Mapping Study on the Capacity and Work Experience of Counselling Officers/Assistants Attached to the Ministries of Social Services and Child Development and Women's Affairs

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Mapping Study on the Capacity and Work Experience of Counselling Officers/Assistants attached to the Ministries of Social Services and Child Development and Women's Affairs

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Abbreviations

ADS Assistant Divisional/District Secretary

CA Counselling Assistant

CO Counselling Officer

CMHRC Community Mental Health Resource Centres

CRPO Child Rights Promotion Officer

DS Divisional Secretary

Dis Sec District Secretary

DipC Diploma in Counselling

GIS Geographic information system

HDipC Higher Diploma in Counselling

IHP Institute for Health Policy

MHU Mental Health unit

MSS Ministry of Social Services

MCDWA Ministry of Child Development and Women's Affairs

MOH Medical Officer of Health

NGO Non-Government Organisation

NISD National Institute of Social Development

PO Probation Officer

SLQF Sri Lanka Qualification Framework

The Foundation The Asia Foundation

TSC Technical Support Committee

TOR terms of reference

RO Research Officers

SSO Social Service Officer

Acknowledgements

The Asia Foundation would like to acknowledge the dedication and support of several individuals and institutions that made this publication a reality. The study was commissioned in 2013 by The Asia Foundation's Mental Health and Psychosocial Support (MHPSS) Program, on behalf of the then Ministry of Social Services[1] with the generous financial support of the United States Agency for International Development (USAID). The Foundation would like to express its sincere thanks to the following individuals and institutions for their support;

The Ministry of Social Services, for the cooperation and input provided by the Secretary, the Additional Secretary and key Ministry staff in carrying out the Study.

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The Institute for Health Policy, whose team designed, developed and conducted the study with the close collaboration of the **Good Practice Group.** The IHP led research team comprised of,

- Dr. Reggie Perera- Senior Fellow, IHP
- Dr. Shanti Dalpatadu- Senior Fellow, IHP
- Ananda Galappatti- Medical Anthropologist and Director (Strategy), GPG
- Nilanga Abeysinghe- Psychologist and Associate, GPG
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- Chamara Anuranga - Research Officer, IHP
- Prashantha Bhagya Bandara Senarathne, Adikari Pathirannahalage Dilini Madushani Adikari and Tharshana Kugadas – Interns, IHP

The final report of the study, on which this publication is based, was compiled by IHP.

Dinesha deSilva Wikramanayake
Country Representative- The Asia Foundation
May 2015

1 Presently the Ministry of Social Services, Welfare and Livestock Development.
2 Presently the Ministry of Women's Affairs.

Key Messages

- The Counselling Assistants, a fledgling cadre in public service, are a visible and acceptable psychosocial support mechanism in the community.
- There is a need to clarify and define the strategic role of CAs in responding to psychosocial problems at a local level, especially in relation to specific issues and in relation to other existing service providers.
- There is a need to clarify the roles and coordinating mechanisms between the different parallel services in relation to issues relevant to counselling and psychosocial support.
- A systematic technical supervision and support mechanism is needed to maintain quality of service, support management of challenging cases and further develop skills of CAs.
- In-service training and technical support to CAs in implementing evidence-supported interventions for common psychosocial problems is also needed.
- The CAs are satisfied with the counselling role and enjoy their work. However, due to visible risks of 'burn-out' inherent in this area of work, there is a need to establish a systematic mechanism for personal support.
- The infrastructure and administrative needs of the hour are counselling rooms, transport facilities, computer facilities with internet access, access to technical resources, awareness creation among higher level officers to the work of CAs and establishment of a career ladder.
- The service deals inter alia with patients with medical conditions and may necessitate regulation by the Sri Lanka Medical Council. A suitable amendment may be necessary to the Medical Ordinance for the purpose. The role of CAs in relation to persons with medical conditions must be defined clearly.
- A national policy regarding counselling and psychosocial support and a service minute for the service is a priority.
- The COs and CAs must be linked to an appropriate professional body for ongoing professional advancement and maintenance of standards.

Executive Summary

An important objective of the Ministry of Social Services (MSS) is coordination and provision of Counselling Services. The Diploma in Counselling conducted by the National Institute of Social Development (NISD) commenced in 2001 to inter alia, equip Counselling Assistants (CAs) / Officers (COs) for the role. As a part of this, the NISD collaborated with The Asia Foundation (the Foundation) to revise the Diploma in Counselling and develop a Higher Diploma in counselling to further equip practitioners with skills to meet the current needs of the clients.

The main objective of this study is to map the capacity and work of 96 CAs attached to the MSS and seven COs attached to the Ministry of Child Development and Women's Affairs (MCDWA), across the nine Provinces. This is a collaborative effort by the MSS, MCDWA, NISD, the Institute for Health Policy (IHP) and the Foundation. The study was steered by a Technical Support Committee (TSC) consisting of key representatives from each stakeholder. The overall sampling frame was the entire 103 counselling staff.

A three-step methodology which triangulated quantitative and qualitative aspects of the study was followed. Step I was Preliminary data collection by advance pre- tested, self-administered questionnaire in Sinhala and Tamil. Step II was in-depth site visits to a purposive sample of 10 CAs. Step III consisted of focus group discussions to clarify and further study data in self-reported questionnaire and in-depth site visits.

Ethical clearance was given by the in-house IHP ethics review committee. Informed consent was obtained from respondents, and all responses to postal survey, and during interviews or focus group discussions were anonymized before reporting.

The response rate for the self-administered postal survey was 79.6%. Highlights of the demographic characteristics, qualifications, service environment, and functions performed by CAs in the community as well as their aspirations for continuing professional development are outlined in this report. A user-friendly GIS map which can be accessed at *http://bit.ly/17Kk3Ey,* reveals that there are vast geographical areas in the country without coverage by CAs. There is a majority of women in this young cohort, whose periods of experience (mean and maximum) is similar to the men. Over 60% have more than one working place and more than one supervisor. The immediate supervisor (Divisional Secretary) is sought predominantly for technical guidance and emotional support. The mean population served by a single CA is 132,642 and the maximum, 1,600,910. English language skills are uniformly good—around 60%. About 10% show all round proficiency in all three languages.

Counselling Assistants are utilized by both the public and other services for support in relation to a wide range of psychosocial problems, with counselling provided for 428 problems and 93 awareness raising workshops, 17 networking activities and 26 psychosocial activities reported by the 82 survey respondents for the week of May 27-31, 2013. Based on a sample of 428 problems dealt with by the CAs during the same week, the most common problems were marital and family problems (41.4%), educational problems (13.8%), and mental disorders and psychological problems (11%) although there are also overlaps with others such as suicide (2.6%), substance abuse (3.3%) and economic or job related problems (3.5%).

Although the diversity and complexity of problems dealt with by CAs often exceeds the initial training they have received prior to recruitment, through self-study and access to ad hoc or supplementary training, the CAs have sought to improve their skills and knowledge in order to serve their clients. There is a lack of ongoing formal systematic support for CAs but they have sought to mitigate this through informal arrangements amongst themselves and contact with other resource persons. Administrative supervisors and peers at a local level are largely supportive of CAs and appear to be appreciative of their work, even if they do not always understand it well.

The role of CAs, however, goes beyond provision of counselling alone – since they are involved in a range of psychosocial interventions, especially in community-level programs related to common psychosocial issues. Even in responding to the needs of individual clients, they often have to go beyond a strict counselling role – for example in the context of persons with mental disorders, as there is a shortage of psychiatric social workers. It is clear that their education and training has not formally equipped them for these roles, and it is uncertain whether the informal skills and knowledge acquired by individual counsellors has adequately filled this gap consistently for all CAs. However, it is clear that CAs are serious about their professional development and are investing in this considerably on their own.

At the level of the overall service of CAs, there is a lack of a broad strategic vision on how the CAs' contributions to addressing psychosocial problems in the community can be maximized. The arrangements for CAs work vary across locations, with activities and collaborations apparently determined by opportunities and initiative on the part of the CA, his/her supervisor and other relevant institutions and staff (i.e. mental health services, government community services, courts, etc.). It is very clear that CAs cannot meet the volume of psychosocial needs of the large populations that they are assigned to serve, and their current approach of combining a couple of days with a counselling focus and the remainder of their time on what might be described as promotional or preventative public programmes is an on-the-ground response to this challenge. Clear direction around the

balance between responding to individual cases and community-level interventions, as well as prioritization of particular areas of work, would benefit both CAs and the populations they serve. This will also help define the specific competencies and knowledge that CAs should develop in each area, with implications for pre-service and in-service training content and approaches.

CAs are largely satisfied with their counselling and psychosocial work. However, the content of this work is stressful and distressing at times, and they feel the absence of a support mechanism to sustain them both professionally and personally. There are warning signs visible for 'burn out' of CAs if this is not provided, which will likely have negative consequences for the individual CAs and also their clients. It is necessary to recognize that this area of work carries an inherent risk of psychosocial impacts on workers, and this needs to be addressed in both pre-service and in-service training and most importantly in the systems for managing CAs in the field.

