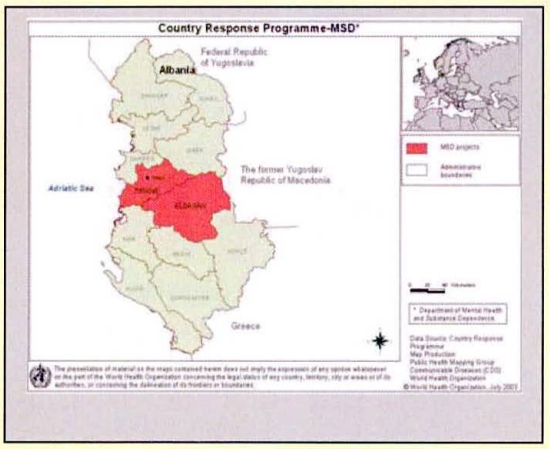
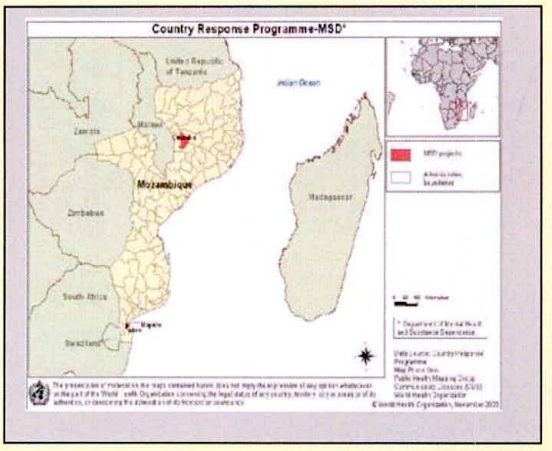
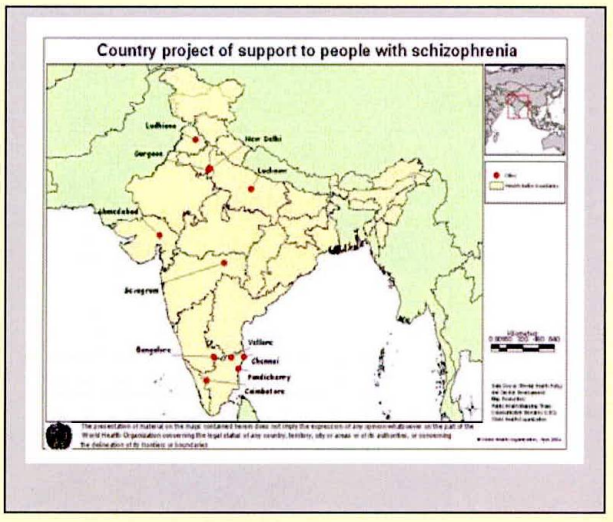
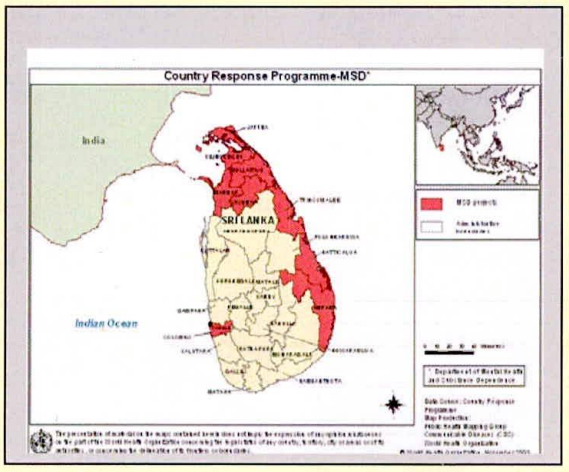


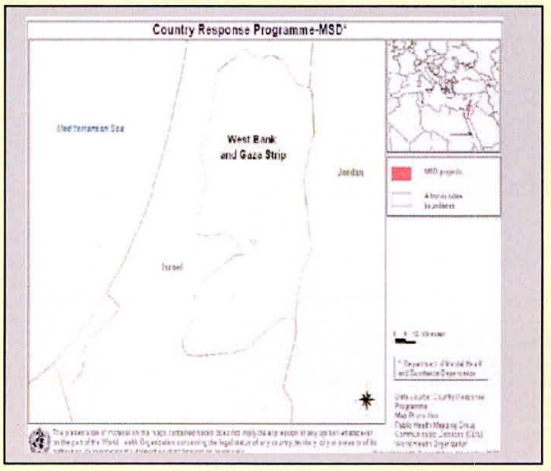


DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE



COUNTRY PROJECTS on MENTAL HEALTH: SELECTED CASES





For more information

Department of Mental Health and Substance Abuse
World Health Organization
Avenue Appia 20
CH-1211 Geneva 27
Switzerland
Tel: +41 22 791 21 11
Fax: +41 22 791 41 60
E-mail: mnh@who.int
Website: www.who.int/mental_health

Addresses of WHO Regional Offices

WHO Regional Office for Africa
Cité du Djoué
PO Box 06
Brazzaville
Congo
Tél: +47 241 39100
+242 8 39100
Fax: +47 241 39501
+242 8 39501
E-mail: regafro@afro.who.int

Pan American Health Organization/
WHO Regional Office for the Americas
525, 23rd Street, NW
Washington, DC 20037
USA
Tel: +1 202 974 3000
Fax: +1 202 974 3663
E-mail: postmaster@paho.org

WHO Regional Office
for South-East Asia
World Health House
Indraprastha Estate
Mahatma Gandhi Road
New Delhi 110 002
India
Tel: +91 11 2337 0804
Fax: +91 11 2337 0197
E-mail: pandeyh@whosea.org

WHO Regional Office
For the Eastern Mediterranean
WHO Post Office
PO Box 7608
Cairo 11371
Egypt
Tel: +20 2 670 2535
Fax: +20 2 670 2492
E-mail: PIO@emro.who.int

WHO Regional Office for Europe
8, Scherfigsvej
2100 Copenhagen Ø
Denmark
Tel: +45 39 17 17 17
Fax: +45 39 17 18 18
E-mail: postmaster@euro.who.int

WHO Regional Office
for the Western Pacific
PO Box 2932
1000 Manila
Philippines
Tel: +63 2 2 528 8001
Fax: +63 2 521 1036
E-mail: postmaster@who.org.ph

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MENTAL HEALTH AND SUBSTANCE ABUSE

The proportion of the global burden of disease attributable to mental, neurological and substance use disorders is expected to rise from 12.3% in 2000 to 16.4% by 2020. More than 150 million persons suffer from depression at any point in time and nearly one million commit suicide every year. Moreover, there is strong evidence that mental disorders impose a range of consequences on the course and outcome of comorbid chronic conditions, such as cancer, heart disease, diabetes and HIV/AIDS.

The rise in the burden of mental, neurological and substance use disorders will be particularly sharp in developing countries, primarily because of the projected increase in the number of individuals entering the age of risk for the onset of disorders. These problems pose a greater burden on vulnerable groups such as people leaving in absolute and relative poverty, those coping with chronic diseases and those exposed to emergencies. Mental health has been raised much higher up on the international health agenda owing to WHO's international campaign during 2001, with its unprecedented series of events, including the World Health Day, which was celebrated in more than 150 countries, the round tables at the Fifty-fourth World Health Assembly, in which more than 110 ministries of health participated, and *The World Health Report 2001*, which was devoted to mental health. Governments are now much more aware of the major mental health disorders and substance abuse, recognizing their impact on the health and well-being not only of individuals but also of families and communities. Although effective treatments for mental and neurological disorders exist, there is a big gap between their availability and their implementation; even in developed countries only a few of those suffering from serious mental illness receive treatment. Improving treatment rates for those disorders and substance abuse problems will not only reduce the burden of disease and disability and health care costs, but also increase the overall productivity and quality of life.

In the year 2002, following resolutions adopted by regional committees, the Executive Board adopted a resolution on "Strengthening mental health" (resolution EB109.R8) and the World Health Assembly, in resolution WHA55.10, affirmed its provisions. As a response to these issues and challenges, in 2002 WHO launched the mental health Global Action Programme (mhGAP). This programme is WHO's major effort to implement the recommendations of the World Health Report 2001 and projects presented in this report are embedded in the mhGAP framework. The programme is based on four strategies described below, that should enhance the mental health of populations.

Strategy 1: Increasing and improving information for decision-making and technology transfer to increase country capacity.

WHO is collecting information about the magnitude and the burden of mental disorders around the world, and about the resources (human, financial, socio-cultural) that are available in countries to respond to the burden generated by mental disorders. This is pursued by the ATLAS project. The ATLAS' aim is, in fact, to provide information on mental health from all countries. The information relates not only to epidemiology but, more significantly, to resources and infrastructure for mental health care within each country. The sources of this information are Ministries of Health,

government documents, WHO Collaborating Centres, professional associations and scientific literature. Country profiles have been published making it easier for planning, priority setting and monitoring change over time. WHO is also disseminating mental-health-related technologies and knowledge to empower countries in developing preventive measures and promoting appropriate treatment for mental, neurological and substance-abuse disorders.

Strategy 2: Raising awareness about mental disorders through education and advocacy for more respect of human rights and less stigma.

The World Health Organization is maintaining constant communication and information networks with professional NGOs, parliamentarians, family members and service users' groups in order to sustain the groundbreaking work of the last two years. The Global Campaign Against Epilepsy is a successful history of advocacy and collaboration. The Global Campaign is managed by a Secretariat consisting of representatives of three responsible organizations: WHO, International League Against Epilepsy (ILAE) of professionals, and International Bureau for Epilepsy (IBE) of lay persons. The Campaign tactic is to help organize demonstration projects and to generate regional declaration on epilepsy, produce information and facilitate the establishment of national organizations of professionals and lay persons who are dedicated to promoting the well-being of people with epilepsy.

Strategy 3: Assisting countries in designing policies and developing comprehensive and effective mental health services.

The *World Health Report 2001* and the *Atlas: Mental Health Resources in the World*, have revealed an unsatisfactory situation with regard to mental health care in many countries, particularly in developing countries. WHO is engaged in providing technical assistance to Ministries of Health in developing mental health policy and services. Building national capacity is a priority to enhance the mental health of populations. In this logic, country projects are planned and implemented with constant support provided by the Department of Mental Health and Substance Abuse.

Strategy 4 : Building local capacity for public mental health research in poor countries.

Besides advocacy, policy assistance and knowledge transfer, mhGAP formulates in some detail the active role that information and research ought to play in the multidimensional efforts required to change the current mental health gap at country level.

The country projects reported in this document are selected cases exemplifying the *modus operandi* of the Department of Mental Health and Substance Abuse in different scenarios. The cases reported in the following sections are restricted to the area of mental health. Country projects on Substance Abuse are also promoted and supported by the Department, but are not included in this report.

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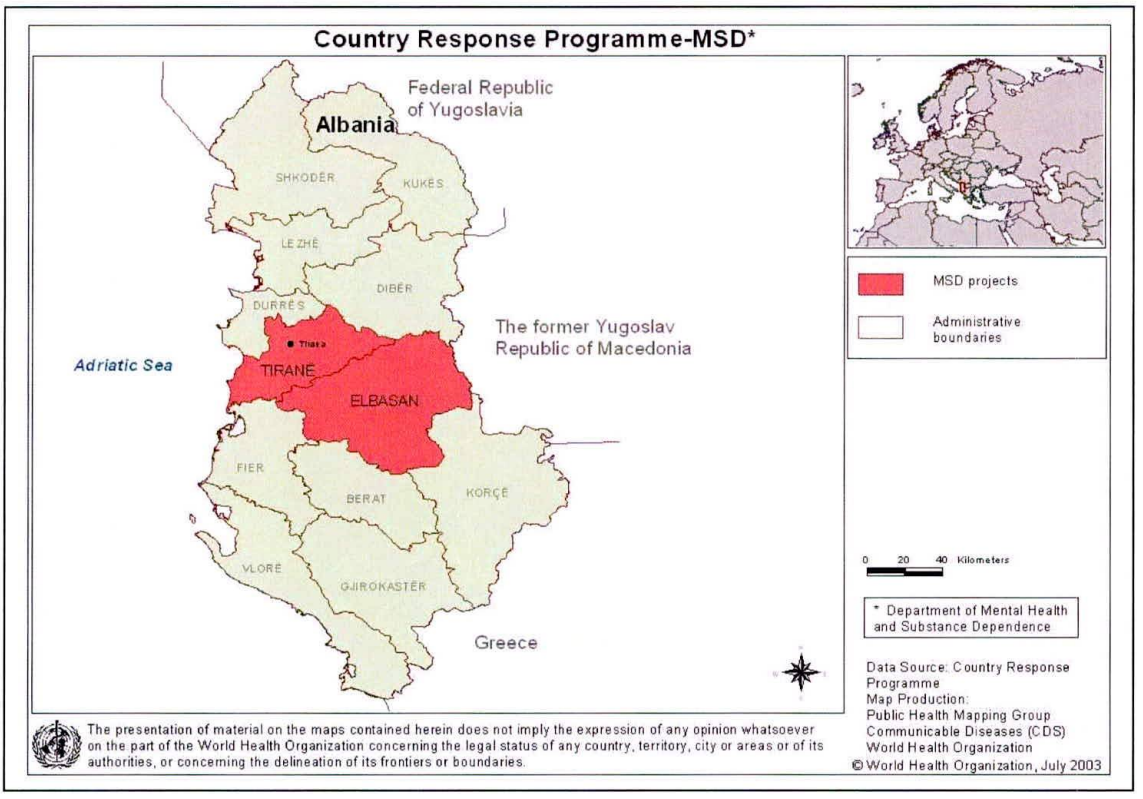
Albania Reform



Project Goal

To assist in designing the necessary steps towards the implementation of the Policy for Mental Health Services Development in Albania (endorsed by the Minister of Health in 2003).

