

# Thematic Research Study 2008

**Practice of Community Mental Health:  
Seeking Reliability and Quality  
Assurance in Low and Middle Income  
Countries**

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**Case Study on Mental health and  
Development Programme in  
Southern Province, Sri Lanka**

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**Practice of Community Mental Health:  
Seeking Reliability and Quality Assurance in Low and Middle Income Countries  
Case Study – Southern Province, Sri Lanka**

**(1) Introduction**

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BasicNeeds initiated its programme in 2003 in Sri Lanka with 32 people with mental illnesses in one province in country. Since then programme has covered 7 provinces out of total 9 in country by including 5205 (This included number of other provinces, not only Southern, as end of May 2008) people with mental illnesses. Presently programme is functioning in 5 provinces through 4 projects including 'Community mental health expansion', 'Improving mental health of Tsunami affected people', 'Improving mental health of war affected people', and 'Horticulture therapy for institutionalised people with mental illnesses at Angoda mental hospital'.

These currently operating projects are based on approaches, modules and experiences which originally gained through pilot 'Community mental health and development' project designed and tested in 5 year period, 2003 – 2007. Most successful module from its quality and quantity in this pilot was Community Mental Health (CMH) module. In relating to addressing needs and problems of people with mental illness, Community mental health and Livelihood are modules which directly take field implementation while Capacity Building, Research and Policy and Management and Administration are operating as cross modules which link to all other.

In this context, though study is basically focusing on practices of CMH, it is analysing impacts and changes which has links with cross modules mentioned above. Through this study basically focus on relevance of CMH practices in Sri Lankan context, assurance of its quality and reliability. This base on Southern provinces as a case study. Reasons to select this province are existence of experience of pilot project and availability of information which covering impacts for a long period, which is sufficient to reach conclusion in relating to research questions.

Study was therefore guided through following research questions.

1. How do practices of community mental health relevant in context of Sri Lanka against mental health problems and services available?
2. How did community mental health module evolve as a response to mental health problems and needs in country?
3. What are the locations where different aspects of CMH take place? What is the process and different practices exactly? (This including identification of people with mental illnesses, diagnosis, follow-ups after that, happenings at mental health camps, clinics, SHGs and service providers and people involvement in process).
4. What other/alternate treatments are available? Where exactly and by whom?

5. What records/documentation is done? Who does this? Where is it kept? How is it used?
6. What resources are required for providing community mental services? Money, medicines, psychiatric staff, general health staff, community workers/volunteers etc.
7. User perspectives on reliability, quality of CMH services they receive and some issues they bring up

## **(2) Description of study location - Southern Province**

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Southern province is consisting with three districts , Hambantota, Matara and Galle with 2,278,271<sup>1</sup> total population. This population are living in 2,122 Grama Niladari divisions in 46 Divisional secretarial divisions. According to census information, total of people with mental disability living in province are 12,751<sup>2</sup>.

BasicNeeds Sri Lanka started its initial works in Southern province in 2003 with pilot project covered 4 DS divisions (Agunukolapalassa, Katuwana, Suriyawewa and Dickwella) in the province. In last five year to present (up to May 2008) Mental health and development programme in Southern has expand its coverage up to 22 DS divisions (48% from 46 total divisions in province). There are following reasons behind this programme coverage which BNSL given priority in Southern province.

- High suicide incidents recorded in the province.
- Prevalence of mental illnesses are high compared to services available services at localities.
- Impacts of poverty is remarkable in remote areas of province.
- Effects of post-conflict situation (89 youth rebel against government)
- Highly Tsunami affected area.

Since 2003 to end of May 2008 , Mental health and development programme covered 5112 people with mental illnesses in Southern province through collaborative works with health administrators, health professionals , community volunteers and other stakeholders. This is 40% from total of 12,751 identified through national census in 2001.

Within last 6 year periods , there is also considerable progress in mental health services at local level as well at provincial level. This progress is high in Hambantota district where influence of initial mental health and development works exist.

## **(3) Methodology**

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<sup>1</sup> National Census Report – 2001 (Last census done in Sri Lanka)

<sup>2</sup> However, this figure may be questionable due to stigma and discrimination attach with mental illness. So there is tendency to hide such status by family when census officer come directly and collect information for this. Some social researcher also think that this figure may be included mental retarded people due to misrecognition of their behaviour.

This Case Study used a qualitative approach with available information of five year field implementation of CMH works in Southern province. In some instances, quantitative information were also used to make strength points mentioned qualitatively. In addition to available information, primary information were also gathered to examine present status of some aspects of CMH works in new projects.

### **3.1 Sample/scope of study**

As qualitative study , it is considered generally all areas and people at present and past in Southern province as scope of the study. This is because conditions (problems and services) of all areas and groups are equal to certain level in relating to relevance of CMH practices. However , study of quality, impacts, and reliabilities of practices are limit only to information and population in DFID pilot project completed in March 2007.

This is because, it is necessary to have scope which represent sufficient time of implementation and its impacts in relating to CMH. Implementation at mid level in Big Lottery funded present CMH expansion project in area is not sufficient for such information. Study is therefore cover evidence relate to works of pilot in 4 DS divisions and 417 people with mental illnesses included all community mental health practices from 2003 to March 2007.

However , study also include information present projects to examine relevance of CMH practices and its present status link with impacts of pilot. Primary information collection mentioned in data collection basically cover scope of present projects.

### **3.2 Data collection**

Information on new programme areas was directly gathered through using following data collection methods. This is necessary in studying relevance of CMH module in new areas and how situation of mental health services fit with it.

*Key informant interviews* – Research and policy officer conducted 2 interviews with Dr Rubi Ruban, psychiatrist in Hambantota district and Dr. Bihan Kamalrathna in MOMH in Galle district, as responsible officials for coordinating and implementing mental health activities in two districts. They are also mental health professionals who collaboratively works with BNSL for community mental health activities in two districts. Objectives of interviews with them are:

- To understand situation of mental health services available in relating to CMH practices.
- To understand gaps of mental health services provide by government at localities compared to CMH practices.
- To understand allocation of resources (medical officers, drugs and transport etc) to sustain CMH practices after completion of BN projects.
- To obtain recommendations for quality and reliable mental health services at community level.