CAs also expressed a need for a framework for professional advancement, within their current post/role and more broadly within the field of counselling and psychosocial work. In light of issues of 'burn out' it is worth considering the need for options of lateral movement away from direct support work, where CAs are unable to continue effectively in this role. The CAs also identified a need for greater recognition vis-a-vis other officers working at the DS level, and expressed a dissatisfaction with their 'assistant' title.

There are several practical challenges that most CAs experience in their daily work, most importantly the lack of access to a private room for counselling sessions and limited transport facilities to enable them to access community-settings. Overall, the study reveals that the CAs actively deal with many serious psychosocial problems at a community level and, they are committed to their own professional development and improvement of the services they provide. The issues identified by the study also provides an opportunity to develop systems that support the CAs professionally and personally and maximize their contribution to improve the psychosocial wellbeing of individuals and groups in the communities they serve.

CHAPTER

1 The Background

The National Institute for Social Development (NISD) was established by an Act of Parliament in 1992, and holds as its mandate "to enhance human resources for social development through the preparation of competent manpower in social work at all levels, generate and disseminate new knowledge and technologies for social work practice, provide specialized services for social welfare and social development." In line with this mission, the Sri Lanka School of Social Work, a division of the NISD, conducts a two year Diploma programme in Social Work, a four year Bachelor's degree programme in Social Work and a two year Master of Social Work degree programme. To complement this work, a Diploma in Counselling was first introduced in 2001 by the Training Division of the NISD, as an 18 month training programme conducted mainly over the weekends.

The Diploma programme consists of eight course units and one field practicum unit. During the first semester of first year, the course covers modules titled General psychology, Development Psychology, Social Psychology and Psychology of Abnormal Behaviour and during the second semester modules on Counselling Theories, Counselling Techniques, Counselling Treatment Planning and Counselling Skills Development are offered. The field practicum is offered over a six month period in the second year. According to a 2012 review, the eight course units contain 288 hours of lectures (19 credits) and the field practicum contains 144 hours of field work (three credits) totalling 21 credits, which is less than the 30 credits required for a National Diploma according to Sri Lanka Qualifications Framework (SLQF) standards of the Ministry of Higher Education. The diploma reflects standard NVQL5 specified in the Sri Lanka Qualifications Framework.

In order to address this, the NISD collaborated with The Asia Foundation to revise the curriculum at the Diploma level to meet the SLQF standards. The revised curricula with 30 credits was launched in February 2013 and the NISD, also with the Foundation's support, for the first time developed a Higher Diploma in Counselling (HDipC), to further equip practitioners with skills to meet the current needs of the clients.[3]

The CAs and COs, government cadres mandated with providing counselling support to adults and children with psychosocial problems, were identified as an important and appropriate target group that may benefit by obtaining the HDipC. Prior to the development of the curriculum, it is important to identify the needs of the CAs as expressed by them.

3 At the time of the publication, the Higher Diploma curriculum has been successfully completed and is offered at the NISD. The study findings fed into to the development of the curriculum.

A mapping study on their capacity, work and skills further needed was therefore proposed. The current duty list of COs / CAs is included in Annexure I.

NB: The difference between COs and CAs seems to be based on their location and not the duties. The former are based at the district level, either in the District Secretariat or at counselling centres while the latter are based in the Divisional level, in the Divisional Secretariats. COs are seven in number as against 100 CAs. For the purpose of the study, both categories will be referred to as CAs.

CHAPTER

2 Objective

The main objective is to conduct a mapping study on the capacity and work of the CAs attached to MSS and MCDWA. This is a collaborative effort by the MSS, MCDWA, NISD, IHP and the Foundation. The mapping exercise concentrates on:

a) Mapping where the CAs are based

b) Identifying the type of clients they see

c) Identifying the common problems that the majority of clients have

d) Identifying how and when awareness programs are conducted by the CAs

e) Identifying the supervision structure available for the CAs

f) Recommendations for improving the services of the CAs

CHAPTER 3

Methodology

The study was steered by a Technical Support Committee (TSC) consisting of:

- Director General, National Institute of Social Development
- Additional Secretaries, Ministries of Child Development and Women's Affairs and Social Services
- Academic Advisor, NISD
- Representatives of the Women's Bureau of Sri Lanka, NISD, IHP and the Foundation

The overall sampling frame was 103 COs/CAs of both Ministries spread over all nine Provinces (the four CAs attached to the MSS in Colombo were excluded as they do not perform the same functions). IHP followed a three step methodology which triangulated quantitative and qualitative aspects of the study:

Step I. Preliminary data collection by advance pre tested, self-administered questionnaire in Sinhala and Tamil, developed by the IHP team and posted under registered cover (Annexure II). All 103 CAs were studied for:

- Mapping out where they are based, their demographic characteristics
- Supervision structure, support mechanism, etc.
- Identifying the type of clients they see
- Identifying the common problems the majority of clients have
- Identifying additional skills necessary to perform their functions

This quantitative data-gathering tool was posted to the CAs along with covering letters from the Secretaries of both Ministries stating that the tool is for a collaborative project and requesting the CAs' cooperation. Follow up was done by telephone by Dr. Reggie Perera. The subsequent steps constituted the qualitative component of the study.

Step II. In-depth site visits were undertaken by two psychologists and one psychosocial practitioner in the research team to study an approximate 10% (ten in number) purposive sample of CAs from four crucial provinces to ensure coverage of different needs of clients in diverse geographical areas. The four provinces selected for the purposive sample were,

the Northern Province (focus on Vavuniya – two CAs), the Eastern Province (focus on Batticaloa – two CAs), the Central Province and the Southern Province – three CAs each.

Step III. Focus group discussions to clarify and further study data in self-reported questionnaire and in-depth site visits.

Access 2007 version was used for data entry and STATA version 2012 was used for data analysis.

Limitations in resources/ time constraints did not permit the research team to sample more CAs for in depth study, conduct key informant interviews of clients, supervisors and other categories of staff collaborating with CAs, which would have provided rich insights. The short time-frame for data collection, and limited direct contact with CAs placed constraints on the depth of data collected and verification of reported responses. However, efforts were made to address these limitations through inclusion of in-depth interviews and FGDs and by including all CAs in the study—although the participation rate was fractionally under 80%.

Ethical Considerations - Ethical clearance was received for the study by the IHP ethics review committee. Informed consent was obtained from respondents. The study was designed to prevent compromising the privacy of the CAs and their clients.

CHAPTER 4

Results of Self-Administered Questionnaire

The response rate for the self-administered postal survey was 79.6% (82 /103), which is considered very good for a postal survey. The following tables, charts and graphs highlight the profile of CAs, their service environment, roles in the community and their aspirations relating to continuing professional development.

CA's Profile

Figure 1: Distribution of respondents by age group and sex, 2013

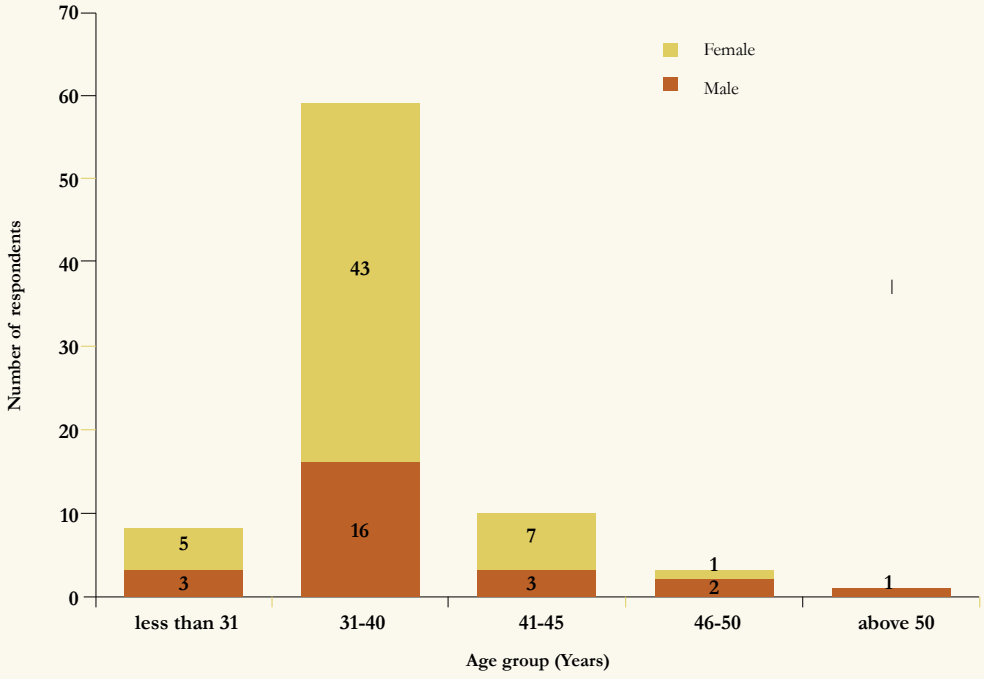


Table 1: Distribution of Counselling Assistant's by age and sex, 2013

Age group	Male	Female	All
27	0	1	1
28	0	2	2
29	1	1	2
30	2	1	3
31	1	0	1
32	0	2	2
33	1	12	13
34	3	3	6
35	2	6	8
36	0	5	5
37	3	3	6
38	1	4	5
39	0	4	4
40	5	4	9
41	1	3	4
42	2	3	5
43	0	1	1
46	2	0	2
48	0	1	1
51	0	1	1
Missing	1	0	1
All	25	57	82