Project Objectives

1. *Provide technical support to WHO Albania and the Ministry of Health in planning and developing mental health services in Albania.*
2. *Provide technical support to the National Steering Committee for Mental Health, WHO Albania and the Ministry of Health in the design of a very concrete operational action plan to implement the Policy for Mental Health Services Development.*
    a. *Collection of relevant information on Albania through the WHO Department of Mental Health and Substance Abuse's new instrument to monitor mental health system and services in countries;*
    b. *Defining achievable targets (i.e. Gap Reducing Achievable National Targets) in discussion with relevant health authorities. Key targets are in relation to the following areas:*
        - *Organization of comprehensive community mental health services along with deinstitutionalization in four catchment areas of Albania (600,000 inhabitants).*
        - *Capacity building of mental health and primary health care professionals.*
        - *Implementation of the Mental Health Act 1996.*

Background

Albania is located in southeastern Europe in the Balkan Peninsula. It is bordered by the Federal Republic of Yugoslavia in the north, the former Yugoslav Republic of Macedonia in the east and Greece in the southeast. The country covers an area of 28,750 square kilometres and has a population of approximately 3.2 million persons, of which one third is under the age of 15 years and 40% under the age of 18. The population is also largely rural with some two thirds of persons in 1993 living in the countryside. Albania is one of the poorest countries in Europe with a Gross Domestic Product per capita of $1290 in 1996.

Albania has experienced civil and political unrest in the 1990s. First, in 1991 and then in 1992 following the fall of communism. Opposition parties were introduced for the first time and there were subsequent rapid changes in leadership. Further unrest also occurred in 1997 and 1998 following the collapse of several saving schemes, which saw an estimated loss of US$ one billion to the population. This was further exacerbated by the influx of refugees and the humanitarian disaster from the war in Kosovo in 1998 and 1999.

For purposes of governance, the country is divided into 12 administrative areas, called Prefectorates, each with a centrally appointed administration. Each Prefectorate is made up of around 3 districts. Districts had been the main administrative divisions in Albania for the previous 50 years. There are 26 districts that are further divided into rural and urban areas as follows: rural areas are divided into communes and have elected local authorities; urban areas are divided into town municipalities and have elected councils. Each district has a least one municipality and a number of communes. In the case of Tirana, there are also semi-urban municipalities. In total, there are 315 communes and 42 municipalities in the country. The Ministry of Health provides services through the country's 26 administrative districts.

Health services

In the 1960s an extensive primary health care system was developed. In the 1970s the emphasis shifted to the construction of hospitals in every district to provide basic inpatient care and specialist outpatient care by polyclinics. By the 1980s the Ministry of Health provided and regulated all health services through the district system. Health services were organized and controlled from the centre by means of vertical programmes that were administered at the district level via separate directorates responsible for medical care. Tertiary hospitals were run directly by the Ministry of Health.

The health system was badly affected by the civil unrest in the country. In 1991 and 1992 the violence which accompanied political changes destroyed almost one quarter of health centres in cities and two thirds of health posts in small villages. In 1997 and 1998 the violence also involved the widespread looting of drugs and equipment and some destruction of district hospitals, health centres and public health departments.

Despite the setbacks caused by civil unrest, the 1990s saw two public administration reforms that have had an impact on health services. One is

the transfer of more administrative authority from the centre to the prefectorate (1993). The other is aimed at strengthening the role of local government through the Local Power Law, which regulates the election of local authorities along with their responsibilities and relations with the national government. As part of this change of responsibilities, some responsibility for primary care has been given to local authorities in rural areas.

The Albanian health system can be described as going through a period of transition. This means that although many of the essential elements of the old system exist, health reforms occur. The Ministry of Health continues to provide and regulate all health services in the 26 administrative districts of the country. Most of the work of the Ministry is therefore focused on health care administration rather than policy and planning.

The Ministry manages most health services with only primary health care being partially not under their direct control. The 320 local rural government authorities are partly responsible for primary health care and own the facilities. The funding for these primary health care facilities comes directly from the Ministry of Finance. However, in the urban areas the primary care services are administered by the Ministry of Health's district offices.

In 1993, the Ministry produced a national health policy, but work needs to be done on updating the policy to reflect developments in the health sector. Some of the basic goals are stated as:

- care at an affordable price;
- to give priority to those forms of health care that offer the best chance of improving health at the lowest price;
- to base the health system on a foundation of primary health care;
- to introduce market elements in financing health care;
- to give more managerial autonomy to districts and to create health regions.
- to streamline health services.

The most important components of the reforms can be seen as:

1) Streamlining health services
   a) maintaining and rationalizing the network of primary health care facilities;
   b) transforming rural hospitals into outpatient health centres;
   c) maintaining a network of district hospitals offering four basic health care services;
   d) upgrading a few district hospitals to the level of regional hospitals offering 10-12 specialized services;
   e) reorganizing national level facilities into a unified university hospital.

2) Improving the quality of health services through rehabilitation of its infrastructure and standardizing medical equipment.
3) Protecting and increasing financial resources for the health services; protecting and increasing the public budget for health; introducing private services; introducing health insurance; increasing regulation at the same time as allowing privatization.
4) Developing human resources by: reducing the number of students in the faculty of medicine; reviewing the national curriculum and standardization of postgraduate training; upgrading nurse training; introducing regular in-service training and new post graduate

training in family medicine; introducing public health and health management.
5) Decentralizing and regionalizing health services.
6) Strengthening and improving statistics and health information.

The planning process that was being undertaken in collaboration with WHO was interrupted by the violence in 1997. Subsequently sub-sector plans have been produced with the assistance of international experts. These include:

- a policy for primary health care (European Union PHARE programme);
- plans for the development of Vlorë and Shkodër regional hospitals;
- a strategy for the Tirana regional health system (World Bank);
- a master-plan for the development of the Tirana University Hospital (Assistance Publique des Hôpitaux de Paris);
- a national mental health policy (National Steering Committee for Mental Health/ Albanian Development Centre for Mental Health).

What is now needed is integration of these reforms and plans within the framework of the national health policy and a health sector plan. In the current situation, day-to-day administration takes precedence over planning.

Planned reforms

Two parallel training initiatives have been reported. First, the launching of World Bank and the Ministry of Health six-month training course in health planning/management at the district level after piloting six short-term training courses, with a focus on primary health care. This course was prepared through the support of the University of Montreal. USAID and the Faculty of Medicine planned a second postgraduate training course in health management, which began in 2000, with the assistance of New York University. In addition, the University of Tirana proposes to develop a new field of study in public health management. The Faculty of Medicine has already started a postgraduate training course in public health.

Mental health care

Mental health care in Albania has traditionally been largely hospital based, biologically oriented and symptom focused. There are two large psychiatric wards in general hospitals in Tirana (120 beds) and Shkodra (110 beds) and two State hospitals at Elbasan (400 beds) and Vlora (280 beds). Because of the location of these facilities, they are largely inaccessible to the majority of the population. There is much that is needed in order to reform the mental health system as a whole, but in particular, to improve mental health service provision. The Policy Document of Mental Health in Albania, which has been approved by the Government in 2003, addresses some of these priorities. In describing the context in which service provision is to be improved, the document states the following:

- There are 840 psychiatric beds in the country, most of which are used for long-term treatment.
- There is around one psychiatrist per 78 000 inhabitants or maybe less considering the centralization of psychiatrists in four districts.
- No nurses have been previously trained in psychiatry, although there are around 200 nurses working in psychiatric settings (including hospitals and ambulatory care). Again, this

figure is less, considering that many nurses in psychiatric hospitals are not engaged directly in patient care, but in administrative and laboratory activities.

- Until recently, there were no social workers and psychologists employed in the psychiatric services.

In 2001, the country reports from the WHO European Network on Mental Health listed some additional facts concerning the poor state of mental health services in Albania. Included among them are:

- The first psychologists graduated from the university in the year 2000.
- Contemporary psychotherapy has not been available.
- GPs have had limited knowledge about mental disorders, although they are consulted by many people with mental health disorders.
- Drugs for people with mental illness are limited.
- Professional knowledge in general has not been up to international standards.

With regard to outpatient treatment, this service has been provided by neuro-psychiatrists who are however not present in every district. Very often however, they cater for neurological as well as psychiatric consultations although some neurologists have little knowledge of the latter. Each service consists of one doctor and one nurse only and whereas a minority of neurologists has received some training in psychiatry, nurses have received none since there has been no training for psychiatric nurses in the country. The above situation has been exacerbated by *inter alia:* the poverty of the country, the small percentage of GDP spent on health in general (1.91% in 2000), the high level of stigma against the mentally ill, and the presence of under-resourced, old-fashioned psychiatric services.[1]

Mental Health Reform

As part of the Ministry's commitment and efforts to reform mental health services, a National Steering Committee for Mental Health was set up in May 2000 with the support of WHO to decide and propose what was needed in the mental health field. The Committee is also assisted by the Albanian Development Centre for Mental Health, which was formed in October 2000 and follows up the implementation of the Policy in all its aspects.

The National Steering Committee for Mental Health was mandated to perform four tasks:

1. To develop a mental health policy.
2. To plan the reform of psychiatric services.
3. To follow up, support and coordinate the implementation of innovative activities, experiences, and services aimed at the development of community-based mental health services, and promote and implement deinstitutionalization processes.
4. Monitor the deinstitutionalization processes.

Overall, the reform process in Albania which has been given technical assistance by WHO and has begun to take place at two levels, the policy level and the field level. At the policy level, the Mental Health Policy produced by the National Steering Committee for Mental Health, has

[1] Mental Health in Europe, 2001.

been approved by the Ministry of Health.

Mental Health Policy

The focus of the mental health policy document has been on the re-organization of psychiatric services, although the 14 priorities cited for implementation in the Policy document cover a much wider area of reform. Included in these are: creating a Department for Mental Health Development within the Ministry of Health; continuing the integration of mental health services into primary health care (which has only recently begun with the establishment of Community Mental Health Centres); defining and instituting a separate mental health budget; reviewing mental health legislation with a view to ensuring rights to treatment, housing, education, employment, etc. for persons with mental health disorders; the deinstitutionalization of psychiatric services; establishing community-based demonstration systems; and the provision of continuous training of mental health staff (within and outside Albania).

Community Mental Health Centres

At the field level, six community-based mental health facilities have been established. Four are under direct WHO technical and financial support and a further two in Vlora and Shkodra are supported financially and technically by UNOPS in collaboration with WHO. WHO has been responsible for setting up community mental health centres in four areas of the country. This is with the intention of incorporating them into the mainstream state health system. They are located in Tirana, Elbasan, Gramsh and Peshkopi. More recently, there has been a decision taken for WHO to concentrate relatively more on the development of the Centres at Tirana and Elbasan, and with UNOPS on Vlora and Shkodra in order to achieve wide geographical coverage. The intention is to develop community-based services and undertake training of staff in these four catchment areas.

WHO in Tirana and Elbasan will continue to provide supervision, coordination of NGO activities in the area of mental health, training, evaluation and the preparation of background material for the National Steering Committee for Mental Health. All these activities are done with the support of the Albanian Development Centre for Mental Health. The remit of the Centre is as follows:

- Building knowledge and competence on community-based mental health practice;
- Evaluation of mental health services from a multi-dimensional perspective;
- Approaching the community through information and education;
- Supporting the national organization of the relatives of persons with mental health problems.