*Focus group discussions* – Research and policy officer conducted two focus groups discussion (with support of trained volunteer) at a village (Balapitiya) in Galle district and at another village (Lunugamwehara) in Hambantota district. These areas was selected

by considering factor of difficulties of accessing mental health services compared to other programme areas. 7 people with mental illnesses were selected with their cares , so total participation for each group discussion was 12-15. People who treated for illness before BN intervention and people who had not any treatments before BN were equally selected to compare differences of impacts of treatments at locality.

Observational visits- Two observational visits done by Research and policy officer at two mental health camps conducted in Galle and Hamabnatota. Objective of these visits as follows

- To observe behavior of people with mental illnesses at mental health camp to understand their satisfaction and response to service.
- To understand how different groups –volunteers, psychiatrists , other medical staff and partner organizations – contribute to organize and conduct a camp and challenges they face.

Review and gather information from available sources – Study used both primary and secondary information sources which produced in pilot CMHD project funded by DFID. So following sources was used to gather information which need for research questions.

*Secondary information sources* - . This include publication, six monthly review reports, impacts reports , research reports , community review reports and project evaluation reports.

These document set used as source to gather information which provide overall picture and direction for evidence in relate to research questions.

- Problems and needs of mental health
- Process of CMH
- Improvements of mental health
- Accessing treatments and service
- Building local capacities
- Perceptions on quality and approaches

Primary information sources- 12 life stories were selected as primary information source to find information not included in data collections mentioned above .Stories were selected on basis their relevant to research questions and period of CMH interventions relate with their stories.

### **3.3 Data Analysis**

#### **Analysis of individual information sets**

**Focus groups and observational visits** – Research and policy officer read two reports of two focus group discussions as whole while categorize information to get general idea relating to research questions. (Categories of analysis were developed within readings documents , but with focus of main research questions). Here major opinions and attitudes were coded (through categories) in relating to problems relate to accessing mental health services and to present status. After that summary was produced by using categorized information of two documents.

Records of observational visits this were read to identify people satisfactions about services at mental health camps by comparing recorded notes on their behaviors at the beginning and end of camp. This was read and coded to check whether there was difference between expressions (facial) and behavior in these two instances to see user satisfaction and relief.

Observation records were also coded (with categories) on support of volunteers and psychiatrists to see their relation to user satisfaction. Finally summary was produced with highlighted points to be used with final analysis.

In both documents, main categories of 'Access to treatments', 'Satisfaction', 'Local human resources (for volunteers' work)' and 'Government human resources' were used to code information. This contributed to read documents with focus to develop summary points for research questions.

**Key informant interviews** – Records of two interviews were read and coded by using categories of 'Problems of accessing treatments', 'Available mental health services', 'Gaps', 'Allocation of resources', and 'Problems and challenges'. Coded documents was read again to summaries main points for research questions.

#### **Analysis of statistical information**

In available information in pilot CMHD project, there was statistics which can use to show impacts of interventions for a long period. Following description explain how tables in report were developed on this statistics.

#### Table 01 – Continuation of Treatments

1. Filtered excel list of people in pilot project separately (This excel list is the database of entered information of clinical files updated from 2003 to 2006). Put total numbers in to separate consolidate excel sheet which also show average (used excel function).
2. Filtered people received treatments before BN and did not receive treatments before BN separately. Put total numbers in to same consolidate excel sheet which also show percentage.
3. Filtered list of people continued treatments in 2005 and 2006 separately. Put total numbers in to same consolidate excel sheet which also show percentage.
4. Consolidated excel sheet was used to develop Table 01.

#### Chart 1 – Improvement of mental health status , before and after CMH interventions

1. Filtered excel sheet of baseline survey did in 2003 and 2004 for people in pilot project against three indicators – Engaged in activities of daily living, Doing own works independently and relapses. Put total number with percentage in a consolidate excel sheet
2. Filtered excel sheet of follow-up visits forms completed in 2006 for same people in pilot project against same indicators and put total in same consolidate excel sheet.
3. Used consolidated excel sheet to develop a Excel chart which included in report.

### **Final analysis and documentation**

Read all summarise of three document sets (including summaries of documents of pilot project) and consolidated statistical information to find pattern , similarities and differences of information in relevant to research questions. This contributed to find highlighted points and facts in all set of documents.

Multiple perspectives of same points were considered when extract information as valid evidence to examine research questions.

E.g. when research and policy officer reading information , it was clear that same points mentioned by people with mental illnesses and mental health professionals in relating to quality and approaches of CMH against institutional mental health care. (But their ideas are expressed differently according to their relation to this point.). So this way guided to interpret this point by using their ideas under relevant theme.

All summarised information were interpreted in this way finally under each themes in analysis and discussion. Findings of study were draw from interpretation under each themes and recommendations were developed on issues and problems identified at discussion. Statistical information were also consolidated using Excel to feed discussion at final stage.

It is more appropriate to consider final analysis in two separate sections as in report and but has link to each other.

1. Relevance and Process of Community Mental Health – This is basically discuss process in relevant to research questions.
2. Key Impacts and quality of CMH practices – Discuss impacts in relevant to key ingredients of CMH practices, qualities relate with it and problems.

### **3.4) Limitations and challenges**

One main limitation of study is that it is not able to represent whole areas of present CMH works carrying out presently. This is due to level of works in these areas is still at middle level.

Other challenges faced is develop consistent qualitative analysis method to examine different level of documents which there structures and objectives are differ. So it was difficult exercise to categorise, summarise and analyse these variety of information to find a pattern , similarities and differences in order to interpret evidence in relating to research questions.

