

Community psychiatry service in Sri Lanka: a successful model

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Summary

In the current practice of psychiatry there is a shift from hospital to community based care. Different models of community psychiatry have been tried in different countries. Though this concept is based on several core principles, each country has to find what is best suited for its population. In Sri Lanka too,

community psychiatry projects have been initiated by psychiatrists. We describe below one such project started in a postal area in the capital, Colombo, by one of the authors. The project began in late 2008 and by 2010 was functioning independently and fulfilled the criteria for a community based mental health service.

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Introduction

In the developed world there has been a rush towards community psychiatry. The English word ‘community’ used as a noun or adjective in the context of healthcare denotes a whole range of health care services. It is often employed in conjunction with concepts such as ‘prevention’ and ‘health promotion’. These ideas are linked with a ‘primary health care team’, the development of which is seen as the way forward to improve the health care system. In countries such as the United Kingdom (UK) this has been at the cost of reducing secondary hospital based services.

Different models of community psychiatry have been tried in different countries with varying degrees of success. What is apparent is that there is no ideal model. Each country has to develop its own model depending on the needs of its population, health services structure and available resources. However the current accepted definition of community psychiatry would be the provision of mental health services outside the hospital to a well-defined catchment area demarcated geographically and administratively (1). In 1967 Caplan and Caplan proposed six principles of community psychiatry (2). These are listed in Fig. 1.

Though Sri Lanka has a free national health service the main reason for inadequate mental health care has been the shortage of mental health specialists. The number of psychiatrists per 100, 000 is 11 in the UK and 13.7 in the United States whereas in Sri Lanka it is only 0.2. In neighbouring India it is 0.2 as well; however, in Singapore it is 2.3(3). At the time of writing Sri Lanka had 49 fully qualified specialist psychiatrists most of whom work in the Western Province. It has been estimated in a recent World Health Organisation bulletin that Sri Lanka requires 251 psychiatrists to fulfil her mental health needs (4). The government has trained a substantial number of psychiatrists (88 from 2002 to 2009) but many have migrated to higher income countries after their postgraduate training (5). Though Sri Lanka boasts of a lesser number of specialists in psychiatry than in most other specialties, this does not make a case to abdicate that role to others, when, the world over, this is a position served primarily by them (6). The dedication

of those psychiatrists remaining in the country and the number of psychiatrists returning to the country after training have enabled Sri Lanka to have a psychiatrist providing care to 22 of her 25 districts.

Sri Lanka is also moving towards the establishment of comprehensive community psychiatry services based on the Caplan principles. This has been initiated by psychiatrists themselves who have recognised that purely hospital based psychiatric services are insufficient for the comprehensive treatment of patients with mental health problems. In this article we describe the successful establishment of such a service.

Methods

The Western Province has the highest population density in Sri Lanka with a population of 5.4 million in an area of 3681 km². It has three districts, Colombo, Gampaha and Kalutara. The Colombo district has five Municipal Councils of which the largest is the Colombo Municipal Council (CMC). The CMC is divided into 15 postal zones.

The community mental health service was initiated through the National Institute of Mental Health (NIMH) by the second author (JM) in December, 2008. The NIMH has eight in-patient units each supervised by a consultant psychiatrist. The consultants are expected

Table 1- Principles of community psychiatry - Caplan

1.Responsibility to a geographically defined population
2.Treatment close to a patient’s home
3.Multidisciplinary team approach
4.Continuity of care
5.Patient participation
6.Comprehensive services

to divide their time between the hospital and the community. The catchment area for each unit includes postal zones in the Colombo Municipal Council.

Unit Seven of the NIMH of which the first author (PR) is the consultant psychiatrist was allocated CMC postal zone 15 consisting of the areas Mutuwal, Modera, Mattakkuliya and Madampitiya. In this article we will describe the development of community psychiatry services in CMC postal zone 15 as a model for community psychiatry in Sri Lanka.

At the outset, there were no community psychiatry services in this zone. In the year 2009, 75 patients were admitted to Unit Seven, NIMH from this area and most had more than three admissions within that year due to frequent relapses. The main reason for relapse was defaulting of treatment which was due to the reluctance of patients to attend the outpatient clinic at the country's main hospital, the National Hospital of Sri Lanka (NHSL). Therefore it was decided to set up a community psychiatry service within the area as a first step. A location that also housed the maternity and child health clinic was selected for this purpose.

The team of professionals consisted of a senior registrar, a registrar, a doctor enrolled in the Diploma in Psychiatry training programme and a psychiatric social worker (PSW). However there were no local community workers with access to patients in the area. In July 2010 PR was able to recruit volunteers from a non-profit organisation as community workers. This organisation had 75 volunteers from the Western Province and of them eleven were from the Colombo 15 postal zone. On a request by PR they volunteered to work with families of the mentally ill from their local community.