Reforming mental health in Albania

All of the Centres have received and continue to receive a mixture of technical support, training and an

exchange of valuable experiences from WHO, the Geneva Initiative on Psychiatry, the North Birmingham Mental Health Trust in the UK and the Principado de Asturias, in Spain.

Financial resources, initially from the European Commission Humanitarian Aid Office (ECHO) and later from the Swedish International Development Agency (SIDA) were instrumental in providing the foundation for the modernization of mental health care in Albania.[2] A description of the work of the centres follows along with an analysis of the progress made.

Mental Health Legislation

In 1996, the Parliament approved a Mental Health Law whose implementation status is uncertain. One of the aims of the mental health reform is to implement the law and increase the provision of community based services.

Tirana

The district of Tirana (made up of one urban municipality, three semi-urban municipalities and 15 rural communes) has been served by one psychiatric hospital in the past. In an effort to increase the provision of community care services, and as part of the reform of mental health services, the first community centre for mental health was established in Tirana in December 2000. The team is multidisciplinary, provides therapeutic care, day care and outreach services. It has also created a network for collaboration within and outside Albania.

An analysis of the progress made over the last three years has shown that at the field level the pilot community mental health centre in Tirana will now cease to be a demonstration site and become an integral part of the community services completely financed by the Regional Health Authority. Other supporting activities such as the exchange programme with the Birmingham collaborating centre have been working successfully. A car has been donated for carrying out home visits.

[2] Mental Health in Europe, 2001.

Elbasan

Another community mental health centre has been created at Elbasan. This town has been traditionally served by a 40-year old psychiatric hospital that has also housed forensic patients. The stigma associated with the presence of forensic patients has made the work of the new community team difficult and challenging since its inception in the latter half of 2000. Apart from having to deal with the stigma of mental illness the other challenges faced have been: lack of community awareness about the needs of the mentally ill, lack of involvement of different sectors of the community, lack of links with other health service facilities, and the inexperience of community-based work. However, some links are being made and there has been support from the Public Health Office and Municipality to look at the problems of integration.

Over the last three years, the community mental health centre has been working in the polyclinic and the staff and running costs are being met by the Ministry of Health. A rehabilitation unit close to the hospital has been renovated. The hospital-based team and the community mental health teams have both received training and the UK and Ireland Collaborating Centre has been successful in changing modalities of daily work.

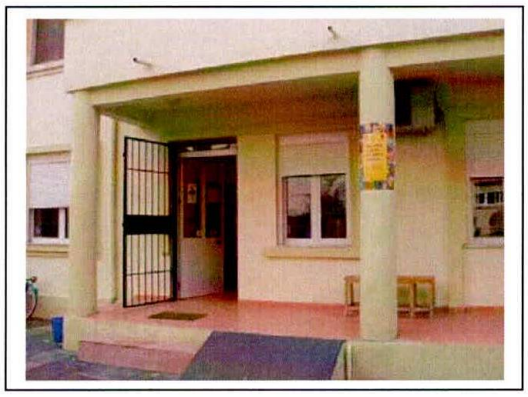
Gramsh

The Centre in Gramsh, which began functioning in January 2002, has received much more support from the local authorities and the local community, which has made its initial work easier. The building and the staff are funded by the local health authorities. This Centre also provides active outreach work especially with families. Outreach is particularly important because the local terrain leads to the isolation of many villages from services.

Personnel at the Centre have also received training locally and abroad and a few beds have been identified in the General Hospital for allocation to mental health treatment. A car has also been donated for outreach work.

Peshkopi

The fourth Centre, in Peshkopi has recently become functional. This is the only one of the four centres that is totally financed and administered by the State. A car has been donated and the team has received in-service training with support from Asturias WHO Collaborating Centre. There has also been an agreement reached over the identification of a few beds in the local general hospital for the treatment of patients with mental disorders.



Visiting Albania Community Mental Health Resource Centres

Setting Achievable National Targets.

The Policy for Mental Health Services Development specifically states that an implementation strategy (operational plan) should be developed to define feasible and sustainable activities that are of the highest priority.

To facilitate the development of such a plan, the Department of Mental Health and Substance Abuse assisted WHO Albania in doing a comprehensive assessment. For this assessment the Department's new instrument to monitor mental health systems and services in countries was administered. Through over 300 indicators, the 10 key components of any mental health system (reflecting the 10 main recommendations made in the World Health Report 2001 on mental health) were systematically assessed. This assessment provides baseline information for the operational plan, which details activities to be implemented over the coming five years in Albania.

For each activity, detailed operational planning has been conducted. Tailor-made plans describe for each activity: the target group, the purpose, the current situation, the overall need, the unmet need, the target (with timeframe), the exact implementation plan, the responsible agents for implementation, the resources needed, the funder, potential barriers to implementation and specific indicators. The writing of the plan is facilitated by the Department of Mental Health and Substance Abuse who assisted WHO Albania and the Working Group of the National Steering Committee on Mental Health in developing the plan. The plan is based on (a) the Policy, (b) the results of the mental health system monitoring exercise, (c) WHO Albania's and the Ministry of Health's experience in the country through aforementioned community mental health projects, (d) the normative information provided in the Policy and Guidance Package developed by the Department in recent years, and (e) the clear vision articulated by the WHO Albania mental health staff.

Supporting activities to be undertaken by the Ministry of Health

- Strengthening human resources for mental health services.
- Establishing a Unit for Mental Health and Substance Abuse within the Ministry of Health to coordinate the implementation of the Policy Document and wider reform.
- Moving resources from the hospital to the community.

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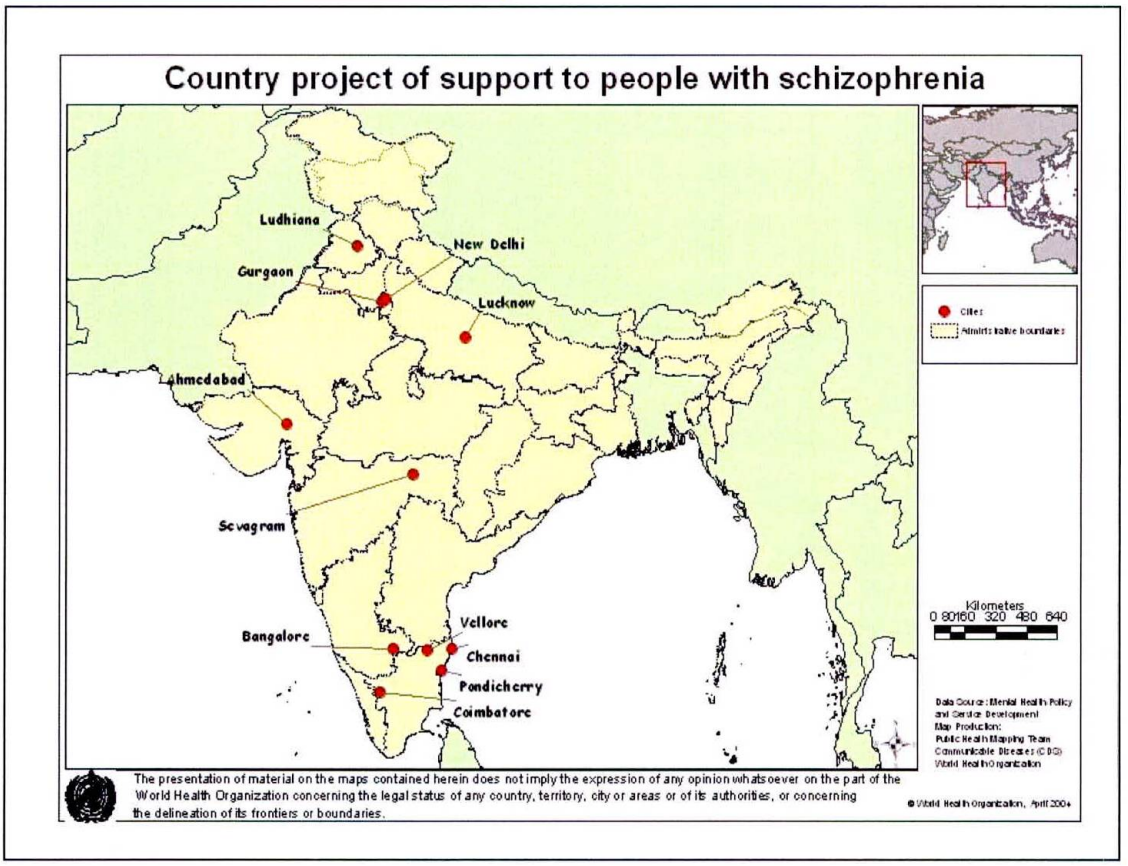
INDIA

SUPPORT TO PEOPLE WITH SCHIZOPHRENIA



Project Activities / Outcomes

1. Development, in local languages, of a manual for family intervention.

2. Training of the local health workers to both raise awareness about mental health problems and their appropriate identification, management and referral, and implement actual interventions.

3. Immediate care to some 1500 families, in terms of brief psychoeducational intervention sessions, whose content covers basic information about the diseases and basic training in daily living, problem-solving and communication skills, and of pharmacological treatment to patients. The opening of day centres for people with mental disorders is a central aspect of this care model.

4. Contacts with relevant NGOs in order to get them mobilized and actively involved in the project, particularly for awareness-raising events and information dissemination about mental health problems and their management. Particular attention is given to the establishment of creating /strengthening of existing NGOs of relatives and friends of people with mental disorders.

Background

Schizophrenia is a severe mental disorder which accounts for much suffering of those affected and their families, in addition to a cost to society estimated as 1.1% of the total burden of disease (in terms of DALYs – disability adjusted life-years) and 2.8% of the total YLDs (years lived with disability).

The ultimate goals of the treatment of people with schizophrenia is the productive reintegration into mainstream society. There is enough evidence that care of persons with schizophrenia can be provided at community level through:

(i) medications to relieve symptoms and prevent relapse;

(ii) education and psychosocial interventions to help patients and families cope with the illness and its complications, and also to prevent relapses; and

(iii) rehabilitation that helps patients reintegrate the community and regain educational or occupational functioning.

The goals of psychosocial rehabilitation for people with schizophrenia encompass a variety of measures that go from improving social competence and social support networking, to family support.

Central to this is consumer empowerment and the reduction of stigma and discrimination, through improvement of both public opinion and pertinent legislation. The respect for human rights is a presiding principle to this strategy.

The incidence of schizophrenia is largely similar in developed and developing countries; there are, however, indications pointing to the fact that the outcome of this disorder is strongly influenced by social factors, of which the family appears to be a key element.

Awareness-raising activity (theatre) in a rural area.

The state of mental health

In India, for a population of nearly one billion people, there are an estimated four million people with schizophrenia, with different degrees of impact on some 25 million family members.

India has a national mental health programme, which was formulated in 1982 and adopted as the mental health policy. More recently, the 10th Five-Year Plan of India for the Years 2002–2007 emphasized some strategies for the National Mental Health Programme as saying *".....and to shift the focus from the present custodial model to a community-based approach with extension of basic mental health care through outreach facilities."*

The objectives of the national mental health programme are:

i) to ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and under-privileged sections of the population;

ii) to encourage application of mental health knowledge in general health care and in social development; and

iii) to promote community participation in mental health service development and to stimulate efforts towards self help in the community.

The approaches adopted by the programme are:

i) integration of basic mental health care into general mental health care services;

ii) training of primary health care personnel in the aspects of mental health care;

iii) provision of adequate neuropsychiatric drugs in peripheral health care institutions;

iv) support and supervision of trained primary health care personnel;

v) establishment of a psychiatric unit at the district level; and

vi) encouraging community participation.

The proportion of health budget to GDP is 5.2%. The country spends 0.83% of the total health budget on mental health (WHO, 2001)[3].

Meeting with relatives of people with mental disorders in a suburban area.

[3] World Health Organization (2001). *Atlas: Country profiles on mental health resources.* Geneva, WHO.

Mental health services

Mental health care is a part of the primary health care system. Mental health care in primary care is available in certain designated project areas but not all over the country. Community care facilities for patients with mental disorders are available in some designated districts. In addition, various nongovernmental organizations provide different types of services.

The District Mental Health Programme which is being operated in 22 districts in the country attempts to take mental health care to the rural and underprivileged sections of the society.