Table 2: The mean, median and modal distributions of age

	Age		
Sex	Mean	Median	Mode
Male	37.1	37	40
Female	36.2	36	33
All	36.5	36	33

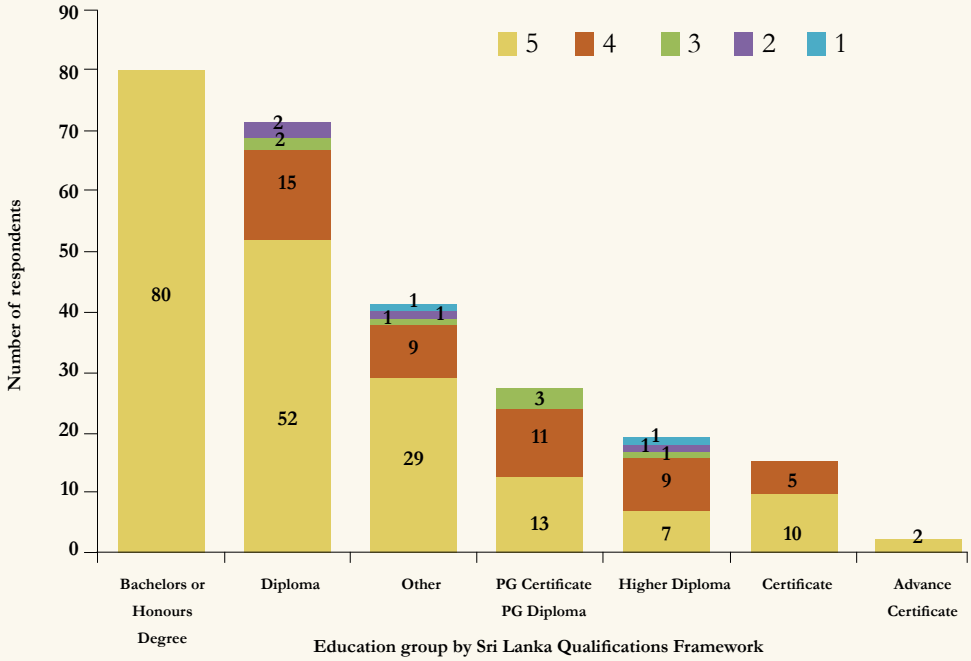
The age ranges from 27 to 51. There is a majority of women (70%) and the cohort is young, with the modal age being 33 years.

Professional Qualifications

Table 3: Professional qualifications, 2013

Category	One	Two	Three	Four	Five	Total
Honours/Bachelor's Degree	80	0	0	0	0	80
Diplomas	52	15	2	2	0	71
Other	29	9	1	1	1	41
PG Certificate, PG Diploma	13	11	3	0	0	27
Higher Diploma	7	9	1	1	1	19
Certificate	10	5	0	0	0	15
Advanced Certificate	2	0	0	0	0	2

Figure 2: Distribution of respondents by professional qualification, 2013



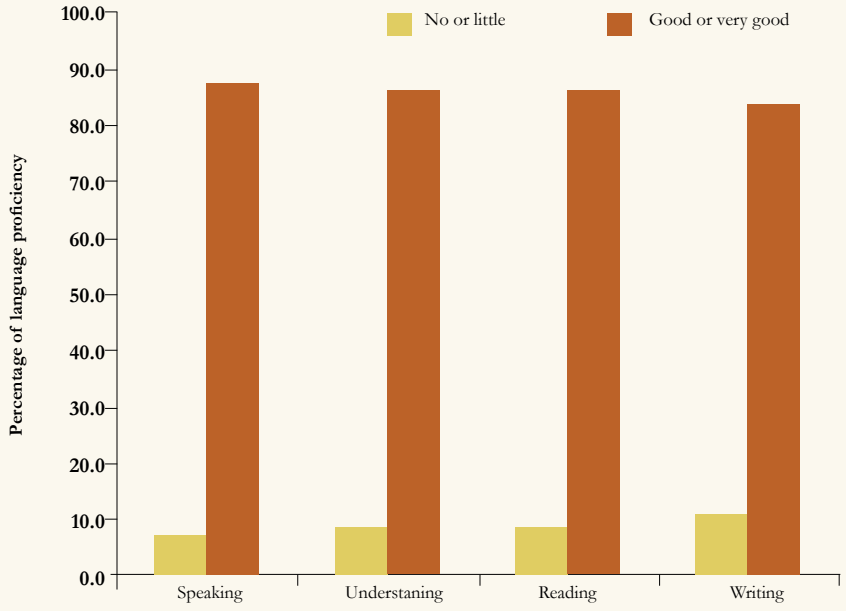
The CAs possess multiple professional qualifications ranging from one to five in each category, reflecting high motivation for acquiring professional knowledge and skills. Nineteen reported higher diplomas.

Language Proficiency

Table 4: Sinhala language skills of CAs (percentage)

Proficiency	Speaking	Understanding	Reading	Writing
No	4.9	3.7	4.9	4.9
Little	2.4	4.9	3.7	6.1
Good	13.4	9.8	9.8	12.2
Very good	74.4	76.8	76.8	72
No response	4.9	4.9	4.9	4.9
All	100	100	100	100

Figure 3: Sinhala language proficiency of CAs, 2013

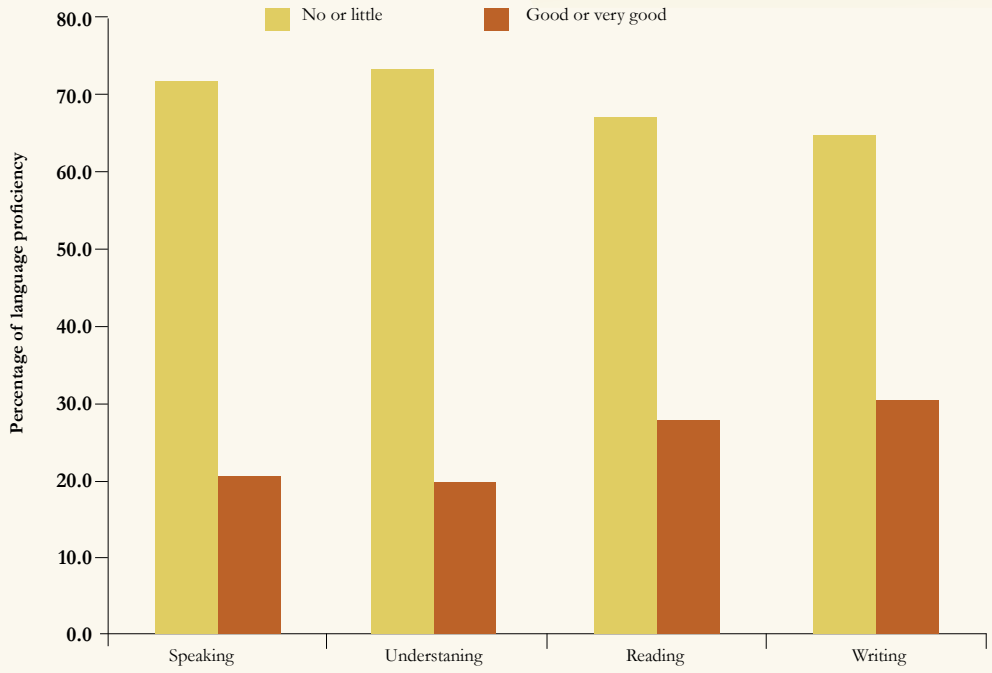


Over 85 % are very proficient in spoken Sinhala, possibly reflecting the fact that most of the CAs are of Sinhala ethnicity.

Table 5: Tamil language skills of CAs (percentage)

Proficiency	Speaking	Understanding	Reading	Writing
No	46.3	36.6	43.9	39
Little	25.6	36.6	23.2	25.6
Good	3.7	3.7	11	13.4
Very good	17.1	15.9	17.1	17.1
No response	7.3	7.3	4.9	4.9
All	100	100	100	100

Figure 4: Tamil language proficiency of CAs, 2013

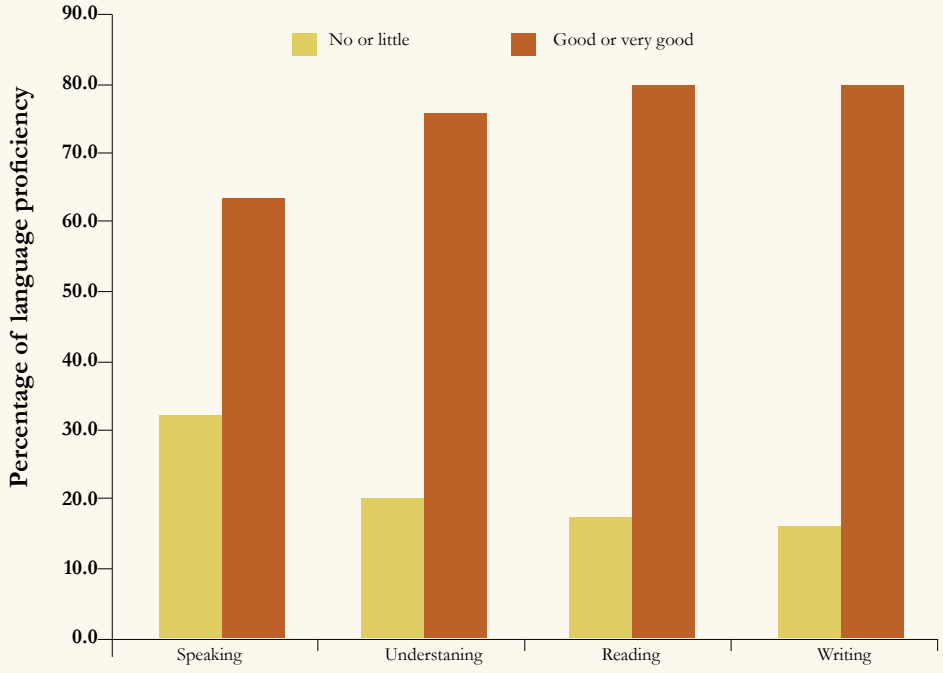


Tamil language skills are limited, with fewer than 21% proficient in spoken Tamil. This is also reflective of the fact that the majority of CAs are of Sinhala ethnicity. This may cause difficulties in addressing problems of Tamil speaking clients in areas where there is no Tamil speaking CA.

