Western model of community mental health care: its applicability to Sri Lanka

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Introduction

The burden of mental illness on a health care system is profound [1]. In 2000 mental disorders accounted for 11.6% of total disability in the world. The prolonged civil conflict and the 2004 tsunami have resulted in 2% of Sri Lanka's population being affected by serious mental illnesses [2]. Sri Lanka also has one of the highest suicide rates in the world. Currently the media target the mental health services in Sri Lanka to severe criticism, with the main mental hospitals, at Angoda and Mulleriyawa, being regarded as "custodial institutions with scant regard for human dignity" [3].

Community mental health care model

Mental health services in the western world have evolved through three stages; ie. the rise and decline of asylums, and reform of mental health services [3,4]. The current community-based approach provides management closer to home for the service users. This new concept of community based mental health care originated between 1940-1960 in Europe and North America, when society began to consider asylums as inappropriate.

The present multidisciplinary Community Mental Health Teams (CMHT) comprising psychiatrists, psychologists, community psychiatric nurses, social workers, occupational therapists and support workers became the cornerstone of this service, with in-patient care being used only as a last resort. The CMHT serve a defined geographical catchment area where they manage new patients, follow up those already undergoing treatment, and liaise with allied services. CMHT mainly target the working population (18-65 years) suffering from severe mental illnesses. People with less serious problems are managed in primary care settings by general practitioners [5]. CMHT have resulted in greater user satisfaction, better compliance with treatment, less symptomatology, and improved social functioning when compared to hospital based services [6,7,8]. Continuity of care and service flexibility have also improved [8]. The reduction in number of hospital days has made CMHT cost-effective as well [7].

CMHT provide services via a 'care programme' and 'case management' approach. An ongoing 'care programme' begins when someone is referred for specialist psychiatric

services. 'Case management' is a method of delivering holistic care. The medical and social aspects are coordinated by the 'key worker' on the team. The community treatment teams provide multidisciplinary mobile outreach services for people with more disabling mental disorders, fluctuating mental states, impaired social functioning and poor compliance [5].

The 'home treatment' and 'crisis resolution' teams of the CMHT manage those in psychiatric crises. They also provide intensive treatment and care at home, making early and safe discharge from in-patient care possible [9]. Acute day hospitals offer multidisciplinary treatment programmes for those with acute, severe psychiatric problems. These provide quicker clinical improvement at less cost. Patients with severe and long-term disabilities are cared for in community-based residential care. These provide accommodation and support for daily living while the CMHT deliver medical care and social support.

Community mental health care model and Sri Lanka

The applicability of the community mental health model to Sri Lanka should be considered with particular reference to social, cultural and economic conditions including the scarcity of mental health personnel, stigma of seeking help for psychiatric problems, strong family involvement, and traditional healing practices.

In 2002 there were 5.5-20.0 psychiatrists per 100 000 population in Europe, whereas Sri Lanka had only 15 psychiatrists in 2005 [10], amounting to 0.07 per 100 000 population. Sri Lanka has very few clinical psychologists, and no trained community psychiatric nurses.

In fields such as maternity care Sri Lanka has good primary care services, indicating that the necessary infrastructure is available even now. The well organised provincial health care system with the respective Medical Officer of Health (MOH) divisions can be extended to the field of mental health services too. A MOMH (medical officer of mental health) who would form part of the CMHT could be appointed to each MOH area [2]. Corresponding to public health midwives, nurses with special training in community psychiatry could be incorporated into each MOH team. An occupational therapist should also be included in each local team.

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Each district or region could have a psychiatric ward in the main hospital (District or Base) under a consultant psychiatrist [2]. The local team could refer severe or difficult patients to this psychiatrist for management, including in-patient care. When the acute crisis is over the patient should be referred back to the community. Each district should have a team of clinical psychologists to whom patients can be referred for counselling.

The majority of Sri Lankans live in rural areas within extended family groups, and family involvement in caring for patients could be improved by providing more support at home. 'Respite homes' where the mentally ill could be admitted for short durations could relieve family members of the burden of care. Local day care centres could also be of assistance to the families while providing vocational training for sufferers.

Over the ages, many people with mental illnesses have sought relief in traditional healing methods such as prayer, invoking the blessings of deities, meditation and yoga. All of these have therapeutic processes inculcated within their disciplines which could be utilised productively to provide medical care at community level. Although many of the traditional therapies appear magical and ritualistic they are in fact components of psychotherapy and counselling.

Local religious places are important centres where people gather for solace. The predominant religion in Sri Lanka is Buddhism. Key elements of this religion are emotional well-being of individuals and collective community expression of their devotion. This aspect of the religion could be a great resource in delivering a sensitive community-based model of treatment, using facilities available at places of worship.

Functioning of this model of community psychiatric care would require enactment of statutory legislation for those requiring compulsory treatment and training of health care providers including nurses, psychologists and occupational therapists.

Changes in the mental services would be maximally effective only if the public and social attitudes also change

to minimise stigmatisation. The last few decades have seen significant changes in the social acceptance of those with leprosy and tuberculosis. A similar approach by the media could reduce stigmatisation of the mentally ill.

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