There are about 40 mental hospitals operating in India with a varying amount of bed strength. They still have a large proportion of long-stay patients. Funding is poor and staffing is inadequate. All this adds to the problem of stigma against mental disorders.

There is a total of 0.25 psychiatric beds per 10,000 population and 0.4 psychiatrists per 100,000 population.

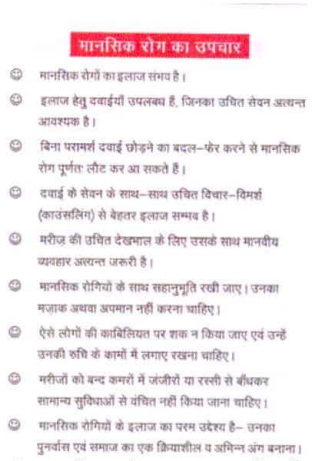
Yet, there are no more than 40 psychiatric hospitals, some 26,000 psychiatric beds in total and some 4000 psychiatrists in the whole country; in other words, approximately one psychiatrist per 1000 persons with schizophrenia.

This clearly indicates:

(a) the importance of developing innovative programmes to help these people and their families in their daily confrontation with schizophrenia, and

(b) that these programmes must be strongly anchored in the community and also be strongly family-based and family-oriented.

With the financial support of Associazione Cittadinanzza and Caritas, WHO has launched a project of support to people with schizophrenia with the ultimate goal of emphasizing the empowerment of families.



मानसिक रोग का उपचार

- मानसिक रोगों का इलाज संभव है।
- इलाज हेतु दवाईयाँ उपलब्ध हैं, जिनका उचित सेवन अत्यन्त आवश्यक है।
- बिना परामर्श दवाई छोड़ने का बदल-फेर करने से मानसिक रोग पूर्णतः लौट कर आ सकते हैं।
- दवाई के सेवन के साथ-साथ उचित विचार-विमर्श (काउंसलिंग) से बेहतर इलाज सम्भव है।
- मरीज की उचित देखभाल के लिए उसके साथ मानवीय व्यवहार अत्यन्त जरूरी है।
- मानसिक रोगियों के साथ सहानुभूति रखी जाए। उनका मज़ाक अथवा अपमान नहीं करना चाहिए।
- ऐसे लोगों की काबिलियत पर शक न किया जाए एवं उन्हें उनकी रुचि के कामों में लगाए रखना चाहिए।
- मरीजों को बन्द कमरों में जंजीरों या रस्सी से बाँधकर सामान्य सुविधाओं से वंचित नहीं किया जाना चाहिए।
- मानसिक रोगियों के इलाज का परम उद्देश्य है– उनका पुनर्वास एवं समाज का एक क्रियाशील व अभिन्न अंग बनाना।

Example of information leaflet in local language (hindi).

Project description

This project has two main lines of action:

(a) **support for families**, basically through interventions such as psychoeducational programmes, and social and emotional support, and

(b) **development / strengthening of associations of families** affected by schizophrenia.

The strategic approach involves establishing mental health extension services in the community, particularly in some which never had this kind of services. It builds up on already existing resources in the community, like buildings and eventual community health workers of Primary Health Care Centres.

In practical terms, the Project initiates community-based and outreach mental health programmes in areas wherein these services have not yet reached or are not accessible in terms of the costs involved in consulting mental health professionals and the expenditure for medicines. Besides these, outreach programmes provide other benefits by reducing stigma and spreading the message that these illnesses can be kept under control, if appropriate professional help is given in time. These efforts of treating the mentally ill within the society makes the reintegration of such persons back to the mainstream of society easier, since they are not separated from the society at any given time of the treatment. The modern concept of Community-Based Rehabilitation is the order of the day in the treatment of the mentally ill. Given the support of adequate resources, appropriate NGOs can augment these services in the existing clinics and further initiate such clinics in several new places.

Information being provided to school children in a rural area.

In order to do that, a manual for family intervention has been developed, translated into local languages and used to train health workers who see people with schizophrenia.

The training of those local health workers covered both awareness-raising about mental health problems and their appropriate identification, management and referral techniques, as well as the actual implementation of those interventions.

A variety of conscientization programmes and student mental health orientation programmes were initiated to propagate the existence of mental health services available at their doorsteps besides making them conscious that there exist various types of mental health problems in varying severity in children and adults and that these can be managed with appropriate interventions if given at the onset of the illness.

Training and orientation programmes are imparted to the village health workers and teachers of the schools in the community, nursing trainees, psychology students posted from both undergraduate and postgraduate colleges. They are given a detailed orientation on psychosocial rehabilitation by the Project's teams.

Relatives of people with schizophrenia attending an information/support session.

The teams visit the villages and slum areas near Delhi, especially local schools, grocery shops, local physicians and the clinics run by them, STD booths and distribute leaflets on mental illness. In addition, they request the shop owners and the school authorities to distribute the copies of these to the children at schools and the public who visit the shops. They advise them to refer or send people who suffer from any of the mentioned problems to the newly opened clinics for free treatment and counselling. These efforts have started showing gradual results, as there is an increase in the number of clients attending these new clinics.

Those who require further in-patient care or any other general medical care are referred to the nearest general hospital psychiatric unit of Government Hospital. This co-ordination helps the actively symptomatic clients obtain the in-patient care until they stabilize medically and later can be followed up in the community by the local mental health team. Those with problems of co-morbid substance abuse and alcoholism are referred to de-addiction centres for detoxification.

So far, approximately 1500 families have benefited from these activities, in terms of brief psychoeducational intervention sessions. The scope of these interventions covers basic information about the diseases and basic training in daily living, problem-solving and communication skills, and pharmacological treatment to patients.

To all of those in need, appropriate psychiatric and other medication is provided free of charge, as is the case with all other interventions.

Hand in hand with the care model is the opening of day centres for people with mental disorders, with active outreach programmes both in rural areas in South India and in different slum areas.

The Project's teams are in a position to bring about a substantial change in people's attitudes by way of multiple activities aimed at conscientization about the mental illness and the treatment available. This has resulted in gradual attraction of the clients with mental health problems towards the clinics running in different suburban and rural areas in both Central and South India. The team consists of a dedicated staff who make regular

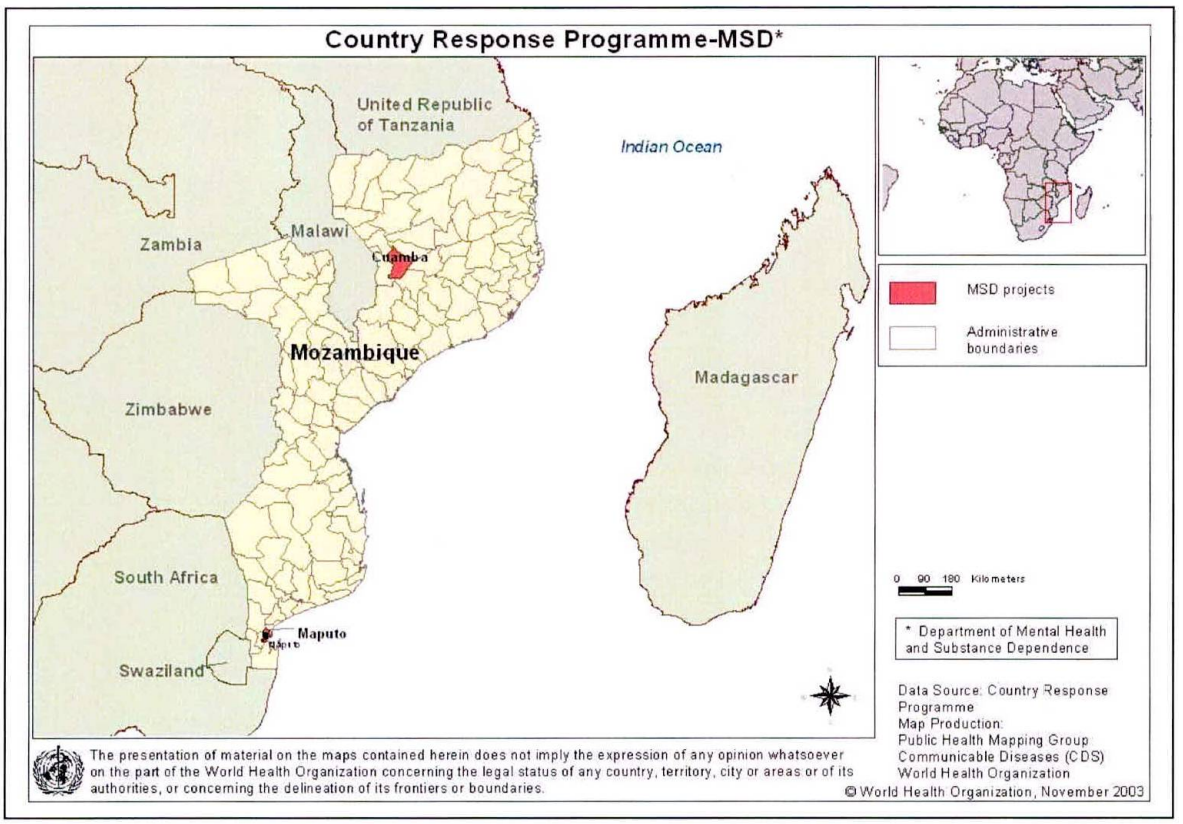
periodic visits to the identified centres. After the initial screening by members of the team, a psychiatrist further reviews the patient in detail to confirm the diagnosis before further professional assistance is given along with free medication. The patients are reviewed periodically and kept on a maintenance dosage. Those who require inpatient care are referred to the nearby General Hospital Psychiatric Units (GHPUs) and once discharged from the GHPUs the team follows them up in the community and continues to provide counselling and medication free of cost.

Contacts are also established and maintained with relevant NGOs in order to get them mobilized and actively involved in the project, particularly for awareness-raising events and information dissemination about mental health problems and their management.

A particular attention is given to the establishment of new /strengthening of existing NGOs of relatives and friends of people with mental disorders.

Regular family support groups are organized with family members/carers of people suffering from mental health problems with the purpose to psycho-educate and to strengthen the services offered by this society for the needy. Family therapy sessions are being taken for the patients' families, especially wherever family pathology exists, as usual.

Mozambique: policy project



Project objectives

- *To increase* ***the technical capacity of Mozambique in mental health policy-making and planning.***
- ***To assist*** *the Ministry of Health of Mozambique to draft a mental health policy and update and improve its mental health programme.*
- ***To build*** *the capacity of mental health professionals to provide community-based care.*

Project strategies

- *Ensuring the harmonization of the mental health plan with the overall health plan.*
- *Strengthening the technical expertise and skills of local mental health professionals especially in the area of community care.*
- *Paying particular attention to the development of community-based services in the planning process.*
- *Ensuring the involvement of non-governmental organizations, especially traditional healers, in the area of training.*
- *Actively encouraging the involvement of a range of ministries, other than the Ministry of Health, in the policy-making process.*

Implementing institutions

- ***Ministry of Health, Maputo***
- *Provincial Health Authorities*

Background

Provisional results of the national census conducted in 1997 put the population of Mozambique at nearly 15.7 million inhabitants. This is approximately 15% lower than earlier estimates of 18 million. Primary care remains the basis for the public health system in this country. The National Health Service is the major provider of all health services.

There are four levels of care in Mozambique's 10 provinces. At the primary level, there are health posts, mobile services, and rural health centres that carry out preventive and basic curative activities. Health posts are staffed by semi-skilled or unskilled personnel. The large health centres have basic inpatient facilities and are staffed by nurses.

Mental health care

At the secondary level, there are rural and general hospitals. The general hospitals provide services in paediatrics, obstetrics and gynaecology, general surgery and medicine. Few rural hospitals provide surgical services.

A rural hospital in the north

At the tertiary level, there are provincial hospitals that offer diagnostic facilities and some specialist services.

The quaternary level includes the three central hospitals in Maputo, Beira and Nampula.

The mental health care system in Mozambique can be broadly divided into three sectors:

1) Services found in primary care facilities

Primary health care facilities are an important source of mental health care delivery. There are currently 34 psychiatric technicians located in health centres throughout Mozambique's 10 provinces. Their main roles are to prescribe and administer psychiatric medication to patients attending the health centres and to provide psychosocial rehabilitation. The health centres also engage in mental health awareness and educational programmes in an attempt to reduce the stigma associated with mental illness and to highlight the risks associated with alcohol consumption. Medication can also be administered by staff in health posts. These are generally smaller than health centres.