Table 6: English language skills of CAs (percentage)

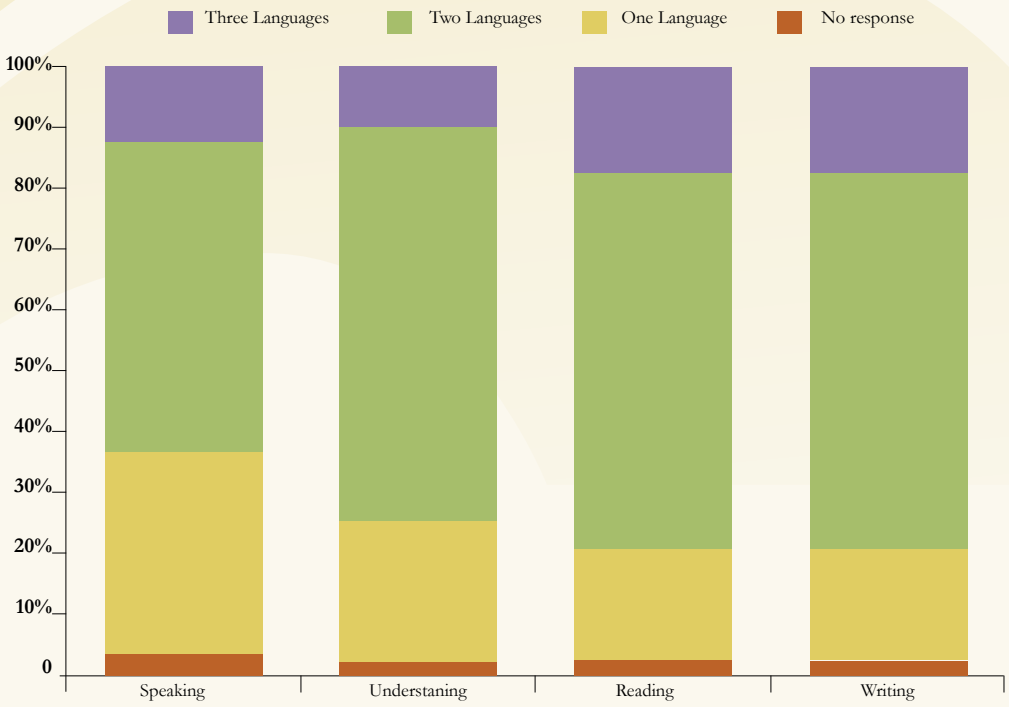
Proficiency	Speaking	Understanding	Reading	Writing
No	2.4	-	-	-
Little	29.3	20.7	17.1	15.9
Good	57.3	59.8	58.5	63.4
Very good	6.1	15.9	20.7	15.9
No response	4.9	3.7	3.7	4.9
All	100	100	100	100

Figure 5: English language proficiency of CAs, 2013



The English language skills are relatively good – with above 60% across all areas. The proficiency enables English to be used for continuing professional development and advancement for the CAs, and may suggest value in upgrading the English language skills of other CAs in order to enable them to access relevant learning content in the English medium.

Figure 6: Composite picture of language proficiency



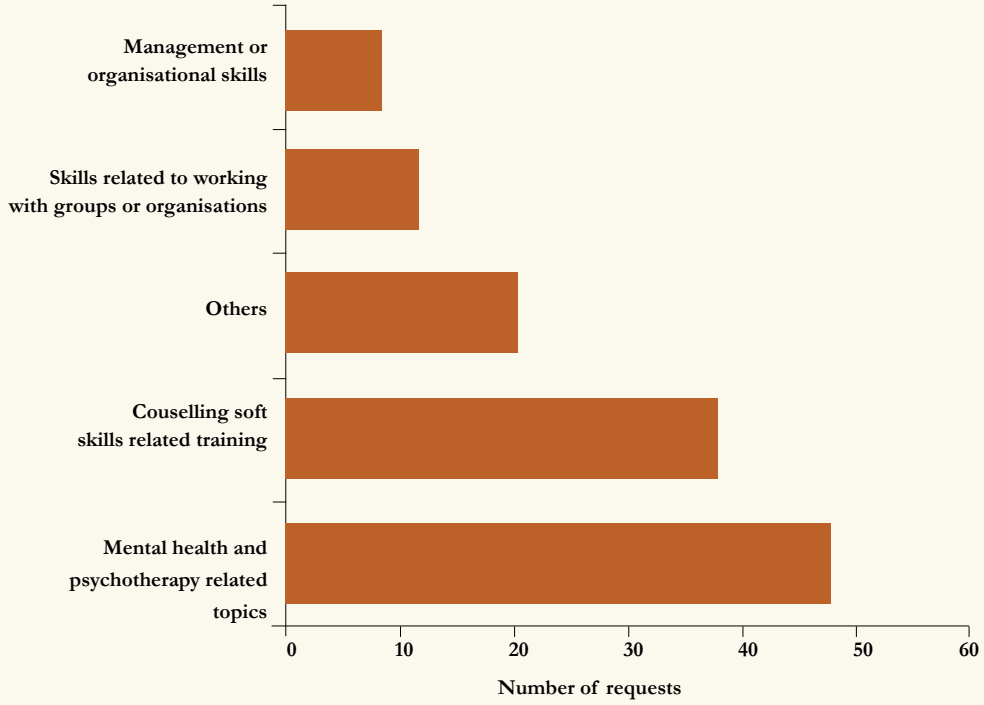
About 10% show all round proficiency in all three languages

Suggested Areas for Continuing Professional Development for Better Service Delivery

Table 7: Suggested areas for continuing professional development

Category	Number
Mental health and psychotherapy related topics	48
Counselling soft skills related training	38
Others	20
Skills related to working with groups or organisations	12
Management or organisational skills	8

Figure 7: Suggested areas for continuing professional development



It is worth noting that while the areas suggested by CAs relate primarily to clinical psychology and counselling-related knowledge and skills, there were limited requests for training related to psychosocial interventions that form a significant part of their actual work.

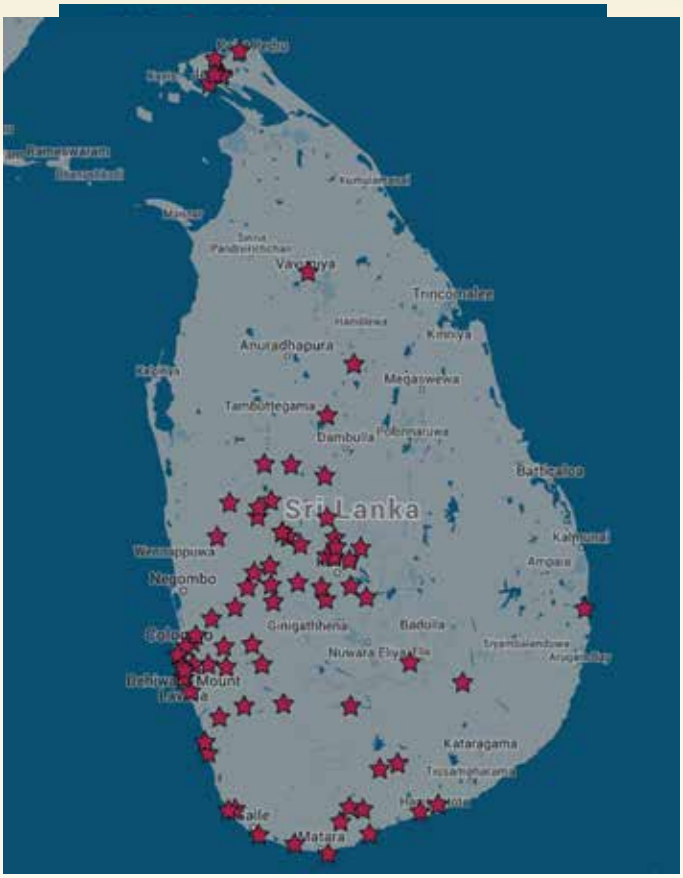
Service Environment

Geographic information system (GIS) mapping of COs / CAs

The GIS system integrates locations and edits, analyzes, shares and displays geographic information that can inform decision making relating to these officers. It displays the gaps in geographical coverage in spatial distribution of CAs. The system allows mangers to create interactive queries (user-created searches), analyze spatial information, edit data in maps, and present the results of all these operations. The user friendly system for CAs designed by IHP can be accessed at https://mapsengine.google.com/map/edit?mid=zQ3lpMHZwOCs.kzVoNU1fiviI. Clicking on the star icon displays information relating to each CA – name, address, date of first appointment. The map clearly shows wide swathes of the country

without coverage. It is important to note that individual CAs also have responsibility for large geographical areas and the sizable populations that live within these areas.

