Building up mental health services from scratch: experiences from East Sri Lanka

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The author describes his experiences as a psychiatrist in East Sri Lanka where he was involved in building mental health and psychosocial services in the context of war and disaster. He stresses the necessity of creating patient and family friendly services, and advocates for the principle of distributing basic services over the whole region, instead of providing a highly specialised service that most of the people who need help cannot reach. He discusses the importance of empowering both staff members and patients, and emphasises the important of valuing common sense solutions and approaches to the problems faced by service users.

Keywords: common sense, conflict, mental health, patient and family friendly services, Sri Lanka, tsunami

Starting from scratch

I started my work as psychiatrist in an old fashioned psychiatric hospital in the capital, Colombo. It was a horrible place, with 2000 patients, many of whom were admitted for long periods. My ward was overcrowded; for 100 patients, we only had 30 beds. The rest slept on the floor. It was a patient unfriendly place, where all in-patients were locked up, and people were sometimes beaten by staff. The sanitary conditions were appalling; there were no private bathrooms, and people had to wait undressed in queues to get to the few showers available. I wanted to leave there as soon as I could, because I was afraid of getting used to seeing people with mental disorders in such dire conditions. I was afraid I would start considering this normal or acceptable. Therefore, I decided to go to a place where there was no psychiatric hospital and no psychiatrist.

In 1999, I started to work for the government health services in Batticaloa, in the Eastern Province of Sri Lanka. The district has a population of almost half a million. It has also been severely affected by the civil war that raged in Sri Lanka between 1983 and 2009. Since 1980, there had not been a psychiatrist in the district. However, between 1978 and 1980, there was one psychiatrist, but all that remained of his presence was a monthly outpatient clinic for the prescription of medication, and the possibility for psychiatric patients occasionally being admitted to the general hospital. The government had not allocated any funds for the development of mental health services in the district.

A patient friendly service

My first concern was to start a patient and family friendly service. I wanted the staff to be kind and put energy in the relationship with the patients and their relatives. I believe that if you invest in being friendly, your patients get better more quickly. If the experience in the hospital is a pleasant one, the person will more easily come back in the future, in case of a relapse. In fact, when the staff is kind, the patients are much more

like to stay as long as they need care, instead of checking out before they have improved sufficiently. Additionally, if people feel they are treated like human beings, they will be much more likely to refer others, or bring along others from their community who are suffering from mental health problems. We never forced people to stay with us for treatment; but when we felt they were not yet ready, we would try to convince them to stay and negotiate a little, '*why the hurry, just stay another day*'. However, we left them in control of their own decisions.

I also stimulated my staff to maintain friendly relations with the traditional healers. We always allowed patients to go to the healers if they wanted to, making sure that they still would feel welcome to come to us. The healers heard of this, of course, and actually started to refer some of their patients to us, telling them that their problems were mental rather than supernatural. In this way, we built up a degree of cooperation with them.

In the hospital, our patients were allowed move freely, going anywhere they chose. We locked away the drugs, but there were no '*staff-only*' areas. We encouraged family members to visit and welcomed them the whole day. Families benefited from meeting other families and learned that they were not the only ones with a person with mental illness in the family. Also, they could advise one another. They can observe how staff members react to their family member, and see that they did not argue about any delusional ideas they may have had, but behaved in a respectful way.

Patients are often hospitalised after a violent incident, such as when they have broken furniture or threatened those around them. If a patient is released, and the family has not seen him since the incident, they often still have that picture in mind. If they see the patient regularly as he recovers, they will see how the patient is gradually changes. As a result, they will feel more inclined to take him home and make a new start. In contexts where this doesn't happen, there is a real problem with families refusing to accept responsibility to care for those that have recovered.

Responses to disaster

In 2004, the Batticaloa district was stuck hard by the tsunami. Over 2,800 people lost their lives and nearly 60,000 people lost their homes. Many more lost their livelihoods. Much of the infrastructure of the densely populated coastal areas was affected. In this post tsunami period, many aid organisations and groups came to offer assistance. Some came without any prior communication, or invitation. They were trying to help, but many well intentioned actions were not thought through and had serious, negative consequences, as I have discussed elsewhere more in depth (Ganesan, 2006). To me, it was disappointing, and sometimes shocking to witness how organisations brought a very medical model in response to the psychosocial needs of the survivors. Moreover, it seems that often the programmes were predesigned somewhere else, without any consideration of local culture or structures in place to help the survivors in this particular context. Many organisations planned short term interventions, sometimes without checking whether there was any effectiveness of their inventions. The few organisations that stayed for a longer period, often had frequent rotations of key staff, so that it was difficult for the recipient community to have a meaningful relationship with these organisations. They often communicated with the people they were counselling through translators. However, these translators were often not trained as translators,

but were nonprofessional staff, such as drivers, and often had a very limited capacity to effectively mediate the sensitive communication that takes place during a counselling session. Despite all the chaos, it was possible for some government, non-governmental and international institutions to create innovative responses for coordination, and for services to vulnerable groups.