2) Mental hospital services and psychiatric beds provided by general hospitals where outpatient services are also available

Psychiatric facilities within general hospitals are very limited. They are available in Maputo from the Central Hospital and in the province of Sofala where there is a small unit in the local rural hospital. There are currently two psychiatric hospitals in Mozambique. They cater primarily to inpatients with severe mental health problems who have been referred by primary care psychiatric technicians. One is based in the city of Maputo and the other in the northern province of Nampula.

3) Traditional healing

The Ministry of Health has looked positively upon traditional medicine because it recognizes its importance to

the people of Mozambique. Given that only 60% of the population has access to formal health care services, particularly in rural areas, healers are most often the preferred port-of-call for individuals who suffer from health and mental health problems.

Since many patients who suffer from chronic mental illness are prone to relapses, one of the most important priorities for the Ministry of Health has been to monitor patients' access to health and social care services once they have been discharged from the hospital. There is evidence to suggest that the psychiatric hospital in Maputo has been a victim of the same "revolving door" phenomenon that bedevils hospital services in many developed mental health care systems. Nevertheless, it is evident that some arrangements have been made with local health centres to monitor patients on discharge and provide general assistance to them and their families in the process of re-integration into the community.

Within the ministerial hierarchy, mental health is one of six sections that together make up the Division of Family Health. The Division of Family Health comes under the Department of Community Health, which has its own National Deputy Director. A National Programme Coordinator for Mental Health is responsible for planning and policy decisions. In each province, there is a coordinator for the local mental health programme. The coordinator is usually a psychiatric technician, except in two provinces where the work is carried out by psychiatrists. A two-year strategic plan for mental health was drawn up but has only been partially implemented. It is related to the National Integrated Plan/Community Health 2001.

In November 1996, a national mental health programme was outlined for the first time. This programme identified several areas of importance for Mozambique that needed to be addressed to improve mental health facilities. These included:

- The failure to prioritize mental health services.
- The dominance of a custodial system of psychiatric care, which perpetuates stigma against persons with mental health problems.
- The lack of epidemiological information on mental illness.

There is a need to incorporate mental health care into general health care.

- The lack of human and financial resources and facilities.
- The lack of awareness among health staff and the community as a whole about mental health problems.
- The lack of systematic knowledge about the influence of social and cultural factors on Mozambique's mental health problems.
- The absence of an agency to organize, promote, coordinate and supervise action in the mental health sphere.
- The lack of continuity in action undertaken. This can be attributed to lack of resources and heavy reliance on international cooperation.
- A highly centralized structure and a lack of intersectoral collaboration.

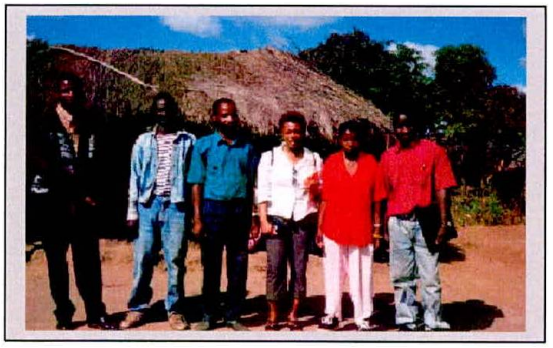
Each issue is discussed in turn, below.

The low priority given to mental health services

This continues to be the case in Mozambique largely because of limited financial resources and the pressing needs created by communicable diseases.

The dominance of a custodial system of psychiatric care, which perpetuates stigma against persons with mental health problems

There has been a noticeable improvement in the conditions of patients in the psychiatric hospital and in their management. Therapeutic work, in the form of agricultural projects, has been developed on land surrounding the hospital in conjunction with members of the local community.



WHO is encouraging joint-working between mental health workers and traditional healers

Owing to the work of Italian Cooperation, the management of the hospital has been improved and work in the community has been encouraged and promoted. Italian Cooperation has also had an input into the training of psychologists, nurses and psychiatric technicians through the Central Hospital in Maputo. A new project to further develop community activities will shortly begin. Community projects have also been developed and implemented by the Italians in Manica and Sofala and by WHO in Niassa.

The lack of epidemiological information on mental illness

For the first time as part of this project, WHO has funded the undertaking of a pilot epidemiological study to provide an evidence base for the mental health policy.

The Ministry of Health has outlined the benefits of the pilot epidemiological study as follows:

- Increase the availability of reliable epidemiological information on mental health in Mozambique.
- Begin the integration of mental health epidemiological information into the general health information system (statistics).
- Improve, monitor and supervise the effectiveness of mental health interventions on the basis of the initial evidence.
- Monitor the changes and trends in mental and neurological disorders. These are a major cause of disability in Mozambique, a country undergoing rapid and severe social, political and economic changes with serious impacts on the population.
- Work towards reducing the incidence and prevalence of mental and neurological disturbances with better information systems.

The lack of human and financial resources and facilities

These continue to be a big challenge to the provision of mental health service particularly in the community. Until 2002 there were only five psychiatrists in Mozambique, (none of whom are Mozambican). Three Mozambican doctors have been trained as psychiatrists, but their location and the duration of their stay in Mozambique in the future cannot be predicted with any degree of certainty. In addition, because of the shrinking pool from which to draw nurses for training as psychiatric technicians, no new

psychiatric technicians were being trained. Most of the psychiatric technicians who provide the bulk of psychosocial rehabilitation and are trained to administer medication, are due to retire shortly (two-thirds) or are planning to change careers. Training of new technicians was not envisaged because of the lack of financial resources in the Ministry of Health to absorb staff at this level. The issue of training is therefore a crucial one and is addressed in the mental health policy.

The lack of awareness about mental health problems among health staff and the community as a whole
The first training sessions given to mental health personnel in June 2000, have been continued in a limited way with general health staff at some health centres, in particular in Cuamba where there was another WHO community-based mental health project.

The lack of systematic knowledge about the influence of social and cultural factors on Mozambique's mental health problems
While anecdotal knowledge exists, no systematic research has been carried out on a national scale. However, a study was carried out as part of the preparation of another WHO-funded project in the province of Niassa in the north of the country. Beliefs about the causes, the types of treatment and where treatment is sought, were recorded. The study also gathered information about local names given to mental health problems. As part of an epidemiological study, a comparison was made between these and ICD-9 classifications.

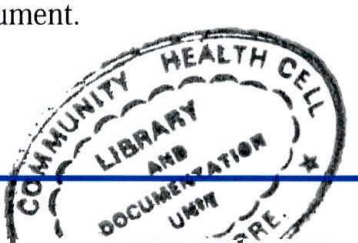
The absence of an agency to organize, promote, coordinate and supervise action in the mental health sphere
This has been overcome to some extent by the appointment of a National Programme Coordinator for mental health based in the Ministry of Health. However, this programme is only managed by two people and the Coordinator also has clinical responsibilities. Some progress has been made to coordinate action in the mental health sphere by giving people in the province (mainly psychiatric technicians) responsibilities for mental health. However, whether or not a mental health programme is implemented remains the responsibility of the provincial director of health.

The lack of continuity in action undertaken, attributable to the lack of resources and heavy reliance on international cooperation
This continues to be the case except in a few provinces where community services have been established.

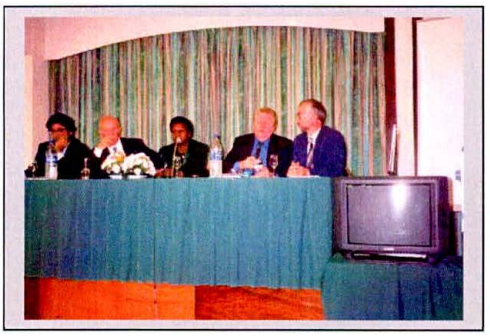
A highly centralized structure and lack of intersectoral collaboration
At the regional and provincial levels, there has been some decentralization of services, and regional and provincial officials responsible for mental health have been appointed.

Project description

Mozambique faces many problems and challenges due to the lack of human and financial resources in the field of mental health. There is a need to address all of these issues in a systematic and practical manner. Because of the scale of communicable diseases in Mozambique, that are exacerbated by periods of flooding and drought, the health sector in general is under considerable pressure. The project therefore set out to address the objectives spelt out at the beginning of this document.



Increasing the technical capacity of Mozambique in mental health policy making and planning



International training seminar for health professionals in Maputo, June 2000

WHO has assisted the government of Mozambique to develop and write a mental health policy. The policy has addressed *inter alia*, a number of key areas. Among them areas such as: the organization of mental health services; human resource development; the provision of psychopharmacological drugs at all levels of the health system; intersectoral collaboration; the role of the traditional practitioners; and, the need for adequate epidemiological information to support the planning process.

The policy-making process was achieved through joint collaboration and planning between officers responsible for mental health in the Ministry and consultants hired by WHO to collaborate with the Ministry and guide it through the process.

As previously mentioned, a pilot epidemiological study has been undertaken and has provided a base for policy-making and planning. It was conducted in one rural and one urban province and included a sample of people in the community, as well as people in primary care and general hospitals.

The training given by WHO as part of the pilot epidemiological study has been part of a capacity-building exercise to enable the Department of Epidemiology within the Ministry of Health to begin to integrate some information into its routine statistics and for record-keeping purposes.

Strengthening the technical expertise and skills of local mental health professionals especially in the area of community care

In June 2000, approximately 90 mental health professionals and representatives of non-governmental organizations from all 10 provinces of Mozambique were trained in best practices in community mental health. The training also included persons from the statutory and non-statutory sectors.

Participants at the international meeting in Maputo, June 2000

An international meeting of experts and local mental health policy-makers and practitioners was also convened in June 2000.

The following received training as part of the project:

- *Clinical psychologists*
- *Psychiatric technicians*
- *General practitioners*
- *Psychiatrists*
- *Traditional healers*
- *Technicians in preventive medicine*
- *Nurses*
- *Nursing tutors*
- *Heads/representatives of nine NGOs*
- *Chiefs of provincial community mental health services*
- *Senior primary health care staff*
- *National Programme Co-ordinator for Mental Health*
- *Psychiatric technician based in the Ministry of Health*

Paying attention to the development of community-based services within the policy and planning process

It has already been recognized that this is a fundamental part of the process of strengthening the role of mental health in primary health care. Discussions with Ministry and clinical staff indicated a high rate of re-admission. It was recognized that there is a need for greater follow-up in the community. This is a problem because of the insufficient numbers of trained staff. Given the size of the country and logistical problems in servicing communities with poor infrastructure, the provision of mental health services is greatly limited. There are however successes in a few provinces where international aid is being injected into the community by Italian Cooperation. Overall however, the issue of staff training, support and retention is one that runs across the whole of the health sector and affects the provision of community services.

Existing community services were visited and discussions held with workers and international NGOs, where they existed, in order to evaluate the impact on community service provision.

Actively encouraging the involvement of a range of ministries other than the Ministry of Health in the policy-making process

This process of building intersectoral collaboration where none has previously existed was initiated with the Ministry of Social Action and the Ministry of Labour. It was then extended to cover a range of other ministries who were consulted to contribute recommend-ations on the way forward.

Other areas that need to be addressed as part of the policy-making process affecting community care include:

- *Integrating mental health into existing community health programmes within the Ministry of Health (such as the Infant and Maternal Health Programme (UNFPA), and the Integrated Management of Childhood Illnesses Programme (WHO/UNICEF)).*
- *Introducing/strengthening the training and use of primary health care staff such as health agents and social agents. This is aimed at improving care in the community as part of a national programme of training by the Ministry of Health.*
- *Ensuring the adequate provision of psychopharmaceutical drugs at each of the four levels of distribution and ensuring the introduction of the necessary psychopharmaceutical drugs into the "kit system" at the PHC level.*
- *Rationalizing the work of psychiatric technicians with the roles of health agents, recently trained psychiatrists and social action agents from the Ministry of Social Action, with particular reference to roles and responsibilities, and career structures.*

As far as future collaboration is concerned, the involvement of the Department of Mental Health in the training of "social agents" who work in the community has been discussed with the Ministry of Social Action as part of this project. This is seen as a fruitful area for cooperation. Future collaboration also includes further work with the Directorate for Women within the Ministry of Social Action. This is because domestic violence is an area of concern.

For the Ministry of Labour, recent labour legislation has been drawn up but still needs to be implemented through various regulations. Input from the Department of Mental Health in drawing up regulations for workers who have mental health problems has been welcomed.

A series of consultations were held with other Ministries during the course of the project. These are outlined below. Consultations and visits covered all of the 10 provinces.

