/

Mental health services

At the time of writing there are an estimated 38 psychiatrists for the whole country (not all of whom are with the Ministry of Health). There are also 17 occupational therapists medical assistants and others, 410 psychiatric nurses, and 9 social workers attached to the inpatient units (ATLAS project, Department of Mental Health and Substance Dependence, 2001, WHO).

In Colombo and its environs, there are three large mental health hospitals.



Psychiatric hospital, Western province

These include, Angoda, which takes new admissions from any part of the country; Mulleriyawa, which is primarily for long-stay female patients; and the mental health hospital at Hendala, for long-stay male patients

who have been transferred from Angoda. In addition, a few provincial “Base” (general) hospitals provide outpatient services. The Central, Northern and Southern Provinces have psychiatric units or “Teaching Units” with beds in general hospital settings as well as effective outpatient services. The three psychiatric hospitals as well as the Teaching Units are under the control of the Central Ministry of Health in Colombo.

General hospital units are only permitted by law to admit voluntary (informal) patients. However, there is some question about whether this does in fact happen in all cases. To admit patients to Angoda and Mulleriyawa requires an order from a Magistrate. If this is by-passed, and patients are admitted involuntarily, they have no legally enforceable rights.



Community mental health team members in Angoda hospital

Outpatient clinics are run in most Base hospitals when psychiatrists are available. In order to strengthen mental health services around the country a total of District Medical Officers have been trained and assigned to Base hospitals across the country to run psychiatric clinics. However, not all of these Medical Officers have remained in their posts. There are also plans afoot by the Ministry of Health to relocate patients requiring long-term care to community-based facilities.

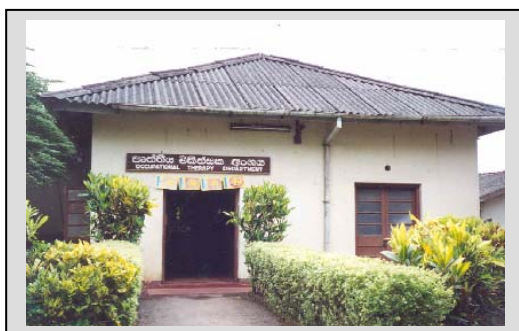


Doctors are being trained to provide care at Base hospitals

The private sector

There are several private practices in the capital run by psychiatrists who are employed by the statutory services but work part-time in private hospitals. District Medical Officers at Base hospitals also sometimes see private patients. Numerous general practitioners see patients privately since general practice is not part of the Government's free health service. A few consultant psychiatrists are believed to run large practices in Colombo.

Counselling services for people with suicidal behaviour, interpersonal problems, stress-related health problems and psychosocial problems are provided by non-medical mental health professionals in the non-governmental sector. Some non-medical mental health professionals also provide psychological services that are based on cognitive behaviour therapy and other psychological models.



Rehabilitation services in hospital

Ayurvedic services

Throughout South Asia, religious healing and forms of indigenous medicine such as Ayurveda have traditionally dealt with mental health problems. There is a large Government Ayurvedic hospital with an Ayurvedic college and research centre that trains physicians. However little is known about their work among mental health professionals. Administratively, Ayurvedic medicine does not come under the Ministry of Health, but under the Ministry of Indigenous Medicine. There is also a Buddhist temple some 20 miles from Colombo that has been using Ayurvedic treatment for *unmada* (equivalent to mental illness) for many years.

Non-governmental organizations

There are at least five NGOs working in the field of mental health. The oldest started in 1987 as a befriending scheme for patients in one of the three mental hospitals (Mulleriyawa). Three of these organizations now run rehabilitation programmes for people with mental health problems. One is a community-based programme and the other two take the form of residential programmes where services are provided for the long-term mentally ill.

Generally speaking, the current range of mental health services, service delivery models, facilities, personnel, funding organization of services and priority-setting processes are totally inadequate to meet the present and emerging mental health needs of the community. Services are not evenly distributed and there are problems with access, particularly to community-based care. Most of the available

services are concentrated in Colombo and other urban areas, leaving the rest of the country largely devoid of services. Hopefully, the situation will improve as medical health officers are trained to work in the Base hospitals. As the project becomes more established, there will be a network of primary care services in some areas; however, much needs to be done across the country as a whole.

Project description

The aims of the project were the same in both the Gampaha district of the Western Province and in the Central Province. The main objectives of the project were to reduce the number of admissions and re-admissions to psychiatric hospitals in Colombo, and to establish an infrastructure of support, including follow-up care, based on the existing primary health care infrastructure. However, the approach has differed somewhat in the two project areas. This has largely been because of the differing mental health services available (or lacking) in the two areas, as well as the availability of human resources in each.