#### **(4) Analysis and Discussion**

##### **(4.1) Relevance and Process of Community Mental Health**

###### **4. 1.1 Relevance of community mental health practices in the context of Sri Lanka**

Mental health and development programme in Sri Lanka was initiated in 2002 by BasicNeeds as a new initiative to address mental health problems and gaps in service highlighted in that period. High suicide incidents and insufficiency of mental health services in areas where mental health problems high were such issues which attracted BasicNeeds to initiate works.

However first initial consultation workshops conducted in five villages of Angunukolapalass<sup>3</sup> in 2003 with people has mental illness, their carers and community reveal mental health problems and issues those are not identified properly even at existed centralised mental health service. These consultations brought following issues which demanded approach to solve challenges of mentally ill which they could not succeed through centralised mental health services in government.

<b>Problems and challenges</b>	<b>Demand</b>
<b>Lack of knowledge and capacity</b> – people with mental illnesses and their carers was not able to understand their condition, which resulted in untreated their illnesses for the long time or in delayed treatments. Though some took treatments , they stopped medicine due to difficulties and lack of understand of proper care. People with mental illnesses themselves and community believe that mental illness cannot be cured.	Raise awareness on mental illness and mental health and built capacity of people with mental illnesses and their families to mange care and treatments.
<b>Lack of mental health services within localities</b> – As result of this , people had to obtain mental services from cities far away from their village. They therefore face difficulties of transport, queuing in hospitals for long-time , waste of money which affected quality of their life.	Develop opportunities to getting treatments within localities
<b>Stigma and discrimination</b> - Labelling and distrust of capacities of people with mental illnesses excluded them from families and communities. This also resulted in untreated their illness and also violated their rights in some incidents.	Raise awareness and provide opportunity for inclusion of people in their own communities.

<sup>3</sup> This DS division once identified as a area which identified as high suicide incidents recorded in country

There is no changes in these issues even in new programme areas in Galle and Matara regardless progress in mental health services centrally in these areas in 2008 compared to 2002. As example, leading psychiatrists, health administrators and non-government organisations believe that mental health service in Galle district are at good level due to services and interventions available at Karapitiya teaching hospital and Unawatuana mental hospital centrally. They consider that people with mental illnesses and their carers in this district could access these services, so there is no need for special interventions at localities. However, MOMHs who has close relationships with the community reveal totally different reality which point out following issues.

- There is considerable percentage (38%)<sup>4</sup> of people who did not have treatments for their illnesses in the district.
- Lack of understand of that they mental illness, difficulties of accessing services available at centrally in district and stigma are main reasons behind this problem.
- Services providing centrally are not enough to address needs of people when concern more demand with sustaining quality services.
- Though mental health clinics are conducted at 5 MOH areas to improve easy access , it is not enough to address needs of people in other 15 MOH areas (there are 20 MOH areas in Galle).
- Resources (human and psychical) are also not sufficient to provide quality service.
- MOMHs believe that stigma in high in some areas in Galle due to semi-urban nature compared to rural areas of Matara and Hambantota.

In Hambantota and Matra , there are considerable progress compared to Galle in 2008. Before start BN programme in 2002 in Hamabantota, there were only centralized service at Tangalle hospital. This conduct monthly clinics for people with mental illnesses. But this was not continuously conducted due to difficulty of obtaining service of one psychiatrist for a long period. However there is considerable progress in this district with mobile clinics conduct at offices of Medical officers of Health (MOH) and availability of new 3 MOMHs (medical officer of mental health) and one psychiatrist.

Before start BN programme in 2002 in Hamabantota – There were mental health clinics at Matara general hospital. However this is also centralized service as in Hambanatota. However in presently there Deputy directorate of health services (DPDHS) initiated mobile clinincs at level of offices of Medical officers of Health (MOH).

Though there is a progress in these two districts, it is not still enough to address needs and problems of people with mental illnesses in area.

There is therefore relevance for practice of community mental health interventions in all three districts in Southern province regardless of improvement of services and cultural differences in those. In this context, community mental health is demanded not only for improving services , but also to reduce barriers and to build necessary capacities to sustain interventions. These second and third needs are missed and not addressed in

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<sup>4</sup> Based on information on clinical files. This mean people did not receive treatments before BNSL came to Galle.

government existing system properly still though there is some improvements in service in area.

#### **4.1.2 Evolution and practices of community mental health**

Development of interventions of CMH in Southern province is not solely based on experience of previous BN India programme or pre-set ideas of health professionals involve in the project. This is also evolution of approach which designed to cater three main needs identified through consultations. These needs are providing treatments in locality, educating community and social support. Mental health camps, home visits, follow-ups and self-help groups are primarily developed as response to these. However, lately community volunteers and field staff showed that these interventions are not enough to solve problems of some people with mental illnesses who struggle with family relationships. So as response to this programme such as 'Home management' and Buddhist psychotherapy were developed as special intervention under CMH practices.

##### **Mental health camp**

*Evolution* - There was no formerly developed idea that programme need to conduct a mental health camp. There was a process which developed idea and practice of the camp as response to community needs. The programme conducted its first mental health clinic at a school to provide treatments to people with mental illnesses identified at initial consultation workshops conducted in 2002 to 2003 in Angunukolapalasa. This clinic limited to diagnosis and providing medicines. Review conducted with community volunteers, BN staff and field staff of BN partner organisations with health professionals (CBR organisations) on this clinic pointed out that there are more mentally ill people in DS division than identified at initial consultations and also providing treatments are not enough, so need to educate community on mental health illness. Finally this resulted in developing mental health camp as a concept and practice.

*Practices* - Mental health camp has been conducting since then with comprises of multiple activities including diagnose illness by psychiatrist and MOMHs, providing psychotropic drugs, domiciliary care, educating people, occupational therapy sessions and individual counselling. These practices are supported by multi disciplinary team including psychiatrists, MOMHs, counsellors, occupational therapists, pharmacists, livelihood advisors, priests and community volunteers. BasicNeeds Sri Lanka field team has prior meetings with these groups at different level to inform and plan works. So these meetings contributed to meet all of these groups together with different tasks at the mental health camp. This also include psychiatrist' and MOMHs' home visits to people with mental illnesses who are unwilling or unable to the camp.