Some of the chief aims of the activities that have taken place included:

- *understanding the problems and issues of mental health;*
- *understanding how health/mental health services were organized at all levels;*
- *discussing recommendations on the key areas that need to be addressed in the policy document and suggestions on how to address the current problems in mental health;*
- *getting a better idea of the role and contribution of the traditional sector;*
- *agreeing on the nature and scope of collaboration with other ministries in order to optimize limited human and financial resources.*

The following consultations and visits have been made:

Ministry of Health

- **Deputy Minister of Health**
- *National Director of Community Health*
- *Head of School and Adolescent Health*
- *National Director of Human Resources and Training*
- *Deputy National Director of Medical Assistance*
- *Head of Pharmaceutical Department*
- *Meeting with Restricted Consultative Group (a Maputo-based group with representatives from the Ministry of Health, the Military Hospital, the psychiatric hospital, the central (General) hospital and NGOs).*

Psychiatric Hospital - Infulene

- *Meeting with the Psychiatric Hospital Director followed by a tour of the hospital.*

Ministry of Social Action

- *National Director of Women and Social Action*
- *National Director of the Institute of Social Action (INAS)*
- *Chief of Programmes – INAS*

Ministry of Labour

- *Permanent Secretary*
- *Head of "Gabinete de Estudos" (Study Cabinet)*

NGOs

- *Italian Cooperation*
- *Executive Director of Reconstruindo Esperanca (Reconstructing Hope) – children and adolescents*
- *Mahotas (adults)*

Focal points for mental health in all of the provinces

- Relevant local health personnel
- Provincial authorities
- International NGOs
- *Local NGOs*
- *Traditional healers*
- *Ministry of Education*
- *Ministry of Youth and Sports*
- *Ministry of Justice*
- *Ministry of Internal Affairs*
- *Ministry of Finance*
- *The City Health Board*

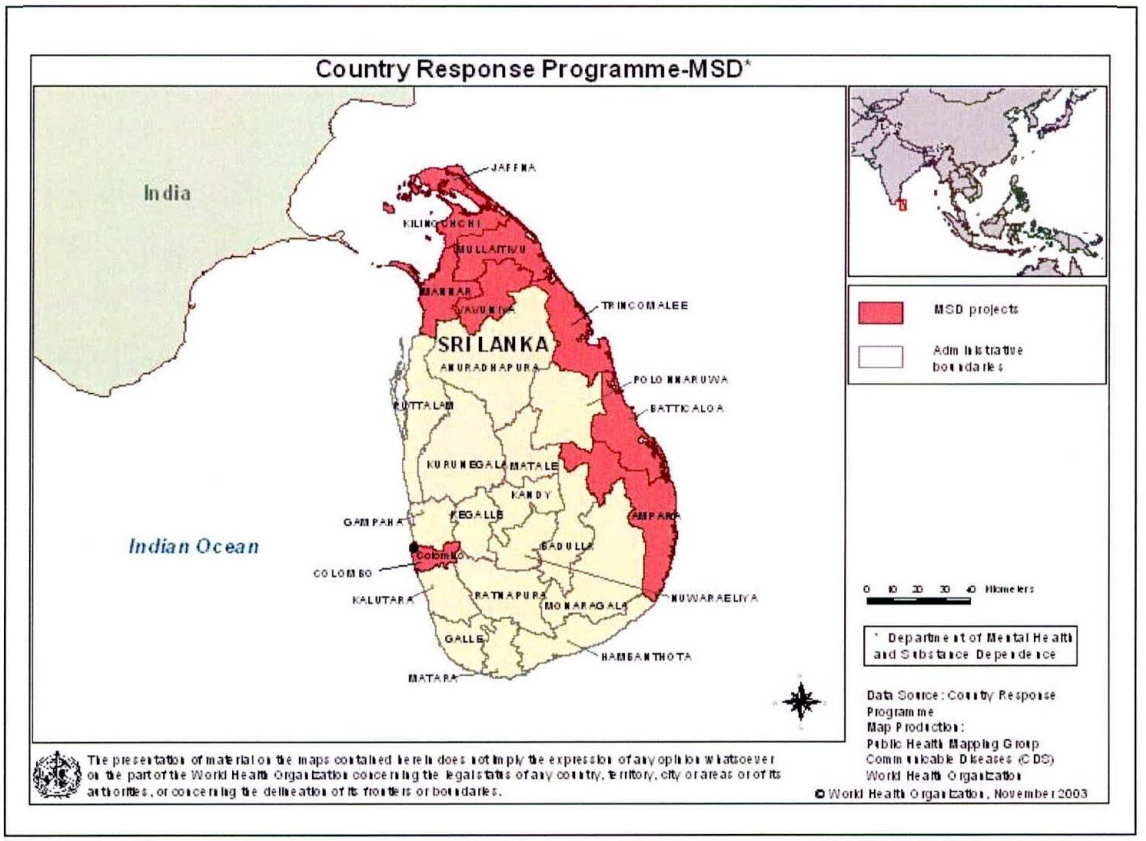
Key results

The formulation of a national mental health policy.

This was achieved through a process of:

- *Political commitment and collaboration with senior personnel in the Ministry of Health.*
- *Training of mental health professionals in the area of community mental health.*
- *Undertaking an initial situational analysis of mental health issues and problems.*
- *Drawing up a clear and costed plan-of-action.*
- *Engaging in widespread consultations and discussions at the central and provincial levels (75 meetings involving over 250 persons).*
- *Ensuring consensus on areas to be included in the policy through a national meeting.*
- *Underpinning the policy with an evidence base by undertaking a pilot epidemiological study.*
- *Building in-country capacity for undertaking epidemiological research.*
- *Disseminating the final policy document for comments.*
- *Holding a final meeting before submission for formal adoption by the Council of Ministers.*

SRI LANKA: technical advice



Provision of Technical Advice to Sri Lanka

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

Country Visit

Participants in the one-week mission were:

Ministry of Health (including the Director of Mental Health Services)
Ministry of Rehabilitation, Resettlement, and Refugees
WHO Sri Lanka
WHO Geneva

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

Background to technical advice

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

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

The state of mental health

A 1994 community survey of the effects of war in the North found 25% depression, 27% anxiety disorder and 14% post-traumatic stress disorder. These rates were higher in a study of outpatient attendees at a general hospital in Jaffna. Schizophrenia has been, is, and will continue to be the major mental health problem for the mental health services, because it is common (affecting up to an estimated 1% of the population), highly disabling, striking at a young, productive age and running a chronic course. There is some evidence that schizophrenia may have a relatively high incidence among Tamils (Somasundaram et al., 1993)[4]. Around the world, the prevalence of schizophrenia is between 0.5% and 1%.

The suicide rate in Sri Lanka ranks among the ten highest in the world, and the most recent official figures of 1991 put it at 31 per 100,000. The rates for men however are more than double that of women (44.6 compared to 16.8). Both the actual suicide rates as well as those for attempted suicide in Northeast Sri Lanka may be particularly high, especially among displaced persons as in Vavuniya, where an epidemic rate of 103/100,000 was observed[5].

Mental health services

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

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

Inpatient accommodation

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

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

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

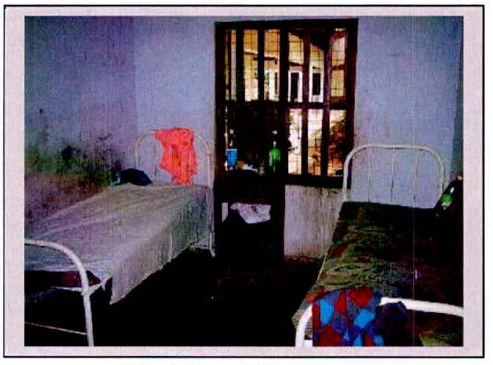
Because of 20 years of violence, service development for persons with severe mental disorders has been severely impaired or destroyed, resulting in the under-provision and fragmentation of mental health services.

War-torn hospital

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

In seven of the nine districts there is no acute inpatient care. There is some follow-up care (through outreach clinics) for patients with severe mental disorder in some divisions, but not in divisions far away from both Jaffna and Batticaloa. Although there have been some efforts to train family health workers (i.e. primary care staff), the majority of primary care staff are still not sufficiently competent to reliably identify mental problems, manage common mental disorders, refer patients when necessary, and provide follow-up mental health care for those with severe problems.

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



Mental health unit

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

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

Rehabilitation unit-gardening

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

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

Hospital visit

Mental health workshop

Recommendations

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

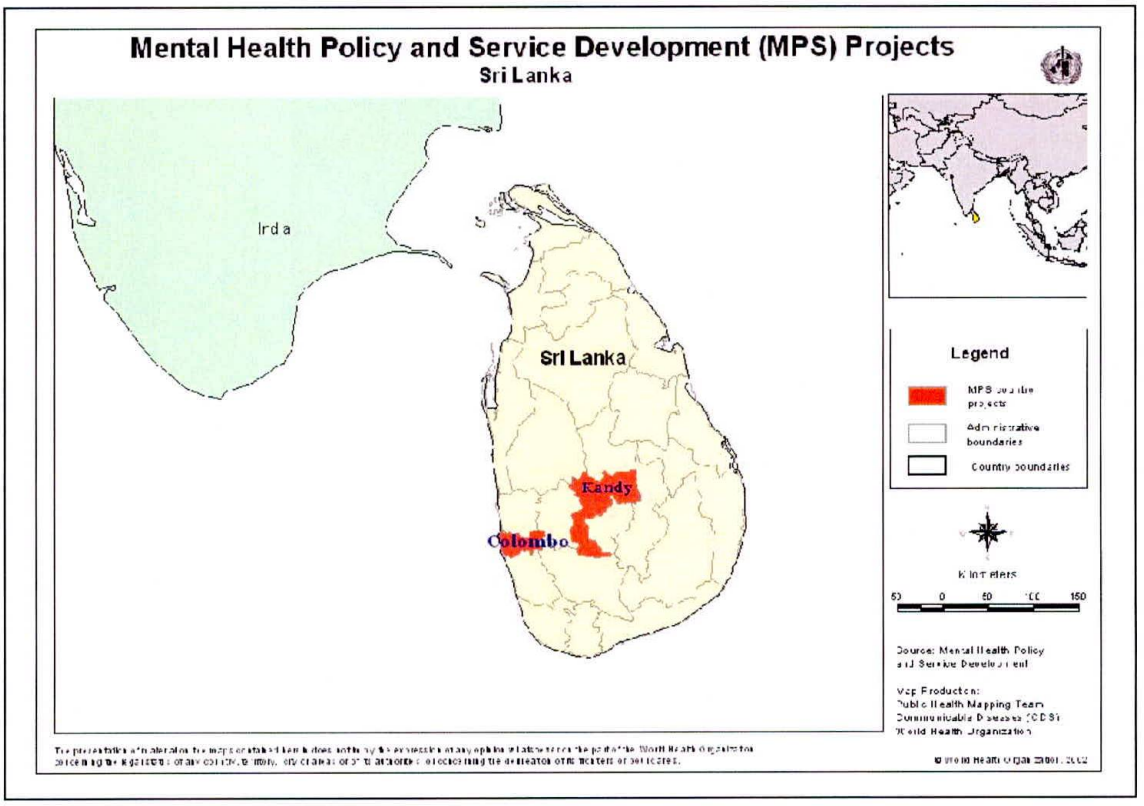
- Giving priority to the development of normal community-based mental health services in Northeast Sri Lanka. The normal mental health system can and should address both severe mental illness and common mental disorders and problems, including trauma-related mental problems.
- Increasing efforts to draw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

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

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

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

Sri Lanka



Project goal

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

Project objectives

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

Implementing institutions

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

Background

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

Health Services

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

Each province has a department of health led by a Provincial Director of Health Services who reports to the Provincial Minister of Health and the Central Ministry. The Provincial Director is responsible for hospitals as well as primary and secondary health care facilities. The provincial Ministry of Health is responsible for policy-making, planning, monitoring, coordination of provincial health activities, procurement of supplies and managerial and technical supervision of divisional health teams.