Figure 8: Location of the respondent CAs, 2013



Work Experience

Table 8: Work experience of Counselling Assistants by sex

Sex	Mean	Minimum	Maximum
Male	6.68	2	7.92
Female	6.42	0.25	8.29
All	6.5	0.25	8.29

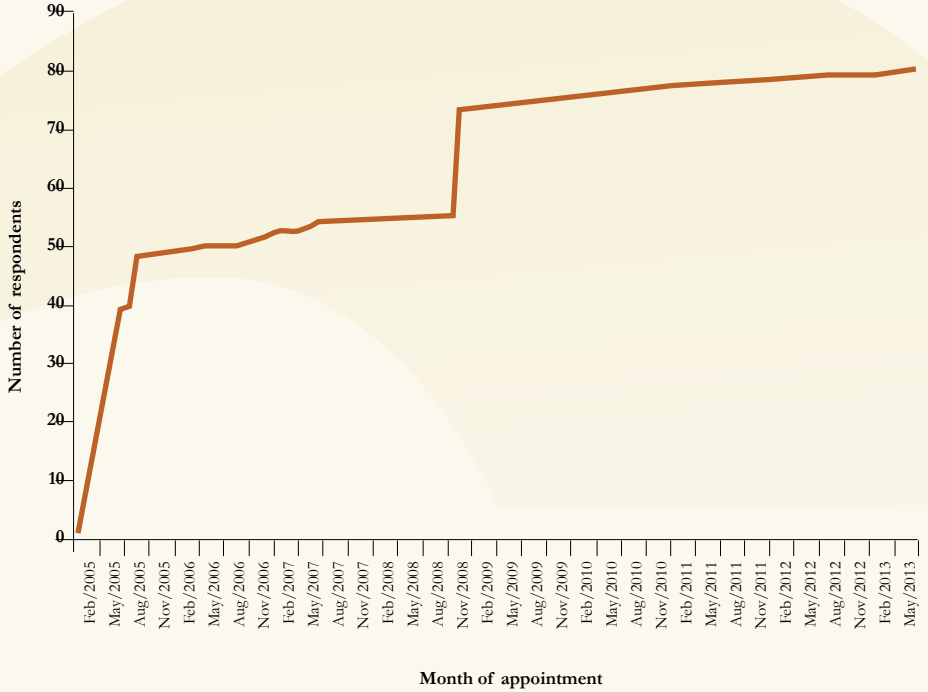
Figure 9: Distribution of work experience of CAs by service period and sex, 2013

The work experience ranges from less than a year (new recruits) to over eight years (first recruits). Although the mean and maximum experience has a similar gender breakdown, the minimum group shows more female cadres.

Table 9: Date of appointment of CAs

Month of appointment	Number CAs
Feb/2005	1
Jul/2005	38
Aug/2005	1
Sep/2005	8
Dec/2005	1
Sep/2006	1
Feb/2007	2
Jun/2007	1
Jul/2007	1
Nov/2008	1
Dec/2008	18
Jun/2011	5
Mar/2013	1
Jul/2013	1
No response	2
All	82

Figure 10: Cumulative number of currently working CAs by month of appointment



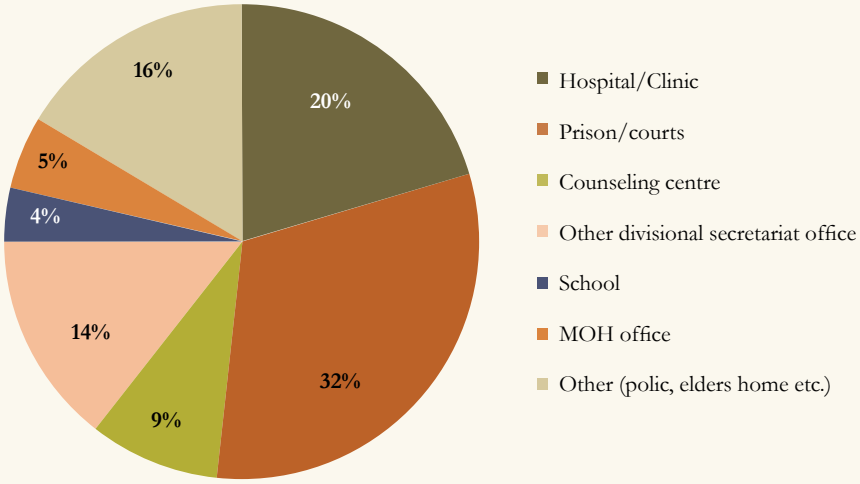
There appears to have been three intakes of CAs around 2005, 2008 and after 2011.

Number of Work Places

Table 10: Number of work places for Counselling Assistants by sex(percentage)

Sex	One place	More than one place	No responses
Male	40	56	4
Female	36.8	61.4	1.8
All	37.8	59.8	2.4

Figure 11: Secondary work places for Counselling Assistants



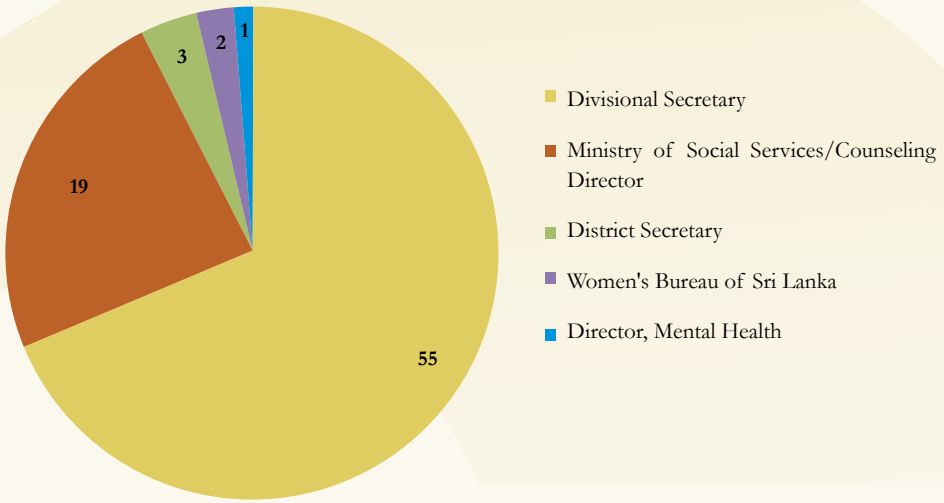
Over 60% have more than one working place (no gender difference). Locations are the Divisional Secretariats, counselling centres, mental health units, prisons, etc. Primary place of work being the Divisional Secretary's office

Table 11: Managerial supervision of CAs

Sex	Mean	Minimum	Maximum
Male	1.48	0	3
Female	1.72	0	3
All	1.65	0	3

Note: Data collected up to 3 responses

Figure 12: Distribution of CAs by immediate supervisor of work, 2013



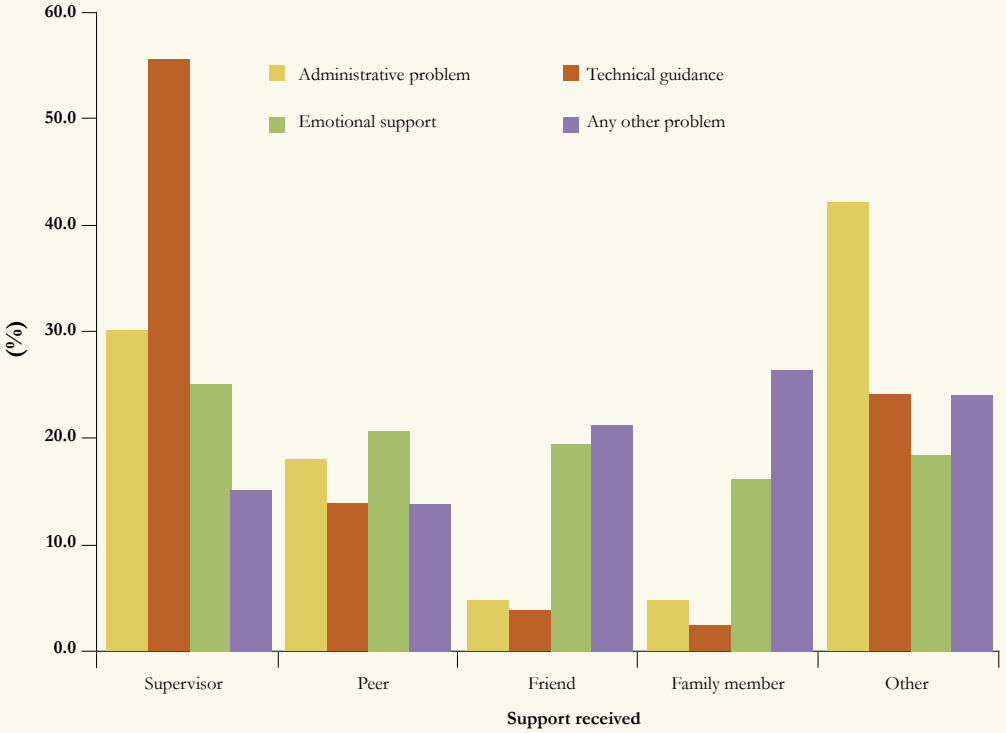
Main managerial supervision is by the DS. Others are, the Director in charge of the service in the Ministry and District Secretary.