Work in the Western Province has been carried out by a team of social workers attached to one of the main mental hospitals in the capital (Angoda). This has been done in collaboration with one of the few psychiatrists to conduct clinics in the community.

In the Central Province, work has been carried out by an NGO active in the field of mental health and well-being (Nivahana Society of Kandy (NSK)), based in the capital town of the Central Province. This NGO was established in 1985 when a group of concerned

individuals, with a shared interest in mental health issues, came together to advocate for improved mental health services within the Province. The director of this NGO is also a consultant psychiatrist at the teaching hospital in the Province. He has been able to engage the Central Provincial Ministry of Health and the Department of Psychiatry of the University of Peradeniya in pursuing the aims of this project.

Central Province

State psychiatric services in the Central Province are provided by general and specialist psychiatric clinics in the two main teaching hospitals in Kandy and Peradeniya, as well as by a 20-bed medium-stay unit in one of the districts. During the period of the project, there were no other formally recognized state-funded psychiatric services.

The main thrust of the project in the Central province was to supplement current mental health services by providing care in the community to those patients recognized as suffering from mental health problems as well as to their families. The idea was that this would eventually be incorporated into mainstream services. The philosophy of the project was to work with patients to maximize their ability to live independently and to facilitate and promote the development of cost effective, accessible, and quality mental health services. This was being implemented through the various activities described below.

Raising awareness among policy-makers and planners about the need for more sensitive community mental health systems

In order to ensure support for the project and to facilitate links with

current services, the project staff have organized meetings both within the Central Province and with senior personnel from the Central Ministry of Health in Colombo. In the Central Province, project staff have met with local policy-makers and now take part in Provincial community health meetings, which are chaired by the Provincial Director of Health. This has meant that the project is now seen as integral to the development of mental health services for the Province and it has therefore secured the support of the Provincial Department of Health. Project staff now take part in regular mental health divisional meetings with the Director General of Health.

Establishing community mental health resource centres

As part of the project, there is a plan to set up three community mental health resource centres in each of the districts of the Province. The first centre was established during the second year of the project and training manuals and journals on mental health and addictions have now been purchased. It is located within the grounds of the district hospital. The main roles of the current centre are to:

- Coordinate service delivery between the specialist services, supporting hospitals, community staff, and other centres and community workers.
- Monitor and evaluate service delivery effectiveness/efficiency and revise as appropriate to improve them.
- Act as a resource centre to provide workers with information on mental health issues, house up-to-date journals and books, and provide internet services.



Katugastota Mental Health Resource Centre

Relocating people discharged from mental hospitals in Colombo to the Central Province

A register of all patients from the Central Province who were eligible for discharge from mental hospitals was compiled and attempts were made to contact their respective families. Assessments were done with patients, and relatives who could be found were questioned about their willingness to take in family members who had been recently discharged from hospital. Based on the responses from relatives, it emerged that because of the length of stay of some persons in mental hospitals in Colombo, and the loss or weakening of family ties, of the original 150-200 persons who could be relocated, only an estimated 15% could be reintegrated in their families. It became clear that different types of accommodation would need to be established to house patients following their discharge from hospital.

The project has therefore worked to establish medium and long-term accommodation for patients within the community. To this end, 20 beds were added to a medium-stay psychiatric unit in the district of Deltota to accommodate 40 people (roughly equal numbers of men and women). The average length of stay has been approximately 18 months. The

Provincial Department of Health has provided extra staff to cater for the increased number of patients. In turn, the staff has been trained by the project to undertake psychosocial rehabilitation with patients who have been discharged from the Angoda mental hospital in Colombo. As part of this process of rehabilitation, the female residents have been engaged in craftwork (batik, needlework, soft toys, embroidery and making utensils out of local materials such as coconut shells), while the men are employed in animal husbandry and gardening. The plan is to make products that can be sold at the local market.

The project also planned to convert an old hospital site, owned by the Provincial Department of Health, into a long-stay unit. This unit will house patients who have been discharged from the Angoda hospital complex in Colombo and who have little chance of returning to their families in the Central Province. The provincial government has given its approval and support for the establishment of this long-term rehabilitative facility. Funds are currently being sought to undertake refurbishment. The facility will offer different levels of sheltered accommodation, according to the different needs of individuals.

Establishing effective systems, policies and procedures to support the emerging community mental health care services

A number of activities have been undertaken to fulfil this objective. These include training different categories of staff, establishing clinics where none previously existed, ensuring adequate drug distribution, and establishing effective methods of recording, storing and analysing services' data.

As far as training is concerned, five groups of professionals have been targeted: Base hospital doctors (in five Base hospitals), Divisional Directors of Health Services (DDHS), public health nursing sisters (PHNS), public health midwives (PHM) and public health inspectors (PHI). A training manual has been compiled for teaching public health midwives. The manual covers basic information on mental illness, medication and communication skills.