In start of pilot project (2003 -2004), mental health camps were commonly conducted at public places in villages such as schools and temples, excepts few camps at Hospitals. However, more mental health camps were lately conducted at rural hospitals by giving attention to administration procedure of health services and to sustainability of local mental health service built with the camp. Mentally ill people first diagnosed or received treatments at the camp were informed to continue their treatments by follow-up clinics established afterwards at same hospitals or by closest hospitals where services available for mental illnesses.

### **Follow-up visits**

*Evolution* - Debrief meetings conducted with psychiatrist and community volunteers at the end of the mental health camps raised question of how they could ensure people with mental illness continue their treatments and avoid relapses. Idea of follow-up visits to homes of people with mental illnesses emerged as result of these reviews. Community volunteers were therefore trained in mental health, mental illness, treatments, and side-effects in order to built local capacity to follow-up and support people received treatments at the camp. Afterwards , project team realised that these trainings are not enough to meet expected needs. Consequently training on follow-up visits was introduced and special format was developed to record situation and changes of people with mental illnesses at each period.

*Practices* - Follow-up visits are commonly done by community volunteers on monthly basis. However frequency of these visits depends on factors such as geographical coverage of villages and number of people with mental illnesses whom should be visited by a volunteer. They verify at follow-up visits whether people with mental illness continue treatments or stopped , with aim of avoiding relapses. Awareness on mental illness, treatments and side effects for people with mental illnesses and their carers are also provided by volunteers at these visits. Status of each person with mental illness being visited are recorded in follow –up formats which included in their individual files those keep at partner organisations.

### **Self help Groups**

*Evolution* – One request presented by people with mental illness and community volunteers was that they need opportunity to be relax, enjoy and sharing experiences with each other , in addition to treatments, consultations and reviews they usually have as common activities. This required as activity which support them to spend their time happily in their daily life. One complain of some people, their life at home was boring. Field staff of partner organisations and BNSL also identified that programme need to develop more new activities for people as recreational interventions. They presented their idea of SHGs (This was already existed idea in relating to rural micro-credit programmes under other NGOs in Sri Lanka) to community to consult their ideas. They suggested that they need to have such a group which provide space to meet people with mental illnesses, their carers and community volunteers who live as closely as neighbours. They also invited field officers to give inputs to design usual activities under SHGs. However field officers usually gave this inputs at initial level of SHGs and afterwards responsibility was delivered to community volunteers who take leadership in conducting groups at each level.

*Practices* - Each SHG has about 6-10 members. All members are from the same locality and comprise people with mental illnesses, their family members and volunteers. They meet once a month in the home of a member, the meeting place being rotated among all members. Activities conduct at SHGs vary from area to area which depend on skills and resources available in response to needs and demands. Experience sharing, discussing problems and needs and recreational activities are usual activities in SHGs. Some SHGs

giving priority to conduct livelihood activities such as group farms, home gardening etc in order to support people with mental illness as therapeutic activities.

### **Alternative healings**

*Evolution* - Common experience most of people with mental illnesses was keep more faith on traditional healings such as witchcraft and religious activities. Some of them and their families tried to solve their mental health problems solely through these ways. Other rest of groups used these traditional healings while they were using western medication same time. There were people also used indigenous medicine without any western medication. People with mental illnesses believed that they had remedies for this alternative healings to certain level , but that was not existed for a long period to restart their normal life.

Health professionals involved in CMH activities and community volunteers show that strong trust on these healings were common behaviour of majority of people with mental illnesses in their villages. People understand of mental illness as a effects of spirit and unnatural influence were main reasons behind this trust. They therefore consider this as result of lack of knowledge in people in villages to understand mental illness and behaviour relate with it. However , this behaviour was changed significantly after education provided by programme on mental health for people with mental illnesses and their cares. They so tried to get benefits of western medication as much as possible .

However , findings of follow-up visits show that some groups (28% of 417) in pilot project area) are still keeping trust on these alternative healings as they involved in rituals while they were having western medicine at same time. Their involvement in religious activities are also high. People with mental illnesses think religious ceremonies bring therapeutic experience to them.

*Practices* - In this context, field team and community volunteers showed needs for religious interventions also existing beyond medication treatments. As a response to this , programme developed contacts with Buddhist priests in temples in direct project areas to conduct religious activities for people with mental illnesses, their carers and community. Additionally special Buddhist psychotherapy programmes conducted for selected people with mental illnesses. This included individual therapy sessions , meditations suit to personalities, problems sharing discussion with participation of family members and common religious activities.

### **Information collection and documentation**

*Evolution* – There was general guidelines for information collection such as process documentation and life story writing even at initiation of pilot project in 2003. These methods were used at consultation workshops to collect information as baseline. However , with planning of specific activities under CMH programme management and field staff needed to develop specific and simple information collection methods and formats for regular activities. So field team developed clinical individual file format to use at mental health camps and clinics and follow-up visit form to use at home visits. However these formats were changed period to period as response to new demands at community level and policy level.

Practices - Information collection and its uses occur as follows with relevant CMH activities.

Clinical Individual file - opened for each mentally ill person at mental health camp.. This file includes information on diagnosis, treatment, status of illness (symptoms and daily activities). Basic information in these file are filled by community volunteers with discussion of people with mental illnesses and their carers at the camp. Rest clinical information including diagnosis and treatments are completed by relevant mental health professionals who provide treatments.

Uses- Information of these files are entered into excel database and partners use those to review outcomes of mental health camps. Prevalence information are presented at some review meeting with health administrators to next CMH activities in areas.

Follow-up visit forms – These formats are filled by community volunteers at home visit by a discussion with people with mental illnesses and their carers and by observing their present conditions. They record changes and problems of people with mental illnesses in relating to mental status, treatments, side effects, livelihoods, relationships with family and community.