Support Structure

Table 12: Classification of support received by CAs

Support received from	Administrative problem	Technical guidance	Emotional support	Other problem
Supervisor	30.1	55.7	25.3	15
Peer	18.1	13.9	20.7	13.8
Friend	4.8	3.8	19.5	21.3
Family member	4.8	2.5	16.1	26.3
Other	42.2	24.1	18.4	23.8
All	100	100	100	100

Figure 13: Classification of support received by CAs



The immediate supervisor (DS) is sought predominantly for technical guidance, emotional support and administrative problems. Most often CAs are likely to get support from other sources such as religious leaders, counselling teachers or professors at university, other administrative officers, or a few senior employees at the work place who are not their official supervisors.

Clients Counselled in May 2013

Table 13: Average number of counselling in May 2013 by age and sex of clients

Sex of CA	Children		Adult		All
	Male	Female	Male	Female	
Male	8.2	9.1	11.0	13.6	38.5
Female	4.9	5.0	8.5	10.9	24.0
All	6.0	6.3	9.3	11.8	28.4

Table 14: Modal number of counselling in May 2013 by age and sex of clients

Sex of CA	Children		Adult		All
	Male	Female	Male	Female	
Male	4	3	6	9	18
Female	3	3	6	9	21
All	3	3	6	9	20

The counselling activities cover group discussions and training sessions conducted in schools and other public places. The average value shows higher values as number of counselling. In order to have a proper understanding of individual counselling activities, the modal number by age and sex can be used.

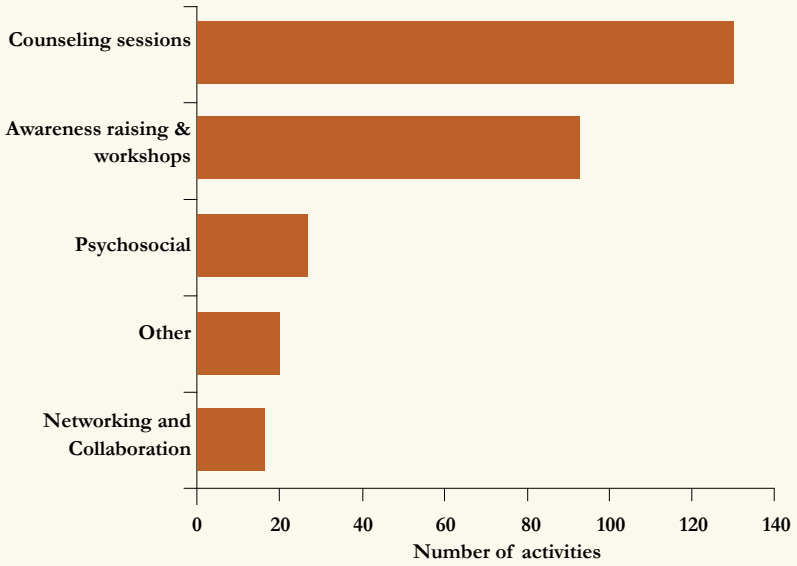
The total clients were 20 per CA per month. The numbers of children counselled shows equal distribution by sex. There is hardly any difference in the sex of counselled clients.

Number of Activities in the Period of May 27-31, 2013

Table 15: Number of activities

Activity	Number
Counselling sessions	131
Awareness raising & workshops	93
Networking and collaboration	17
Psychosocial	26
Other	20
Total	287

Figure 14: Number of activities



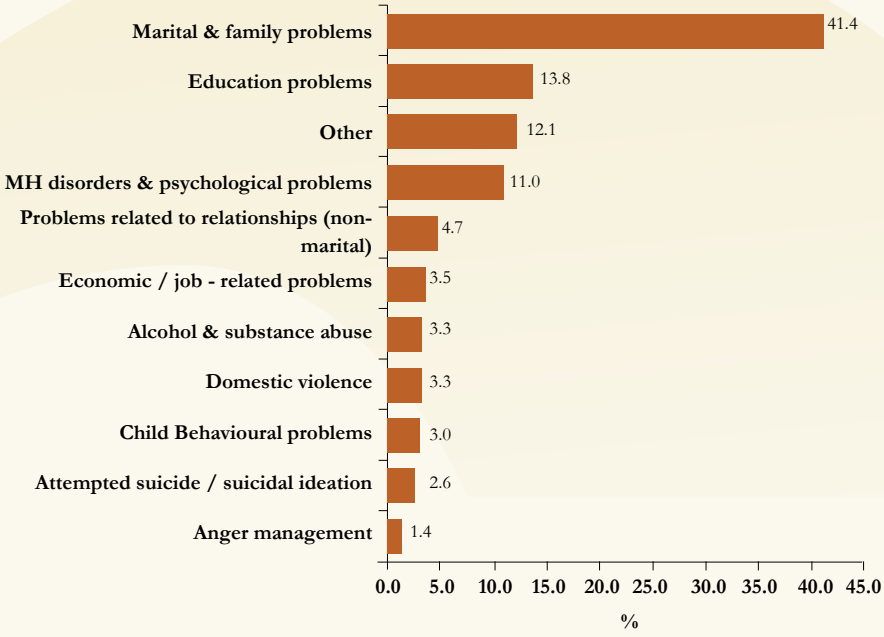
Counselling and awareness creation were predominant activities during the reference week.

Number of Clients Attended To for Psychological Counselling from May 27- 31, 2013

Table 16: psychological counselling

Problem type	Percentage	Number
Marital & family problems	41.4	177
Domestic violence	3.3	14
MH disorders & psychological problems	11.0	47
Education problems	13.8	59
Child behavioural problems	3.0	13
Problems related to relationships (non-marital)	4.7	20
Anger management	1.4	6
Economic/job-related problems	3.5	15
Attempted suicide/suicidal ideation	2.6	11
Alcohol & substance abuse	3.3	14
Other	12.1	52
Total	100	428

Figure 15: Psychological counselling (percentage)



The range of problems presented during counselling sessions over the period of a week were coded for analysis. The categories are not mutually exclusive, with some overlap between these (i.e. marital and family problems and domestic violence, or educational problems and child behavioural issues, or mental disorders and psychological distress and suicidal ideation). In addition, differences in level of detail provided by the respondents in describing problems also limited the ability to differentiate problems further than the given categories. It is also worth noting that coding was done on the basis of problem identification by the clients and the counsellors.

Marital and family problems predominate among the 428 persons counselled, and descriptions of the issues covered under this category related to divorce, separation, conflict between spouses and also amongst other family members, extra-marital relationships, and experiences of marital neglect. Domestic violence was explicitly mentioned in a number of cases, but may be more prevalent – especially in cases described as 'family conflicts' in the previous category. The domestic violence category included assault, harassment and acts of 'inhuman' sexual behavior. Problems in non-marital relationships were predominantly about the consequences of the breakup of relationships, but also explicitly included pregnancy

outside marriage, sexual assault and abuse. The lack of detail available means that it is difficult to identify whether some of these events might qualify as child sexual abuse, but it is likely that they would.

Educational problems were the second most common category, covering refusal to attend school, disruptive behavior, poor educational performance, learning difficulties, fear of going to school (in some cases explicitly because of teachers), and loss of interest in or difficulties in continuing university education. The category of child behavioural problems included instances of disruptive behavior (at home and in school), stealing behavior, anti-social or morally questionable behavior, bed-wetting, non-compliance ('stubborn') and disobedience, fearfulness and 'abnormal' behavior.

Mental disorders and other psychological problems were classified together because of the difficulty in distinguishing between the continuum of presenting problems in the absence of definitive diagnoses and problem definitions. Often symptoms were described that were consistent with a disorder but also possibly indicative of psychological distress that did not meet diagnostic conditions. Under this category, there were reports of depression, anxiety, grief, stress, fear of social situations, insomnia, poor self-care, obsessive compulsive behavior, paranoid thoughts, 'abnormal behaviour' and loss of memory. Alcohol and substance abuse-related problems (involving alcohol, heroin and other addictions) were classified separately – although they clearly overlap with the above category and also sometimes with the domestic violence category. Anger management issues were also categorized separately, though they too are likely to overlap with the same two categories. Attempted suicide and suicidal ideation was also listed separately from mental disorders and distress or other family or extra-marital relationship-related problems, despite likely linkages with these types of problems.