In the second year of the project, weekly psychiatric clinics were introduced in two of the five Base hospitals. These clinics act as a gateway to the main psychiatric clinics in the two local hospitals. The DDHSs currently specialize in child and maternal health and are responsible for community and preventative services. With training, their role has been extended to incorporate mental health. They will in turn support the public health nursing sisters by providing care to people living in the community and suffering from mental health problems. A link has also been made between trainee doctors at the University of Peradeniya and doctors at the Base hospitals in order to offer training in mental health as part of training in community medicine.

All of the 800 public health midwives and public health inspectors in the 33 divisions of the Central district who offer community preventive services, have been trained.

As far as drug distribution is concerned, the project manager was involved in writing a paper, which was submitted to the Director General of Health Services, and proposed that key psychiatric medications be made available in the district. Historically, patients requiring psychiatric treatment travel to Kandy General Hospital. This

involves long journeys at a time when patients are unwell. This may be one of the reasons why large numbers of patients who do not attend outpatient clinics, and therefore cease to take their medication, subsequently suffer a relapse. A ward survey in the teaching hospital showed that 50% of all admissions to the wards were people who had discontinued their medication.



Long waiting times at psychiatric clinics

The project therefore proposed that psychiatric medication be made available in all Base hospitals, in all district hospitals and to all Divisional Directors of Health. The introduction of Medical Officers at the Base Hospitals has facilitated the achievement of this objective.

A data collection system and a system of psychiatric referral has been piloted. In addition to patient records held in Base hospitals, these include: referral forms to and from the divisional psychiatric service; home visit forms; two monthly psychiatric forms completed by public health nurses and doctors; quarterly forms from the medical health officers to consultant community physicians.

Western Province, Gampaha District

The Angoda/Mulleriyawa/Hendala mental hospital complex houses

approximately 2800 inpatients. Of those, around 1500 are long-stay patients with little access to psychosocial rehabilitation or specialist nursing care. The only provision of statutory community care is through a team of 6-8 psychiatric social workers (the numbers have varied over time) attached to the Angoda hospital, and one active consultant community psychiatrist (who is one of the project managers).

A lack of infrastructure for follow-up and family support has led to frequent re-admissions and a heightened risk of rejection by the family, as well as burnout. The project aims to address these issues by locating families and preparing and supporting them to receive their relatives. It also plans to train primary health care workers to identify individuals in need of help and carry out basic follow-up in the community.

The main efforts so far to reduce the number of admissions and re-admissions to hospital, have been through the provision of targeted ongoing support in the community. In addition, building a wider network for support through the primary health care teams who were equipped to both identify cases and provide follow-up care. Unlike the Central province, most of the patients discharged to the community have been sent back to their families. The emphasis on reintegration therefore has focused on working not only with patients in the community but also with their families. A small number of people have been referred to non-governmental community facilities because there were no statutory facilities in the district.

To establish a supportive infrastructure, including follow-up care, based on the existing primary health care infrastructure

Reducing re-admissions to mental hospitals and establishing effective support systems in the community

The project has sought to achieve these objectives by increasing the level of support in the community to persons discharged from hospital. This has been done through training different categories of staff to identify cases and conduct follow-up and placing patients who have been discharged but who cannot be returned to their families in community-based rehabilitation facilities.

As a starting point, the project identified all the patients who lived in the five divisions of the Gampaha district and who had been admitted to hospital more than two or three times in the preceding two years. A range of demographic and diagnostic data was collected on all patients discharged from the Angoda and Mulleriyawa hospitals. Patients were then assessed in terms of the degree to which they were deemed to be at a minimum, low or high risk of relapse after discharge. Diagnosis, family situation, previous number of admissions, history of violence at home, suicide attempts and other factors were taken into consideration in these assessments. This in turn determined the frequency with which community visits were organized not only by project staff, but also with the participation of newly trained primary health care staff.

Follow-up visits were then undertaken by the project team. The team

consisted of psychiatric social workers and a consultant community psychiatrist who runs three to four clinics a week within a 75-kilometre radius of the hospital, as well as the follow-up visits carried out as part of this project. It was found that visits by the psychiatric social worker helped family members to better understand persons suffering from mental disorders and helped them to rebuild their personal social connections.

The psychosocial intervention provided by the project included not only counselling and supervision of medication, but also other types of support such as assistance in finding employment. If patients were unable to find employment, they are encouraged to become self-employed by making handicraft items for sale in local markets.

As in the Central Province, the emphasis in staff training has been on training primary health care professionals such as medical officers of health (MOH), public health midwives, public health nursing sisters and public health inspectors. The project team has conducted training sessions in all five divisions of the Gampaha district and has trained all



Training of primary health care professionals

167 primary care staff (14 medical officers of health and 153 public health nursing sisters, public health midwives and public health inspectors). Ongoing

support is provided to primary health care staff through monthly case conferences.