Uses -So these information are used at SHGs and volunteer committee level to assess impacts of CMH activities and to get inputs for next field interventions. This information they mostly use to identify problems such as tendencies for relapses , and to minimise those through interventions as team at community. Partner organisations also enter these information in to excel database to review status of people with mental illnesses , as in whole province.

Participatory community reviews – Participatory community reviews provide space for mental ill people and other members of the community ,where they live, to review the impact of interventions of the programme. and come up with suggestions for improvement. Generally trained volunteers as local people conduct these reviews annually.

At these reviews, groups of mentally ill people, their carers and volunteers conduct separate focus group discussions to review the impact of the 4 modules of the CMHD Model, namely, Community Mental health, Sustainable livelihoods, Capacity Building and Participatory research

## **4.2 Key Impacts and quality of CMH practices**

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### **4.2.1 Provide treatment at locality and continuity**

One highlighted impact of CMH practices by people with mental illnesses and their families is freedom and relief they experiencing in accessing treatments at localities with establishment of mental health services at their localities. They consider this as a great relief compared to difficulties they faced in accessing treatments in centralised mental health services (mental health hospitals and teaching hospitals at provincial level). Time

and money wasted in accessing service in distant clinics, difficulties in queuing, and losing carers involvement in income generation are more usual problems among these. However, as seen by users receiving treatments at locality is providing them more opportunity to control their illness more easily than before. Presence of community volunteers as knowledgeable resource contributed to identify people untreated before and direct them to take treatments. This resulted in providing early interventions for people who had tendency to suffer from illness due to absence of treatments. Other way this contributed to ensure continuous treatments of people who have stopped treatments time to time without knowing effects of their actions. Prior programme there were instances people stopped treatments due to think that mental illness can not be cured from western medicine. However, awareness provided by community volunteers at follow-up visits caused to change this attitude and built reliability of western medication and continuity of treatments as showed in Table 01. This also show how people who did not have treatment prior CMH were continuing treatments. As mentioned by psychiatrist, continuous treatments is necessary for persons who have severe mental illnesses to avoid developing chronic status of disorder happen as result of recurrent relapses. As Table show 90% of people with severe disorders continue their treatments. This include both 44% who had not treatments prior CMH and 56% who had prior treatments.

**Table 01 – Continuation of Treatments** (Based on follow-up records 2003 to 2006, of 417 people in pilot project areas, these people received treatments at camps conducted in 2003)

Category of Mental Illnesses	People did not receive western treatments before CMH interventions		People received western treatments before CMH interventions		Continuity of treatments, as recorded at end of 2005		Continuity of treatments as recorded at end of 2006	
	Total	%	Total	%	Total	%	Total	%
<b>Epilepsy</b>	5	14%	31	86%	33	91%	31	86%
<b>Common</b>	24	25%	73	75%	87	89%	91	93%
<b>Severe</b>	67	44%	84	56%	140	92%	136	90%
<b>Other Disorders</b>	74	69%	33	31%	75	70%	78	72%
<b>Diagnosis not specified</b>	8	31%	16	66%	22	91%	20	82%

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However, these figures show status of treatments in a period where CMH practices were directly supported by BasicNeeds Sri Lanka as part of pilot project. Problem is therefore how to sustain this status even after completion of projects. Progress in mental health services providing by government in these areas are important in sustain these status. However as findings of final evaluation of DFID project, these progress is still not enough to cater this need compared to growing demands of people in villages.

<sup>5</sup> In here study followed BN categorization of mental disorders as follow.

Common – Anxiety and Depression.

Severe – Schizophrenia, Psychosis, Bipolar affective disorder.

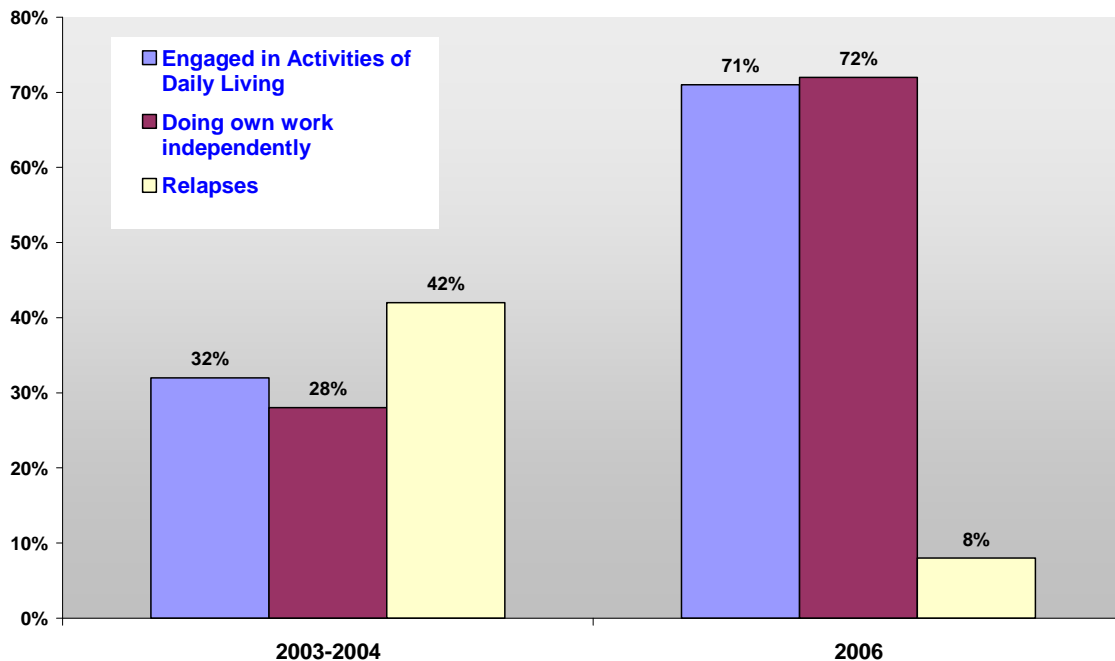
Other disorders – Somatoform disorder, Adjustment disorders, Obsessive compulsive disorder, Alcohol dependents,