Serious psychiatric disorders as the main priority during war

I always kept severe mental disorders as my priority. That required some persistence, particularly during the war and during the post tsunami period when many institutions wanted me to focus on '*trauma victims*' and people with posttraumatic stress disorder. I decided to focus on the serious psychiatric disorders for the simple reason, no one else was. Psychiatric illnesses cause real problems within a community, and there were many other service providers who provided community based support to the survivors of violence. It did not seem strategic to use the small mental health team to engage in direct work with a vast population that had a range of complex problems related to conflict. We would be swamped, and make little difference.

It was also a matter of equity, as people with severe mental disorders were among the most disadvantaged people. Although in Sri Lanka the health service is free, it is not really easily accessible to the very poor, because of hidden costs like travel and loss of income when one is visiting a hospital. Improving mental health means reaching out to these people. So we started to organise out-patient clinics in other towns in the region. The first was in Kalmunai (in a neighbouring district with no psychiatrist), where we began with eight registered patients, only once a month. Now there are 18 bi-weekly clinics, with over 3,000 registered patients. The manpower came from the local hospitals, the directors allowed us to use the services of their staff. They needed some training, but basically we selected those who we thought had a friendly attitude towards patients and the right sort of humanistic values.

I also found people in the local communities who were willing to help us as volunteers, and also school teachers who had training through the education department. They were released for three days per week to counsel children and their families. The Kalmunai monthly clinic has now become a mental health unit, and with some private donors we have been able to construct a new building in the backyard of the hospital. Since 1999, I have been able to help develop six mental health units in conflict affected districts, all in the compounds of an existing government general hospital, where people felt at ease to visit.

Egalitarian leadership

I did not make rounds. In hospitals, there is a tradition of the doctor making rounds, talking about the patient in difficult words that the patient cannot understand. Instead, I spoke with the patients and my staff in an informal way, like chatting in the morning when we feed the fish in the pond in our compound, or when walking around on my own. I did not tell the nurses what to do, since they knew the patients best, however, I did try to stimulate them to use their common sense. Of course, a nurse could ask my advice when he or she had encountered difficulties. A nurse could also ask me to talk to a client to check the diagnosis, and I signed the prescriptions.

This approach requires training staff members, but not through lecturing. The knowledge base of psychiatry is not very

impressive anyway. I prefer using roleplay of real situations, and challenge the participants to use their common sense. That was my biggest job, to make people use their common sense, and to relate to patients more in the way that they would approach their friends and relatives.

With the mental health team of medical officers, nurses and social workers, I also realised that a part of my job was simply to give them space to work, without fear of punishment. Operating in a hierarchical, and often harsh institutional environment, I saw that if I gave '*my staff*' support to use their own common sense, stimulate reflection on their efforts and stood up for them when they came up against institutional barriers, they were able to work wonders. As the team blossomed, I found that as the consultant psychiatrist, I became more peripheral to much of the daily work.

Getting involved in the community

My emphasis on severe mental disorders did not keep me from getting involved in other problems within the communities. There is a home in Batticaloa, run by Catholic sisters, that houses children with intellectual disabilities. I started to pay monthly visits. Then it became clear to me that there were many intellectually disabled children staying at home, because the regular schools did not accept them. I found some social workers who made a survey, and then we started day-care centres for these kids. There are now 18 centres in the area, providing services to over 500 children and their families. There is also now a child guidance clinic with a multidisciplinary team at the general hospital. The people of the Eastern Province now have easier access to these services than people in the capital.

In a similar way, the mental health unit of Batticaloa became involved in child protection. First started case conferences with personnel from the legal system and non-governmental carers. One of the aims was to make the legal people more aware of the needs and welfare of children. They were used to seeing children as witnesses of a crime, not as victims that needed care and emotional support. The legal process around child abuse basically is unfriendly to children, often a retraumatizing process, and we wanted to change this. We therefore started a transit home that could work as a temporary safe place for abused children.

In a similar way, we got involved in gender based violence (GBV) by organising a taskforce that included both government staff and nongovernmental workers. We trained all 700 staff members of the Batticaloa hospital (including doctors and nurses, but also non medical staff, including the cleaners) to recognise signs of gender based violence. We then opened a GBV desk at the hospital where victims could be referred. The workers have good connections with the police, safe houses, community workers and all kinds of nongovernmental organisations. That started in 2005, and now we now have such desks in six hospitals in the conflict affected districts.

Skills

I was not educated to build mental health and psychosocial services, as it was not part of my medical training. It helped that I have a sceptical approach to what the pharmaceutical industry tell us to do, and to what we read in books. Furthermore, I trust my common sense.

For the job, I needed to develop my networking skills. Part of that is supporting the people who are willing to help you when they are facing challenges. I made my networks

in the communities, and did not rely so much on psychiatrists.

Another important skill I had to develop was giving interactive training, i.e the skill of helping people to explore the skills they already have, making them more aware of these skills, naming these skills, and at some point also challenging their skills so that they can reflect on them and improve them.

At some point, I needed funding for the initiatives I was developing. That required the skill of thinking in terms of projects and writing project proposals. Again this is not something that I picked up in medical school. Perhaps the most important skill is being able to learn from your experience, including learning from your mistakes.

Reference

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