Job-related and economic problems were listed together, and included issues such as distress (and symptoms such as sleeplessness) due to financial difficulties for the family, loss of job, loss of interest in work and difficulties at the workplace.

The remaining category of 'Other' includes diverse issues such as poor concentration, personal problems such as a son being jailed for stealing or a daughter's divorce, loss of interest in sexual relations, childlessness, pressures of caring for a child with mental illness, obesity, post-stroke recovery, or referrals from court after an offence. There was insufficient supporting information in most cases to classify these under other sections.

The numbers and diversity of problems presented in counselling suggests that CAs are a viable source of support for a range of problems, including those of an intimate nature. The preponderance of marital, family and relationship problems suggest that a focus on these in training and ongoing skills development would be useful. Similarly, a focus on educational and behavioural problems could be helpful – although as with mental disorders and serious psychological distress (including suicidal behaviour and substance abuse) there would need to be clarity on how CAs work in conjunction with other appropriate professionals to support clients. This would also be the case in terms of situations of potential or actual violence and sexual abuse, where cooperative links with other services would be essential.

Qualitative Section of the Study

This part consists of in-depth interviews and focus group discussions. The qualitative approach was adopted to understand the relationship between values, attitudes and beliefs in relation to behaviours. These approaches can provide a deeper level of comprehension that is not easily accessible from quantitative approaches.

CHAPTER 5

In-Depth Interviews

The sections below summarizes the findings from the qualitative in-depth interviews carried out with CAs and their supervisors. All the individual reports from each of the interviews can be found in Annexure III.

Work Arrangements, Referrals & Networking

The CAs spend two days a week in the office (usually the Social Care Unit), with the rest of the days in the field following up on referrals and conducting community awareness programmes. Some also attend mental health clinics or visit prisons regularly. One CA reported working closely with registrar of marriages and local midwives to provide pre-marital and marriage counselling. The arrangements for work collaborations and locations outside the two days in office appear to vary from location to location, and are largely at the initiative of CAs (or their supervisors). It is possibly also shaped by the available services and personnel with whom to work.

The CAs report seeing between five and eight clients a week, sometimes for multiple sessions. They usually work as individual counsellors, but in some settings (i.e. child protection) may work on cases as a part of a multi-disciplinary team approach.

Referrals for counselling or other interventions are often received through Social Care staff (SSO, WDO, CRPO, PO), Grama Niladhari (GN), Public Health Inspectors, the police and in the case of children sometimes via teachers, pre-school teachers and parents. Some people prefer to bring children to CAs as the stigma of attending MH clinics is a barrier to accessing services there. The Magistrate's Courts and Qazi Islamic courts refer clients to the counsellor in some cases, such as in the matters of marital conflicts.

In some instances, the lack of understanding of counselling and the role it can play in addressing problems by some categories of government staff means that they do not collaborate closely with CAs. In other cases, a lack of confidence or autonomy of some staff means that they will not refer without approval from their supervisor. Where the DS has been in touch with their supervisors and asked for help or suggested collaboration, referrals move more smoothly.

Some CAs reported that after conducting school programmes, children often contact the CAs directly (via phone or SMS) regarding problems they have - for instance related to exam stress or developmental issues. Other CAs also identified the mobile phone (or a landline at their office) as a means of clients making contact with them.

Referrals from CAs are usually made to the local MOH or the district psychiatry unit, for psychological issues and also to other government officers for other forms of assistance.

One CA reported that participating in monthly meetings with local government officers, police, MOH staff, school principals, bank managers, etc. helped to make contacts that were useful in managing cases. Links with MOH, police, Education Dept. and schools, and local NGOs working with women and children were seen as useful. In one context, it seemed that the CA had been told not to work with non-governmental organisations, but in others it was quite the opposite, with one CA saying that there is "a section of our duty list requiring us to work collaboratively linking up with other organisations that have expertise".

Working within the Social Care Unit of the DS office is viewed positively, as the problems of clients are often relevant to many of the staff stationed there (i.e. SSO, Social Services Assistant, Elders Rights Development Officer, etc.). It was unclear whether the overlap between the roles of multiple categories of staff was an effective use of human resources, or if coordination between these roles was well-defined.

Understanding of the process and features of counselling is limited amongst other staff members within some Social Care Units or DS offices - with impacts on how they value the role or even respect issues like the privacy of a counselling session.

The line managers (DS or ADS) were reported to be generally very supportive of the CAs and in a few interviews spoke positively about the work that the CAs were able to undertake. They also seemed to understand some of the practical challenges facing CAs– in terms of travel and counselling facilities– and endorsed these needs.

Operational Resources

The facility provided to CAs for free outgoing calls within their group is a positive resource, and allows colleagues to support one another. It also enables CAs to contact their managers easily and also to contact more experienced counsellors for advice.

The lack of a dedicated private space for counselling (i.e. a counselling room) was identified as a common problem, as CAs often share office space with others and this is not suitable for counselling.

The Rs.2000.00 allowance received by CAs for travelling was well appreciated. However better transport facilities (i.e. scooters or motorbikes) to access rural areas were recommended by most CAs, as travel by bus can often result in significant time spent on the road. One CA with visual impairment was constrained in terms of his ability to travel, because of the lack of appropriate transport.

The need for access to computer and internet facilities was emphasised by most CAs, for the purpose of accessing information online. Others spoke about the need to maintain confidential files on clients - and one reported using his own personal laptop for this purpose.

CAs reported very large geographical areas (~100 GN divisions and often more) and large populations - which means that sometimes travelling to meet clients (or for clients to travel to meet them) is impractical. As a result some counsellors conduct sessions over the phone. Regardless of strategies to minimize the difficulties of travel, the size of the populations that CAs are responsible for means that they will only be able to meet the needs of a limited proportion. There does not seem to be clear strategies or priorities defined for focusing the use of the CAs time and efforts in this context.

CAs sometimes receive financial resources (in the range of Rs.20,000.00-25,000.00) from the Ministry for special events (i.e. Deyatakirula or Mental Health Day) or other awareness raising programmes. They sometimes mobilise resources from NGOs or collaborate with other government programmes to deliver awareness raising or public education sessions. If finances are not available, the programmes are limited to an hour or two.

One CA identified that even though the area he worked in had approximately 40% Tamil speakers, he did not speak Tamil and so could not help this segment of the population if they came to him for help. The opposite problem also existed, where there was a significant Sinhala speaking population served by a CA whose primary language was Tamil and whose Sinhala skills were limited. Where possible, there are efforts to link clients with colleagues who can speak their language - but this is an ad hoc arrangement that is highly dependent on availability of colleagues with the right language skills nearby.

Supervision, Technical Support & Training

Technical support is obtained from peers such as university batch mates who are also CAs – pointing to an informal system of support in the absence of a formal one. The lack of formal supervision was identified as a problem by most of the CAs. Peer supervision arrangement have not materialized yet and are largely ad hoc or informal where they exist. Some CAs are frustrated by the lack of formal supervision or counselling support for themselves - especially since their work sometimes leads to stress or distress, with implications for their own personal lives. There may also be a need for options for technical supervision and personal support from outside of their group of colleagues or administrative supervisors, for reasons of privacy and confidentiality.

Problems with which CAs were commonly presented included 'family problems' including some marital conflicts and relationship problems, substance misuse, child abuse, mental disorders (i.e. anxiety, depression, obsessive compulsive disorder, etc.), and financial difficulties.

In some instances, it is clear that the original training has not fully equipped counsellors for the realities of work in the field. One CA said, "the counselling that we learned in books does not exist over here". Whilst CAs are supplementing their training (from NISD or Ministry) with other programmes of varying duration and content - it is unclear what sort of quality these are, or indeed what particular skills or knowledge they provide to CAs - although the CAs clearly value some of these inputs greatly.

CAs are often faced with very specific problems that they have not been specially trained to respond to– for instance managing substance misuse or assessing children with special needs, working with convicted offenders, or supporting clients with serious mental illness. They also undertake significant amounts of psycho-education and public awareness-raising work, but have not received any formal training or technical support in doing this - whether in terms of life-skills, parenting or behavioural change. Typically in such situations, the CAs have been resourceful in trying to gain additional knowledge related to these issues via the internet or other forms of independent study. This, in addition to the periodic residential training provided by the Ministry has helped the CAs to provide support to clients. The CAs also attend other training programmes provided by government and non-government agencies, which are useful in terms of new knowledge but do not offer much opportunity for practical skills development. One CA reported that since their interaction with NGOs

has declined, they have fewer opportunities for accessing new materials or learning about new topics.

Some CAs had become involved in elaborate psychosocial and development interventions for people with mental health problems or vulnerabilities that could result in serious outcomes. CAs identified that some of the psychosocial issues they worked with could not be tackled solely from within a counselling room. At times they are frustrated because they know what is needed to solve a problem but are unable to do anything about it - since it is the responsibility of another person or institution or because they lack the resources and capacity to respond.

In many instances it is clear that CAs are also filling the gap left by the absence of community mental health workers (i.e. psychiatric social workers etc.), but it is not clear that they are either technically or structurally equipped for this role. There are often informal arrangements made with the local MH services, but there is no guidance about how to ensure that these do not overburden CAs or put clients at risk. There is no recommended or mandatory coordination system, so arrangements are ad hoc - working well in one DS division or not in another.