The community psychiatry clinic was conducted every second Friday of the month and the first clinic was held in August 2010. On the first day itself eight patients were brought in by the volunteers. Some of these patients were already on the 'difficult patient register' and had defaulted treatment. In November 2010 a community psychiatry nurse (CPN) joined the team and worked with the PSW conducting home visits and a depot injection program. At present 47 patients are registered in this clinic including 15 new patients.

A major limitation is the non-availability of psychotropic drugs at the clinic. The dispenser at the clinic is reluctant to take on the extra duty of dispensing psychotropic medication and the CMC does not provide antipsychotics. This has been overcome by the volunteers collecting medication from the outpatient psychiatry clinic at NHSL for distribution to patients attending the community clinic.

Discussion

We note that within a year it has been possible to set up a community psychiatry service which subscribes to the six basic principles proposed by Caplan and Caplan (2). The service was provided to a geographically defined area, is situated within walking distance of the

community it served, was manned by a multidisciplinary team, was held every month and provided a range of services.

The ethnic composition of the Colombo city consists of Sinhalese (41%), Tamils (29%) and Moors (24%). Therefore a significant proportion of the population is Tamil speaking. Most of the volunteers were from the area itself and were bilingual. The doctors in the team had a good understanding of all three cultures (Sinhala, Tamil and Moor) and the four common religions (Buddhism, Hinduism, Islam and Christianity). The team was therefore able to deliver a culturally appropriate community psychiatry service.

Compared to a community psychiatry service, an outpatient clinic in a tertiary care hospital has inherent problems. Some of these are the stigma of seeking mental health services, lack of a culturally appropriate service to accommodate the needs and beliefs of diverse patients, fear of experiencing discrimination in the treatment setting, language and communication barriers based on differences in verbal and nonverbal styles, lack of familiarity with Western or mainstream mental health services, overcrowding, long waiting lists and distance from the local community.

This community psychiatry service was able to overcome these barriers using several strategies. The clinic was located at a venue housing the maternity and child services clinic thereby reducing the stigma of a psychiatry clinic. This service was linked with other 'acceptable' services such as family planning, immunisation and child care and also with religious and social service organisations.

Homes were visited and challenging patients were identified with the help of volunteers who lived in the community. As the clinic was located close to the patients' homes they were able to walk to the clinic thereby reducing transport costs and time. If further information was required patients were able to bring their family members or fetch previous records within a short period of time. If the patient was not able or willing to come to the clinic, the relatives were able to take the CPN to their home to review the patient or administer a depot injection.

Some of the patients who had stopped attending follow up clinics because of unpleasant experiences in the hospital were willing to attend the community clinic as they found the atmosphere more pleasant and less intimidating. The maternity and child services clinic, which was located at the same venue catered to a population of 100,000 and deployed 14 Family Health Workers (FHW). Though mental health care was not designated as one of their duties these workers identified and referred new patients to the clinic and informed the local population about the community clinic.

Shortcomings of the program have also been identified. The lack of psychotropic drugs on site is a major drawback. The clinic at present is held only monthly when a weekly clinic would have been preferred. The support staff was not trained in mental health care. These are mainly logistical problems which could be overcome in the future.

There are also other aspects which need improvement. Substance use and domestic violence are major problems in the area where the clinic is located; therefore special programs and services need to be developed, liaising with organisations dealing with these issues. Culturally appropriate vocational training and job placement services are a need because employment is highly valued by patients and families. Partnership with other state agencies need enhancement to create a comprehensive, integrated service. Increased funding is necessary for prevention, early intervention and outreach programs. Culturally and linguistically appropriate written mental health education material should be made available for patients and families. Provision of all these facilities would improve the quality of the present service.

In retrospect, we propose a seventh criterion in addition to those described by Caplan, i.e. the service provided should be culturally appropriate. State mental health agencies face the growing challenge of accommodating an increasingly diverse and evolving population. The call to provide an accessible and appropriate mental health service to all patients, regardless of ethnicity, language, race, religion, gender or socio-economic standing challenges state mental health agencies to develop effective, culturally competent services and treatment methods. Providing culturally competent mental health services requires that the patient's culture be understood, accepted and respected by providers during all phases of the therapeutic process.

Specific plans for the improvement of this particular community service include the recruitment of a medical officer trained in mental health to conduct a weekly clinic supervised by a consultant psychiatrist, training volunteers and FHW to detect mental health problems and follow up patients in the community, ensuring supply of psychotropic medication through the CMC and assisting the community to form carer and patient groups.

In this article we have attempted to illustrate how an effective community psychiatry service could be set up with limited funding and a few trained personnel. The time frame in which this was achieved was relatively short. It is hoped this service would set an example and encourage other psychiatrists to set up similar services

in their catchment areas. It could be used as a model for other community psychiatry services in the country led by specialists in psychiatry.

Declaration of interest

None

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