## 4.2.2 Sustaining of improvement of mental health

Improvement of mental health<sup>6</sup> is high in life of people with mental illness after intervention under CMH programme than in their earlier status. They see this as a result of continuous treatments , knowledge (to understand illness) and skills (to cope with illness, treatments and side-effects ) they obtained through CMH activities. Effectiveness of CMH activities in relating to improvement is clearly proved through that reduction of relapses (recurrent attacks) from 42% (which existed at initiation of programme ) to 8% (after 3 years of completion CMH activities at village level) as illustrated in Chart1. Compared to 60%<sup>7</sup> relapse rate at Angoda mental hospital , this less rate of programme area shows capacity of CMH practices to reduce relapses.

**Chart 1 – Improvement of mental health status , before and after CMH interventions**

Comparative analysis of findings of baseline survey (2003-2004) & follow-up visits (2006) to 417 people with mental illnesses in pilot project area<sup>8</sup>



2003-2004 = Status of people with mental illnesses at the initiation of the programme, as a percentage; 2006 = Status of people with mental illnesses after interventions, as a percentage (N = 417).

This improvement of mental health is observable in other indicators in Chart 1. Engagement of activities of daily living was also improved 32% to 68% of 417 people with mental illness in villages where all the activities of CMH completed. This indicate a

<sup>6</sup> This mean good mental status to managing mental illness in order to gain normal function in daily life and reduction of symptoms, so this is not about total recovery.

<sup>7</sup> Interview with Dr Neil Fernando (Consultant psychiatrist at Angoda hospital) for mid-term Evaluation (2005)

relationship<sup>9</sup> between integrated approach of CMH which include treatments, therapy, counseling, animation, awareness and social inclusion brought in through CMH activities and improvement of mental health of people with mental illnesses. Key ingredient highlighting here is support of CMH activities to sustain improvement of mental health for a long period which is not easily achieve through accessing centralized mental health services.

This is also highlighting that other social interventions are essential and need to be conducted those with active participation of people with mental illnesses. This is achievable in status where implementation take in small areas. However when it require replication in number of places at once , problem of sustaining impact arise as lack of sufficient human resources with joint skills of mental health and social mobilisations.

### **4.2.3 Perceptions on quality of practices**

Perceptions of people with mental illnesses and mental health professionals show process and quality of community mental health against institutional services as follow. This reveal how community mental health practices contribute to improvement of mental health status for a long period , so support to continuous quality of life.

<b>Mental Health professionals' perspective</b>		
<b>Indicators</b>	<b>Institutional based mental health care</b>	<b>Community based mental health</b>
Service and Care	Mental health care is restricted to few medical professionals.	Involves non mental health professionals , non health professionals and mostly community (volunteers and religious leaders)
Approach	Rather individual based	Targeted towards the population as whole
Relationship	Community being passive recipients of health care	Active participation of the community in the delivering of mental health care
Environment and response of users	Stressful and limited	Patients were more receptive, more cooperative and willing to comply. Supportive environment including family members and volunteers is providing therapeutic background.
<b>Perspectives of people with mental illnesses</b>		
<b>Indicators</b>	<b>Institutional based mental health care</b>	<b>Community based mental health</b>

<sup>9</sup> This is not a link which proved through a correlation of independent and dependent variables as in experimental survey. Here , chart analyse only differences of each status in two periods , so this is considered as enough research tool to see relationship than to academic standard research methodology.

Seeking treatments	Accessed treatments from several health professionals and institutes distant from locality. Sometimes they received treatments from general physicians who are not trained or skilled in mental health.	Direction from community volunteers for treatments from health professionals close to their localities and people able to get exact medicine.
Continuation of treatments	Stopped medicine due to mistrust of their effects or difficulties face.	More tendencies to continue treatments due to knowledge of illness and medicine. Though people try to stop due to some difficulties (side effects) , follow-ups volunteers encourage them to continue treatments.
Relationship	Though doctors are gentle , they do not have time to consult about problems and illness. They give advice use medicine and its effects.	Doctors ask lot of questions about life and illness which encouraged to express suppressed problems.
Environment and response	Isolated and no feeling of connected	There are other people in villages who have same mental health problems at activities, so this make feel confidence.

***Equity and Dignity*** - In this context people with mental illness believe that they faced stigma and discrimination in society when they were accessing services from hospitals famous for providing mental health treatments. In some instances also doctors and other staff in these hospitals had not opportunity to listen thoroughly their problems. However when they are accessing mental health camp or a clinic at a village , they think they do not face same problems. Other people in village could closely see people with mental illnesses at the camp or a consultation which contributed to change their attitudes and build trust on them. Community also see positive changes of people with mental illnesses after treatments that moreover strengthen their changed attitudes. Recognition of these changes and acceptance make confidence in people with mental illnesses to access services with sense of equity and dignity. This is more observable in mental health camps and clinics conducted after considerable awareness activities conducted after initial consultation.

Contrast to centralised mental health services, people highlight more opportunity they have to express their problems , kindness of psychiatrists and MOMHs and adequate advices of pharmacists and support of community volunteers at mental health camps and clinics.

Mental health professionals also highlight free space and opportunity to consult mentally ill people, which make them to have more humane relationship without see them solely through diagnosed categories.

This is therefore a more unique impact of CMH practices that support to people with mental illnesses to feel equity and dignity by respecting their human rights.

#### **4.2.4 Develop local resources**

##### **Human resources**

One key success behind impacts highlighted above is contribution of CMH activities to building local and provincial capacities to ensure effective interventions. This capacity building process is not solely providing trainings and awareness , but also participation that led to enhance existing skills.