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

The state of mental health

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

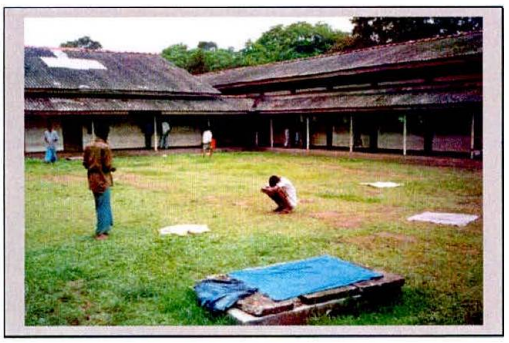
An estimated 70,000 Sri Lankans suffer from schizophrenia. This figure

is expected to rise with the increase in the number of young adults. It is estimated that 5-10% of the population over 65 years of age suffers from dementia. The most recent figures show that the suicide rate in Sri Lanka is 44.6 for men and 16.8 for women. However these figures date back to 1991 (please see WHO website figures at:
http://www.who.int/mental_health/media/en/363.pdf
and
http://www.who.int/mental_health/prevention/suicide/suiciderates/en/

Mental health services

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

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



Psychiatric hospital, Western province

These include, Angoda, which takes new admissions from any part of the country; Mulleriyawa, which is primarily for long-stay female patients; and the mental health hospital at Hendala, for long-stay male patients who have been transferred from Angoda. In addition, a few provincial "Base" (general) hospitals provide outpatient services. The Central, Northern and Southern Provinces have psychiatric units or "Teaching Units" with beds in general hospital settings as well as effective outpatient services. The three psychiatric hospitals as well as the Teaching Units are under the control of the Central Ministry of Health in Colombo.

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

Community mental health team members in Angoda hospital

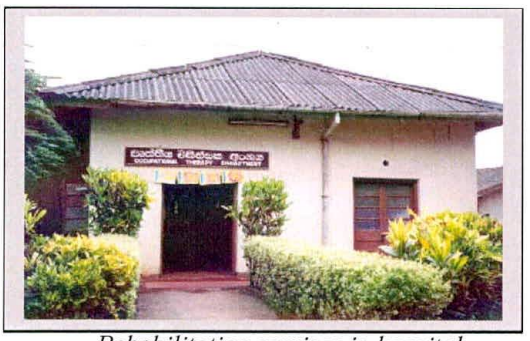
Outpatient clinics are run in most Base hospitals when psychiatrists are available. In order to strengthen mental health services around the country a total of District Medical Officers have been trained and assigned to Base hospitals across the country to run psychiatric clinics. However, not all of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

Doctors are being trained to provide care at Base hospitals

The private sector

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

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



Rehabilitation services in hospital

Ayurvedic services

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

Non-governmental organizations

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

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

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

Project description

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

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

In the Central Province, work has been carried out by an NGO active in the field of mental health and well-being (Nivahana Society of Kandy (NSK)), based in the capital town of the Central Province. This NGO was established in 1985 when a group of concerned individuals, with a shared interest in mental health issues, came together to advocate for improved mental health services within the Province. The director of this NGO is also a consultant psychiatrist at the teaching hospital in the Province. He has been able to engage the Central Provincial Ministry of Health and the Department of Psychiatry of the University of Peradeniya in pursuing the aims of this project.

Central Province

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

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

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

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

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

Establishing community mental health resource centres

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

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

Katugastota Mental Health Resource Centre

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

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

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

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

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

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

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

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

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

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

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

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

Long waiting times at psychiatric clinics

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

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

Western Province, Gampaha District

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

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

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

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

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

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

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

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

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

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

Training of primary health care professionals

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

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

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

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

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

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

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

Mental health education in schools

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

Having 'Open Days' helps to open minds

Providing social service assistance by using a discretionary fund

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

Raising awareness in the community

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

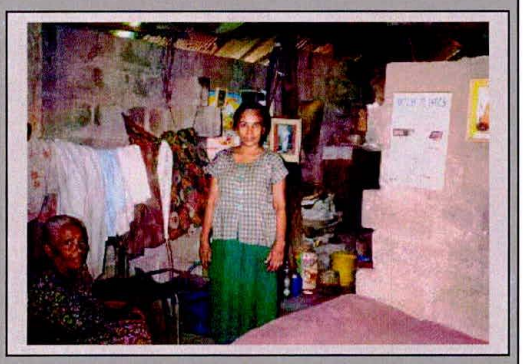
Key Results

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

Rehabilitation in the community: Some success stories

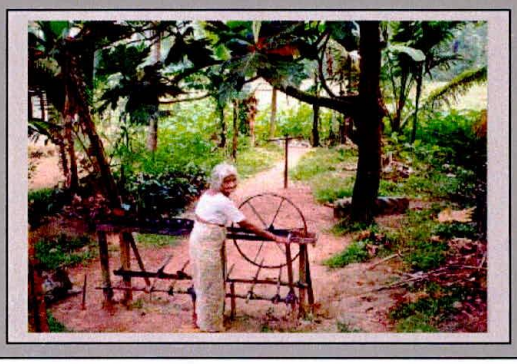
Raj has a history of mental illness that has led to several admissions to psychiatric hospital. He was diagnosed as suffering from schizophrenia and prescribed medication. Although he had been discharged back to his family, he found it difficult to both find and maintain employment because of recurrent bouts of illness. As part of the project for the reintegration of people back into the community, Raj was able to benefit from a programme of support which included help with finding employment. Through negotiation with the manager of the local garment factory where his wife worked, Raj was also able to find gainful employment. In addition, he was given support through home visits that provided both counselling and help in understanding the importance of staying on his medication. At times of crisis, his social worker liaised with his employer and provided additional support. As a result, Raj was able to save money and buy a small house and a plot of land so move his wife and daughter out of the dilapidated house, which they formerly inhabited. He is now able to help support his family financially as well as cultivate a small plot that helps to supplement their basic food supplies. The whole family has benefited from Raj's improved situation. This is a Prime example of how rehabilitation within the community can improve both the quality of life and future prospects not only for individuals, but for their families as well.

Rehabilitation in the community: some success stories

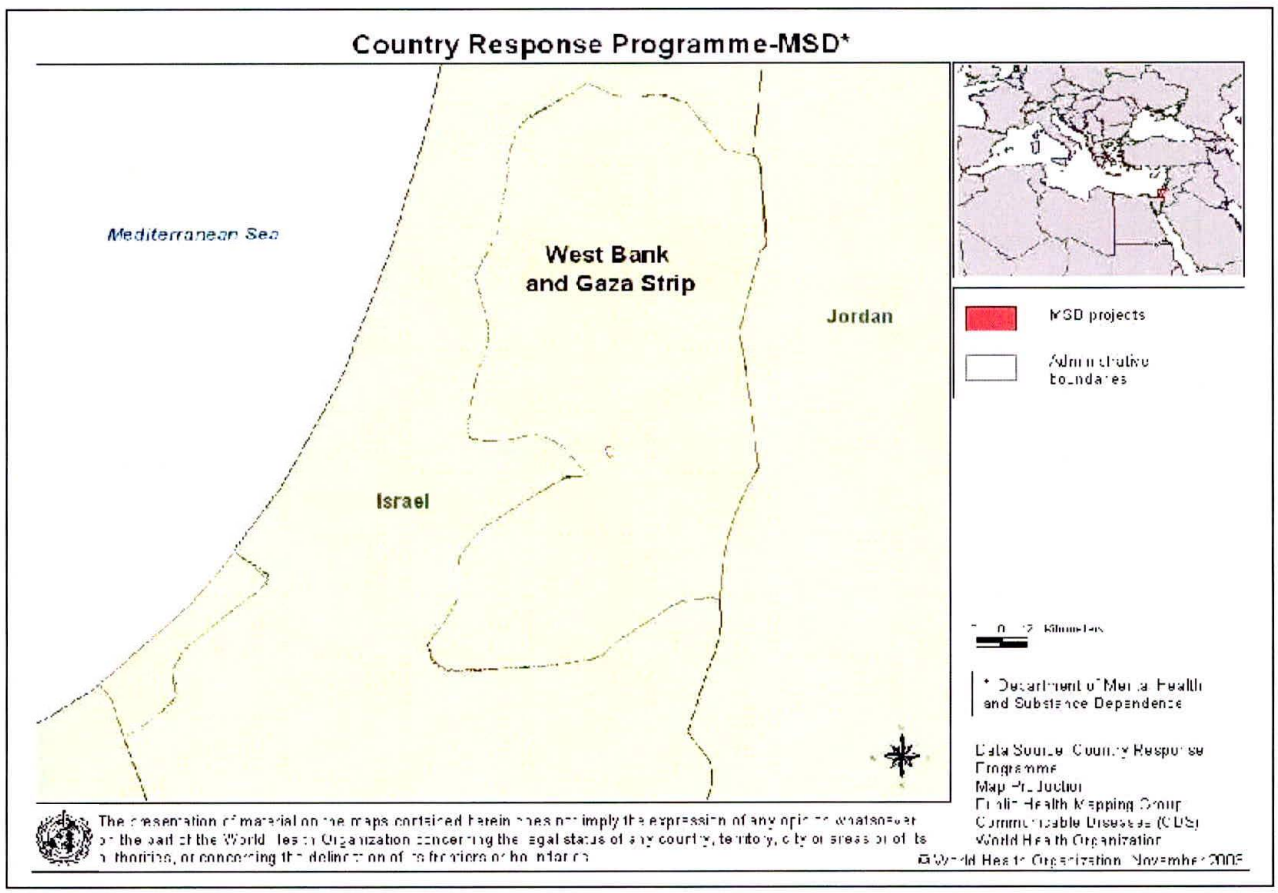


One of the most important ways of helping people in the community after Discharge is to provide a means of employment. By the use of simple technology, such as a weaving machine, items such as rugs and rope can be made for sale in small local markets and thereby supplement the family income. The ability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

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



WEST BANK and GAZA STRIP: improving mental health policy and service delivery



Project objectives

- *To strengthen the expertise of local mental health professionals through training activities and to facilitate international exchange and networking to sensitize local authorities and mental health professionals about international mental health best practices.*
- *To collaborate with the Palestinian Authorities and other significant international cooperation to revise the National Mental Health Plan to ensure the development of coordinated community-oriented services.*

Background

The occupied Palestinian territory (oPt) includes the two geographically separate areas of the West Bank and Gaza. These areas are located between the Mediterranean Coast and the Jordan River. The areas feature several famous cities including Jerusalem, Bethlehem, Hebron, Jericho, Nablus and Gaza.

The West Bank lies within an area of 5800 sq. km west of the River Jordan. It has been under Israeli military control since 1967. Many areas of the West Bank have diversified communities. There are observable differences in the lifestyles and living conditions of the different socio-economic groups, religious affiliations, urban, rural and refugee communities. The population of West Bank is 1.6 million persons (47% urban, 47% rural, and 6% in refugee camps).

The Gaza strip is a narrow piece of land with an area of 360 sq. km, on the coast of the Mediterranean Sea. The area has a dense population mainly concentrated in cities and refugee camps. The main source of income for the Gaza population is employment in Israel, in addition to the export of agricultural products via Israel. The population of Gaza is slightly over one million persons (63% urban, 6% rural, and 31% in refugee camps).

The Palestinian population has lived through several consecutive wars (1948, 1956, 1967), occupation and long periods of unrest. The second of the two *Intifadas* (Uprising of the Palestinian people) started in September 2000. Violence, destruction of agricultural resources, roadblocks and curfews have led to deteriorating economic conditions in the West Bank and Gaza. There are severe restrictions on travel and movement with more than 100 checkpoints throughout the West Bank and Gaza, making travel between many towns and cities extremely difficult. This has had an impact on the ability of people to access health and mental health services.

The state of mental health

In 1997, between the two *Intifadas*, a population-based study (n=585 adults), involving fully structured diagnostic interviews, was carried out among adults in Gaza. Data were collected by the Gaza Community Mental Health Programme (an NGO) and analyzed by a WHO Collaborating Centre. The data show that in the previous 12 months before the interview 10.6% of the adult population met the criteria for the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM-IV) Post traumatic stress disorder (PTSD), 12.3% met criteria for another DSM-IV anxiety disorder, 4.8% met criteria for DSM-IV mood disorder, and 4.8% met criteria for DSM-IV somatoform disorder. (Ivan Komproe, PhD, written communications, 2003). Trauma, loss, and humiliation – experiences that are part of the conflict – are risk factors for mental disorders, and it is thus to be expected that the prevalence of mental disorder has increased since the start of the *Intifada*.

The mental health of Palestinian children and adolescents is of particular concern. Children living in war zones are at high risk of developing emotional problems. In a study conducted during the present *Intifada*, the majority of children exposed to bombardment and home

demolition, reported many emotional symptoms (Thabet et al, 2002)[1].

Mental health services

The Ministry of Health (MoH) of the Palestinian National Authority is the main statutory health provider responsible for supervision, regulation, licensing and control of all health services. Other health providers include the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), military medical services, health services belonging to national and international non-governmental organizations (NGOs) including the Palestinian Red Crescent Society and some private health sector (for profit) organizations.