Although at the beginning of the project referral systems are not as advanced as in the Central District, as part of the training, primary health care staff were made aware of the need to fill out basic referral forms used by the Ministry of Health (MOH). There is also a system in place whereby patients picked up in the community are referred to the MOH. Only in cases where the MOH does not feel able to offer the scope of assistance needed, will the patient be referred to the psychiatric social worker responsible in that particular division.

The establishment of carer support meetings in each of the five divisions initially has spread to cover 11 DDHS areas. Meetings are held in the building in which the medical officers of health and their teams are housed. Transport is provided by the project to encourage as many relatives as possible to attend. In addition, meetings are held on Saturday mornings to enable those relatives who work during the week to attend.

All meetings continue to be organized and attended by the social worker responsible for the division, the senior psychiatric social worker (also one of the project managers) and the project psychiatrist. An officer from the social security office has always been invited to attend to hear the problems of relatives first hand and to facilitate the offers of social assistance to those relatives in need.

Some of the main areas of concern voiced by relatives were the following:

- The negative side effects of medication which affect individuals' ability to function normally.
- Fears for personal safety due to aggressive behaviour of discharged patients (leading to relatives asking for the patient to be kept in hospital).
- Non-compliance with medication (leading to relapses and sometimes aggressive behaviour) and concerns about how to respond to this.
- Worries about their sons'/daughters' not finding marriage partners because of the illness and what can be done to reassure prospective spouses.
- Queries about whether mental illness is hereditary.
- Queries about their own mental health (signs and symptoms).
- Queries about the relationship between smoking and mental illness.

Mental health education in schools

Psychiatric social workers have been visiting schools to provide information about nature of mental illnesses and how they can be identified and what help is available.



Having 'Open Days' helps to open minds

Providing social service assistance by using a discretionary fund

The project has established a small fund to offer social support to needy families since many of the persons discharged from hospital and their families are very poor. This fund is therefore used to offer support for housing and employment when patients are discharged from hospital.

Raising awareness in the community

The project considered it important to combine medical, social and spiritual services for patient's full recovery by maximizing the existing potential in the community. Seminars have therefore been organized involving 53 members of the various social welfare organizations in three of the five divisions. They were aimed at examining the welfare requirements of people with mental health problems more closely so that the relatives can link up with these social welfare organizations and obtain more support.

Key Results

- *Strengthening the network of psychiatric services in the Central and Western Provinces by the establishment of new clinics and by the extension of the range of community-based care and support.*
- *Training of primary health care workers, medical health officers and divisional directors of health services to provide community-based care thus strengthening the integration of mental health in primary and secondary health care.*
- *Raising the level of awareness in the community and among policy-makers and securing their support.*
- *Decreasing the number of re-admissions to psychiatric hospitals (approximately 70% of patients in the Gampaha district).*
- *Intensifying the level of support to reduce re-admissions to hospital.*
- *Establishing forums for carer groups to express their needs and concerns.*
- *Establishing medium term rehabilitation facilities in the community.*
- *Mainstreaming mental health services in the province (Central Province)*
- *Strengthening formal referral systems between primary health care workers and tertiary services through designing and testing various types of referral forms.*

Rehabilitation in the community: Some success stories

Raj has a history of mental illness that has led to several admissions to psychiatric hospital. He was diagnosed as suffering from schizophrenia and prescribed medication. Although he had been discharged back to his family, he found it difficult to both find and maintain employment because of recurrent bouts of illness. As part of the project for the reintegration of people back into the community, Raj was able to benefit from a programme of support which included help with finding employment. Through negotiation with the manager of the local garment



factory where his wife worked, Raj was also able to find gainful employment. In addition, he was given support through home visits that provided both counselling and help in understanding the importance of staying on his medication. At times of crisis, his social worker liaised with his employer and provided additional support. As a result, Raj was able to save money and buy a small house and a plot of land so move his wife and daughter out of the dilapidated house, which they formerly inhabited. He is now able to help support his family financially as well as cultivate a small plot that helps to supplement their basic food supplies. The whole family has benefited from Raj's improved situation. This is a Prime example of how rehabilitation within the community can improve both the quality of life and future prospects not only for individuals, but for their families as well.



**Rehabilitation in the community:
some success stories**



One of the most important ways of helping people in the community after Discharge is to provide a means of employment. By the use of simple technology, such as a weaving machine, items such as rugs and rope can be made for sale in small local markets and thereby supplement the family income. The ability to earn money and be seen as a useful member of the community is an important feature of rehabilitation, especially in low-income countries.

All these people have been helped upon their discharge into the community by means of employment. They are engaged in weaving or growing of plants for sale in the local market.