Capacity building process could be identified at different stakeholders , which is important in implementing and sustaining CMH practices. This process is able to illustrate in following way against each human resources who are vital in CMH practices.

<b>Human Resource</b>	<b>How did their capacities build or enhanced.</b>	<b>How those capacities use in CMH practices</b>
Community Volunteers	<ul style="list-style-type: none"> <li>• Trainings provided on mental health, animation , leadership, family education, Mental health camp organising, data collection and analysing and home management.</li> <li>• Involvement in camps, follow-ups , SHGs contributed to improve capacities with practical directions.</li> </ul>	<ul style="list-style-type: none"> <li>• Identify people with mental illnesses in villages.</li> <li>• Mobilise them and their families to access treatments.</li> <li>• Organise mental health camps by managing resources in village.</li> <li>• Raise awareness of family members in providing care.</li> <li>• Regular follow-ups and limit relapses</li> <li>• Conduct therapeutic interventions</li> <li>• Educating community about mental health and mental illness</li> </ul>
People with mental illnesses and their family members	<ul style="list-style-type: none"> <li>• Family education programmes</li> <li>• Self help groups</li> <li>• Follow-up visits of volunteers</li> <li>• Awareness raising at mental health camps.</li> <li>• Sharing experience with other mentally ill people.</li> </ul>	<ul style="list-style-type: none"> <li>• Built knowledge on mental illness directing them to proper treatments and continuity of that.</li> <li>• Cope problems of illnesses and treatments.</li> <li>• Motivation and empowerment to integrate into society.</li> </ul>
Psychiatrists and MOMHs	<ul style="list-style-type: none"> <li>• Home visits did improve understand of mental illness in relating to whole life.</li> </ul>	<ul style="list-style-type: none"> <li>• Use their improved understand with their specific knowledge to train more human resources (volunteers, medical officers,</li> </ul>

	<ul style="list-style-type: none"> <li>• Mental health camps improved their understand on burden of mental illness in each area and on demands existed in those villages’.</li> </ul>	<p>nurses and primary health care workers) need for community mental health.</p> <ul style="list-style-type: none"> <li>• Contribute to designing of community mental health activities appropriate to communities their identified.</li> </ul>
Health administrators	<ul style="list-style-type: none"> <li>• Field exposure visits provided opportunity to understand burden of mental illness very closely.</li> <li>• Participation in policy related workshops and meetings organised by BN contributed enhanced understand on needs of community mental health</li> <li>• Developed understand on psychosocial and development aspects of mental health beyond medical aspects</li> </ul>	<ul style="list-style-type: none"> <li>• Priority given for mental health similar to other health services in designing health plans.</li> <li>• Allocated more human and other resources (vehicles and psychotropic drugs) need for mental health intervention at localities.</li> <li>• Support BN to improve development interventions link with mental health interventions</li> </ul>
Primary health care staff	<ul style="list-style-type: none"> <li>• Training on mental health, follow-up care and animation</li> <li>• Practical experience at mental health camps</li> </ul>	<ul style="list-style-type: none"> <li>• Support volunteers to organise mental health camps and conduct SHGs.</li> <li>• Identify people with mental illnesses and organise initial consultation workshops.</li> </ul>

This indicate that multiple human resources operate at national, provincial and local levels are essential for effective functions for CMH practices and this included both health and development skills. In to relating to functions and impacts mentioned above, role of community volunteers are necessary in determining unique qualities of CMH. Sustainability of this volunteer intervention at each village is key indicator of sustainability of CMH interventions at village level.

However , sustaining function of community volunteer after completion of projects is problem in some areas. This is mainly relate with problem of allocation of time continuously when fluffing individual requirements for income generations, educations, and family responsibilities etc.

### Partner Organisations to implement CMH activities.

One key source in implementing CMH activities is BNSL partner organizations. In CMH practice implementations , following two partners took responsibility in past (2003 to 2007).

Partners	Their role
<p>Navajeevana- CBR organization working for people with disability. Navajeevana was the first partner who supported BN to identified areas where had need for mental health interventions. Through their earlier programs with disable people ,they have identified even people with mental illness in villages. However due to lack of capacity to work with people with mental illness they started CMHD programme with BN.</p> <p>GIDES – Micro credit enterprise organization work in small scale level in Hambantota.</p>	<ul style="list-style-type: none"><li>• Identify suitable villages to start CMH activities. They do this through discussion with Medical health offices (MOH) , primary health care staff and their own field staff.</li><li>• Organize initial consultation workshops with support of following stakeholders.</li><li>• Organize mental health camps/clinics with community volunteers and BN field staff.</li><li>• Inputs to SHGs conduct by volunteers.</li><li>• Organize and conduct other all field intervention with BN and community volunteers.</li><li>• Inputs to organize and conduct village volunteer committee meetings.</li><li>• Organize and collect field information as guided by BN. Sometime they take part in analysis.</li><li>• Use information to review progress.</li><li>• Conduct policy related meeting with service providers at provincial level as guide by BN.</li></ul>

This role of partners were changed from start of 2008. This mean that though they take responsibilities mentioned above , they have to take all this directly without BN involvement in field works. BN is not involve in any direct implementation of work and they do facilitate partners for field implementations through providing guides and review their works.

There are also new partner introduce as ‘Creative action’ presently work for Southern province. This organization was formed by former field team of BN who mainly involve in its pilot project. Presently they are the partner presently responsible for CMH works in Galle which is the district BN started works initially in.

## **Psychotropic drugs**

Psychotropic drugs' availability at village level is other key factor to make continuous success of mental health activities at localities. Period of 2003 to 2006 , BasicNeeds Sri Lanka programme provided 80% drugs for mental health camps and follow-up clinics collaboratively conducted with health administrators in Southern province. People with mental illnesses suggested their satisfaction of continuous medication after their first treatments they received locally at firstly at mental health camp. Drug estimation prepared through information individually recorded at camp contributed assess demand for drugs in area systematically. Health administrators at hospitals (DMO) were therefore able to demand drugs from DPDHs offices. So these endeavours at initial stages of programme caused to sustain continuous treatments as one necessary requirement of community mental health. Community reviews conducted at initial project areas from (2004 to 2006) revealed that 70% to 85% of people with mental illnesses mentioned that they have opportunity for continuous treatments with medicine and services available at follow-up clinics conducted at hospitals.