Overall, service provision is fragmented. The territory has neither a mental health policy nor a comprehensive plan that addresses both ongoing care for the severe mentally ill and services for those affected by the traumas and losses of the conflict. There is no mental health legislation, and no separate budget line for mental health in the Ministry of Health's budget.

Fifteen community mental health clinics are run as part of primary health care services at a frequency of two to six times per week by psychiatrists and nurses without specialist training. There is one mental health clinic for children. Referrals can be made from these clinics to hospitals. Outreach services in most areas are minimal or non-existent.

[1] Thabet AA, Abed Y, Vostanis P. Emotional problems in Palestinian children living in a war zone: a cross-sectional study. *Lancet.* 2002;359:1801-4.

Gaza

The NGO Gaza Community Mental Health Programme runs four community mental health centres in Gaza. Many organizations in the voluntary sector offer counselling as a part of other (non-mental health) services. There is no formal system of referral between the NGO and Government sectors. The Guidance and Training Centre for the Child and the Family (Bethlehem) NGO, runs psychiatric services with a focus on children.

UNRWA Gaza started a prevention programme to respond to the needs of the refugees during the second *Intifada* in May/June 2002. It involves 66 counsellors working in schools, medical centres and community centres in the camps. Activities are at the level of prevention and patients are referred to professionals in mental health when needed. A link with resources in the community has been developed. Counsellors are mainly involved in group counselling with parents, teachers, children and adolescents.

UNICEF provides educational and promotion services and materials for playing, reading, learning and self-expression to children. NGOs and UN agencies (particularly UNICEF) in collaboration with many ministries run short- and long-term courses on counselling, crisis intervention, nursing and social-work in relation to mental health for health professionals, teachers, parents, adolescents, and law enforcement officers.

West Bank

There is a large custodial psychiatric hospital in Bethlehem in the West Bank. It has an occupancy rate of 50-65% partly explained by problems of accessibility due to restrictions on

mobility. The average stay for non-chronic patients is 5-8 months. About 100 out of 180 patients are chronic, long-stay patients, and their well-being in the hospital is of human rights concern. The hospital in Bethlehem absorbs the majority of resources dedicated to mental health.

Overall, the mental health services in the West Bank and Gaza are fragmented. Donors and NGOs spend millions of dollars every year on psychosocial/mental health activities. However, the mental health system in most areas is not able to provide: (a) rational treatment in primary health care of common mental problems (mood and anxiety disorders, including trauma-induced problems); (b) care in the community for chronic patients with severe mental disorders, and; (c) quality psychological support in the school system for children and adolescents who are faced with trauma and other loss during the conflict.

To address these and other issues, the WHO has initiated a project aimed at improving mental health policy and services organization planning in the West Bank and Gaza. The project was conceptualised on the basis of a May 2001 fact-finding mission by the Director of the Department of Mental Health and Substance Abuse.

Project description

To date various, interlinked activities have been undertaken as indicated below.

Training in Trieste for Palestinian mental health professionals

WHO organized a five-month training course of five Palestinian mental health professionals in Trieste, Italy, which ended in February 2003.

The provision of mental health care in Trieste is organized and delivered through different services and structures, each of which constituted a basis for the training. The central point for service delivery is the mental health centre, which is open 24 hours a day, seven days per week and responsible for a catchment area covering 60,000 persons.

Trainees acquired meaningful knowledge and experience on the organization of services and on the practical functioning of a fully community-based mental health system. Each trainee had a professional, personal tutor. Regular meetings were held to have theoretical discussions, and in collaboration with the Training Programs Office, to evaluate the needs for further training.

The clinical knowledge provided included; (a) the ability to manage cases, taking into account the specific contextual background of each service user; (b) crisis management skills, and; (c) the ability to create comprehensive, personalised treatment programmes for the service user (biological, psychological and social interventions). Trainees were exposed to all activities of the mental health service, including housing for people with severe psychiatric disability, vocational training, and employment generation. Trainees also participated in special programmes focusing on subpopulations at risk and were involved in ongoing work with general hospitals, primary care settings and prisons.

The Palestinian mental health professionals all had the opportunity to become familiar with the operational aspects of different structures of the Trieste Mental Health Department. They were also able to better

understand the importance of different professional roles in multidisciplinary teams and had the opportunity to experiment through collaboration with their tutors and other Trieste staff. This was done through training in case management and by means of direct contact with users, their network and the general system of social support. During 12 seminars organized for the trainees, they had also the chance to learn the theoretical aspects of the transformation from a hospital-centred organization to a community-based system.

In addition to the aforementioned training, a second group of Palestinians visited Trieste in January 2004. This was a one-week visit by senior Palestinian mental health decision-makers. The visit helped these senior officials become aware of alternative ways of managing the severe mentally ill. The Trieste model (a fully community-based model) is a good example of how a cost-effective, high quality, psychiatric service can be successfully provided after a process of deinstitutionalization of a custodial psychiatric hospital. It has been WHO's experience that one of the most effective ways to convince decision-makers about the value of and need to develop community mental health care, is to introduce them *in vivo* to a high quality community service, such as the one in Trieste.

An Arabic translation of the WHO document, 'Mental Health in Emergencies: Mental and Social Aspects of Health of Populations Exposed to Extreme Stressors'

WHO receives frequent requests to advise on strategies to assist populations exposed to emergencies. There is broad consensus that emergencies can severely disrupt ongoing formal or informal care for persons with pre-existing disorders and that exposure to extreme stressors and losses is a risk factor for subsequent social and mental health problems, including common disorders. A range of principles and intervention strategies that have wide support from experts, can be tailored to apply to the local context, needs and resources. WHO has prepared a brief document outlining advice on principles and intervention strategies for populations exposed to extreme stressors. This document has become the basis for the first-time inclusion of a mental and social health section in the *'2004 Sphere Handbook'*. Because of the relevance of the document to the Palestinian context, and on specific request of local organizations, WHO translated, printed, and disseminated an Arabic version of the document. This publication shows how needed social and mental health interventions in and after emergencies can be integrated in one framework that is consistent with the development of normal community mental health services. Indeed, access to mental health care in general health services is a key mental health provision strategy both in times of peace and during war.

Mapping of mental health resources for the West Bank and Gaza

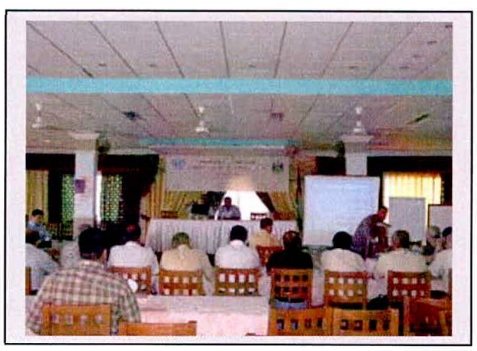
There are numerous NGOs and people in Gaza and the West Bank involved in the provision of mental health and psychosocial services. Many of them provide a vertical service for a narrow target group of beneficiaries. These organizations exist in the absence of an adequate general mental health care system to refer cases that are beyond their mandate or capacity. NGOs typically employ staff who can potentially contribute to a general mental health care system, especially in the area of training. Capable NGOs are also able to accept referrals from

the general mental health care system and can therefore be regarded as a valuable resource.

It is WHO's experience that it is important to make a map of available services. Such mapping can then inform service organization plans. The Institute for Community and Public Health, Birzeit University has conducted the study 'Psycho-Social/Mental Health Care in the West Bank: the Embryonic System'. This study is a careful mapping of mental health resources in the West Bank. WHO has contracted the University to replicate the study in Gaza and to publish the results of the studies in Gaza and the West Bank. The resulting report (expected in May 2004) will greatly facilitate the use of valuable NGO resources in the development of general mental health services.

A mental health plan for the West Bank and Gaza

The Department has supported the development of a Palestinian mental health plan (endorsed by the Minister of Health in February 2004).

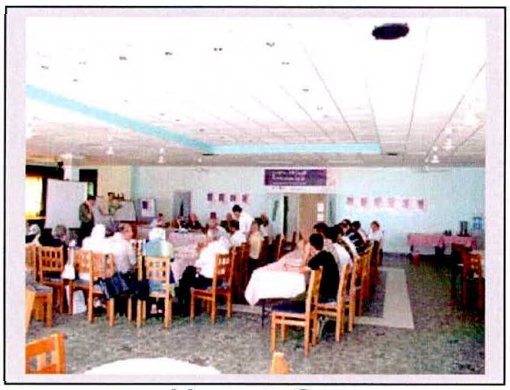


Meeting in Gaza

Stakeholder meetings

To build a good mental health plan, it was crucial to engage and listen to a wide range of stakeholders that have a role to play in the implementation of the plan.

To this end, two stakeholder meetings were organized in July by staff of the WHO Jerusalem Office in collaboration with the WHO Department of Mental Health and Substance Abuse. The Department both funded the meetings and chose a number of international consultants to participate and give guidance.



Meeting in Gaza

The first meeting was held in Gaza and the second in the West Bank (Ramallah). These meetings – under the slogan '*Mental health for all*' - were attended by a wide range of Palestinian mental health and public health employees and by representatives of the UN and NGO communities. Despite severe problems in freedom of movement (roadblocks, curfews, etc), attendance was very good. There were 60 participants in Gaza and 85 in the West Bank, representing:

- Mental hospitals in Bethlehem and Gaza City;
- Ministry of Health-run Community Mental Health Centres throughout the West Bank and Gaza;

- Ministry of Health primary health care system;
- UN organizations-UNICEF, UNRWA;
- Officials from the Ministry of Health, the Ministry of Social Affairs and the Ministry of Planning;
- Key local and international NGOs.

During the meetings, international experts ran intensive group-work sessions with the participants to gather as much input from the field as possible on service organization needs.

Meeting in Ramallah

Substantial and concrete feedback from the various stakeholders informed the first draft of the mental health plan (see next section).

Appointment of a steering committee

The mental health plan was developed by a Palestinian Steering Committee for Mental Health. The Steering Committee was appointed in early 2003 by the Ministry of Health, in consultation with WHO. Members of the Steering Committee include Directors of Primary Health Care in the Ministry of Health (West Bank and Gaza), the Directors of Community Mental Health in the Ministry of Health (West Bank and Gaza), representatives of key NGOs, as well as representatives of the French and Italian Cooperation, WHO functions as Secretariat.

As requested by the health authorities, WHO facilitated the development of a plan describing the (re)organization of mental health services in the West Bank and Gaza. The plan provides guidance to the Ministry of Health on how to advise national and international organizations, as well as donors, in building a well-coordinated community-based mental health system. In addition to providing a practical strategy for psychiatric reform, one of the benefits of such a plan is that it substantially reduces fragmentation, duplication of projects and wastage of resources. WHO therefore made a technical agreement with the Ministry of Health, the Consulate General of France - French Cooperation, and the Consulate General of Italy - Italian Cooperation to ensure that there will be ongoing institutional consultation and collaboration throughout the development and implementation phases of the plan. This is important because the French and Italian governments as well as WHO Jerusalem have generated substantial resources (*circa* 3.5 million dollars) to establish community mental health services and the three projects are being coordinated and run jointly.

WHO has supported the Steering Committee in developing the mental health plan as follows:

- providing scientific justification to reshape services;
- guiding the planning process;
- providing guidelines, protocols and standards;
- supporting the collection and analysis of information on existing services (see above);

- contracting consultants/temporary advisers to provide technical assistance in the field;
- convening meetings.

With respect to the latter, the organization of meetings was challenging. Because of road blocks, curfews, and travel authorizations, Palestinians from the West Bank and Gaza were unable to meet each other. These obstacles were overcome through videoconferencing and meeting abroad.

The final version of the plan was submitted to the Minister of Health in January 2004. The Minister signed and approved the plan in February 2004 during a ceremony at the Ministry of Health. Representatives of the Italian and French Cooperation and the WHO Office in Jerusalem also signed the plan.

The project demonstrates that despite the ongoing emergency and fragmented situation in the area, it is possible to plan community mental health services for the severe mentally ill as well as primary health care for those with common mental disorders, including problems induced by trauma. The plan provides the framework for the development of services by national and international organizations that are present in the West Bank and Gaza. The Ministry of Health, the WHO Office in Jerusalem, and the Italian and French Cooperation, and major Palestinian NGOs are presently working together to implement the plan.

Meeting in Ramallah

Signing of the Mental Health Plan for the West Bank and Gaza by the Palestinian Minister of Health