In same period , BNSL influenced local and provincial health administrators to make available more psychotropic drugs for the Southern province by using statistics of prevalence of mental illnesses and usage of drugs. As result of this they provided essential psychotropic drugs for hospitals where programme directly implemented. However , BNSL continued to provide A-typical drugs for clinics as availability of budgets. This is not however sustainable , so this one problem relate with sustaining user satisfaction in relating to using new psychotropic drugs. There are instances people with mental illnesses believe that they have good results with less side-effects by new A-typical drugs. Though there is some efforts by local administrators to provide this new drugs , that is not enough to meet demands of people.

Compared to 2003, DPDHs offices supply more psychotropic drugs for clinics at hospitals and even for mental health camp collaboratively conduct with BNSL. However as mentioned by people with mental illnesses, carers and volunteers , they are not satisfying with availability of medicine at their local hospitals. There are some instances they faced shortage of drugs at hospitals.

As revealed by study<sup>10</sup> on accessibly and availability of psychotropic drugs in Southern province reasons for this as follow.

- In direct pilot project areas , the systems to estimate and supply essential psychotropic drugs are well developed whereas in other areas it is not so, causing inadequacy of drugs.
- Two reasons that cause problems in drug estimation are: the absence of a system to estimate drug needs of all mentally ill persons in the area as the existing system is based on previous year's drug need and the absence of a psychiatrist / MOMH in the hospital.
- Availability and accessibility of drugs is dependent on the availability of mental health professionals and mental health clinics.

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<sup>10</sup> Study on availability and accessibility of psychotropic drugs in Southern Province, Sri Lanka. (2002) T. Senarathna.

## (5) Findings

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- Mental health problems and needs of people with mental illnesses and situation of services available for them in Southern province demand a practice which enable them to solve those problems within their locality. This reveal that relevance of practices of community mental health in Sri Lankan context to address this demand.
- Practices of CMH in Southern province were designed and developed as a result of consultation of problems, needs of community and their active participation in process. This therefore ensure integration of those practices in to community with respects their social and cultural context.
- People with mental illnesses satisfied about opportunity they have to access continuous treatments and services at their locality with freedom and dignity, which they were not able achieve before. This therefore caused to achieve improvement of mental health status for long period of time, which also they could not obtain from centralised mental health services in distant areas.
- Study in this way reveal following key ingredients of CMH practices, expected impacts and challenges face in sustaining those.

Key Ingredients of CMH	Problems and challenges
<ul style="list-style-type: none"> <li>• Establishment of easy and continuous access to treatments at localities where people with mental illnesses are living.</li> <li>• Ensure continuous availability of mental health professionals and psychotropic drugs at localities. Mental health professionals at localities are essential for proper diagnosis.</li> <li>• Sustain improvements of mental health status without or less relapses to gain quality of life.</li> </ul>	<ul style="list-style-type: none"> <li>• Though there is progress of availability of mental health professionals (psychiatrist and MOMHs) in province , that is not still enough to cater demands sufficiently. There is also tendencies of these professionals to leave local areas with objective of do works in health institutes in cities and in other countries.</li> <li>• Compared to 2003 , health administrators at district level provide more essential psychotropic drugs in 2008. However there is complains by users shortage of drugs at their localities. This is mainly due to lack of sustainable system to estimate drugs need compared to people in each areas.</li> </ul>

- Design and develop other supportive interventions (such as SHGs) lead by community themselves to support people with mental illnesses to integrate in to society , build their life skills and to have therapeutic experience. These intervention are unique practise in CMH that support people other than treatments.
- Success of any CMH practices depends on fact that how it did develop through proper consultation and active participation of people with mental illnesses.
- Establishment and sustain community volunteers committees is the key in implementing activities and achieving all results under CMH.
- Continuous follow-up of people with mental illnesses is essential to ensure direct people with metal illnesses to continuous treatments.
- Building local human resources through appropriate capacity building process which include trainings and reviews for practical directions of skills.
- Resource persons who have social mobilisation skills with understanding of mental health need to give inputs to communities at initiation of this type of activities. However , it is a challenge find appropriate human resources from government and other org when expanding practices of CMH in to more areas at same time.
- This is also a problem of application of animation and consultation to its expect level when programme expand its practices to more areas at once.
- Though there are few volunteer committees registered as legally and function even after completion of project periods , it is common problem of sustain community volunteers for mental health interventions in their localities. This is mainly relate with problem of allocation of time continuously when fluffing individual requirements for income generations, educations, and family responsibilities etc.

## **(6) Recommendations**

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- Higher level mental health professionals and experts (Consultant psychiatrists and professors in mental health) should give priority in building capacities of more people in health service to provide mental health at primary care level. This require change of attitudes of these professionals who are now mainly limited to treating people in hospital based setting. It is important to provide more mental health

trainings for general medical practitioners and primary health care workers who have more and regular relationships with community.

- Community mental health include both health and social development aspects. This is therefore important to influence government officials in social and development sectors and build their capacities (specially in basic mental health, social mobilisation skills require to works with mentally ill) to provide interventions for people with mental illnesses in their working areas.
- Support health administrators and health professionals to develop proper mechanism for psychotropic drug estimation through review and stakeholder meeting conduct with them at partner organisation level.
- BasicNeeds Sri Lanka should develop strategy to educate and influence health and development authorities about the social and development aspects of community mental health.
- Support volunteer committees to develop more contacts and networks with other government and non-government organisation , which provide them opportunity to market their skills and talents in other development works and to obtain recognition as key stakeholder who are vital in improving mental health at community level.