There is no clarity about a promotional ladder or career progression for CAs. The title of 'Counselling Assistant' is experienced as lowering the status of the CAs in relation to other 'officers' at a DS level with whom they consider themselves to be on par. The need for opportunities in higher education - leading to Masters or Doctorate level training - was also identified. Most CAs expressed satisfaction with their work, although some also displayed signs of 'burn-out' as a result of their engagement with problems in the field. One CAs identified that he may not wish to continue this work 'until retirement', possibly due to the emotional toll that the work was taking on him.

CHAPTER

6 Focus Group Discussions

Focus Group discussions clarified and further studied data in self-reported questionnaire and in-depth site visits. The total participation was 59 (57.3%) in four groups (three Sinhala speaking groups of CAs, and one Tamil speaking group of 10 CAs).

The following exercises were carried out with the participants:

- A set of 12 questions to corroborate the questions asked in the in-depth interviews on the field, were answered individually in writing (personal experience/views/ideas related to the CA service). This data confirmed the survey and in-depth interview findings.
- A case study for analysis and presentation in groups of 5-6 (to gauge knowledge, skills and attitudes of CAs).
- An open discussion on recommendations for the future development of the CA service.

Summary of Case Discussion

10 groups of 5-6 participants discussed and provided feedback. Observations based on this feedback and group interaction aimed to glean the following:

- Did groups display sufficient knowledge of the key issues related to the case? (an HIV positive client with Deliberate Self-Harm intent and relationship difficulties)

Observation: All 10 groups were able to identify and name the key issues and were able to prioritize safety needs. Four out of 10 were also able to mention other related issues that may result. e.g: economic impact.

- Did groups demonstrate skill in planning and administering interventions to address all key issues?

Observation: All 10 groups were able to demonstrate a plan of intervening with the DSH (suicidal ideation) issues. Eight groups suggested referral for psychiatric treatment while six groups demonstrated adequately how they would intervene and manage the DSH along with referral. Four groups did not display adequate skill in addressing the self-harm issue.

All 10 groups addressed the issue of the impact of HIV, identifying stigma, fear of the future and isolation. Five of the groups demonstrated their skills in addressing the issues of stigma by empowering the client and challenging core beliefs. Two groups mentioned the use of CBT to change the client's attitude to life. Five other group interventions centred around giving advice on living, promoting spiritual development and focusing on keeping the family together in spite of the situation. One group mentioned follow up of client to see how the client has progressed.

The attitudes demonstrated among all groups were generally progressive and informed in relation to dealing with (in this case) an HIV client. The levels of gender sensitivity among some groups was lower, as evidenced in the ability to recognize and deal with issues related to gender dynamics in the case, the vulnerability factors in the case and participants' differing expectations of the female client and her male partner. The level of confidence and comfort with dealing with DSH (suicidal ideation) varied, with five groups merely making referrals and others confidently listing out interventions they as CAs could make while making the referral.

2-3 groups demonstrated significant helpful attitudes and skill in assessing and intervening in the different issues of the client. 3-4 groups were diffident and uncertain about intervening with the DSH issue but more confident about providing emotional support. Most participants were used to giving direct guidance and "good sound advice" as a means of supporting the client.

Training needs emerging from the case discussion exercise:

- Broader knowledge base related to the range of issues presented by clients (especially more recent post-war trends with the increase of migration, resettlement and mobility).
- Current trends in working with clients with special vulnerabilities.
- Hands on skills in working with deliberate self-harm, victims of violence and clients at immediate risk.
- Establishing and maintaining useful professional links with other services and how to make professional referrals.
- Identifying gender and cultural factors when working with clients.
- Good practice guidelines generally: how to assess progress and conduct follow up.

Suggestions made by the CAs at the FGDs

The following suggestions were made by the Counselling Assistants who participated in the FGDs as part of a plenary discussion. The suggestions were discussed in four categories—namely,

1. Professional issues
2. Knowledge
3. Skills
4. Quality of service and ethics
5. Other

The key suggestions from the CA's for each of the sub categories are as follows:

Professional issues

1. A professional body for counsellors: This should be similar to other professional bodies such as the ones for medical doctors or accountants. This should be an organisation that looks into the development of the profession.
2. Formal recognition for counsellors: At the moment there is no scheme of recruitment for counsellors and there is no formal recognition given to the profession by the State. As a result, the profession lacks a career ladder and the appointments and designations lack uniformity across Ministries (Education, Health, Social Services, Child Development and Women's Affaires) and Departments. These issues should be addressed by introducing a central body that is responsible for quality maintenance of the profession.
3. Lack of administrative support for professional development: This is very evident as many Counselling Assistants across the country work in the absence of a counselling room that will make the client comfortable and ensure privacy. Therefore, the participants suggested that senior state administrators are made aware of the nature of the role of counsellors and the importance of it.
4. Opportunities for continuing professional development (CPD): at least three training opportunities each year.

Knowledge

1. Knowledge on specific techniques and theoretical orientations of understanding mental health problems and treatment (e.g. cognitive and behavioural therapies and techniques, existential therapies).

2. Knowledge related to common problems areas (e.g. HIV/AIDS, Trauma, Child abuse, Depression and Anxiety related disorders, substance misuse etc).
3. Knowledge in medication related to mental health problems that will enable counsellors to be more helpful in the recovery process with better understanding of the diagnosis and the treatment plan of the psychiatrist.
4. Legal knowledge related to working with clients.
5. Training and knowledge in mental and physical rehabilitation.
6. Spiritual counselling

Skills

1. Advanced counselling practice with the supervision of senior counsellors, clinical psychologists and psychiatrists. It will be ideal to have some training in clinical settings too.
2. Teaching skills that will be useful in conducting effective training and awareness raising workshops for children and adults.
3. IT skills to enable counsellors to use technology efficiently to increase knowledge and in conducting awareness raising programmes.
4. Training in relaxation methods for self-care as well as for the use with clients.

Quality of service and ethics

1. Introducing a code of ethics for Sri Lankan counsellors and a registration body.
2. Introducing clinical supervision for counsellors through senior supervisors and through peer supervision.
3. Programmes to facilitate self-care and personal development (e.g. emotional development, yoga, spiritual development).
4. Conducting monthly review meetings /workshop with the leadership of the District Secretary and with the participation of the district psychiatrist, psychologist, counselling officers, psychosocial workers, counselling assistants, educational counsellors. This can be part of the monitoring mechanism.

Other

1. Research in counselling – role of family in disorders, resources, cultural practice in MH and counselling.
2. Audio-visual facilities and equipment for awareness raising programmes.

CHAPTER 7

Conclusions

Counselling Assistants, a fledgling cadre in public service, are a viable and valuable support mechanism in the community. Where they are present, CAs are utilized by both the public and other services for support in relation to a wide range of psychosocial problems. The diversity and complexity of problems dealt with by CAs often exceeds the initial training that they have received prior to recruitment, but through self-study and access to ad hoc or supplementary training, the CAs have sought to improve their skills and knowledge in order to serve their clients. The lack of ongoing formal systematic support for CAs is a major shortcoming that they have sought to mitigate through informal arrangements amongst themselves and contact with other resource persons. Administrative supervisors and peers at a local level are largely supportive of CAs and appear to be appreciative of their work –even if they do not always understand it well.

The role of CAs, however, goes beyond the provision of counselling alone – since they are involved in a range of psychosocial interventions, especially community-level programs related to common psychosocial issues. Responding to the needs of individual clients, they often have to go beyond a strict counselling role – for example in the context of persons with mental disorders, as there is a shortage of psychiatric social workers. It is clear that their education and training has not formally equipped them for these roles, and it is uncertain whether the informal skills and knowledge acquired by individual counsellors has adequately filled this gap. Training provided by the Ministry has at times been helpful, although more is needed – especially with regards practical skills development and in-depth knowledge related to managing the particular problems that CAs are presented with in the field. It is clear that CAs are serious about their professional development and are investing in this considerably on their own.

The arrangements for CAs work vary across locations, with activities and collaborations apparently determined by opportunities and initiative on the part of the CA, his/her supervisor and other relevant institutions and staff (i.e. mental health services, government community services, courts, etc.). Whilst this may have practical benefits in terms of potentially enabling CAs to leverage local resources to increase their effectiveness or impact, the ad hoc and opportunistic nature of these arrangements means that they may not necessarily lead to an optimal use of the CAs as a human resource. At the level of the CA service overall, there is lack of a broad strategic vision on how CAs' contributions to

addressing psychosocial problems in the community can be maximized. It is very clear that CAs cannot meet the volume of psychosocial needs of the large populations that they are assigned to serve, and CAs' current approach of combining a couple of days with a counselling focus and the remainder of their time on what might be described as promotional or preventative public programmes is an on-the-ground response to this challenge. Clear direction around the balance between responding to individual cases and community-level interventions, as well as prioritization of particular areas of work, would benefit both CAs and the populations they serve. Better definition of the CA's roles in relation to particular areas of work, and clarity about division of labour and coordination with other staff and services can also reduce the burden on CAs and protect them and their clients against overstepping the limits of their competencies - for example in the areas of mental illness or child protection. It is important to underline that CAs do and can continue to play an important role in a range of areas – but that this needs to take place within a robust framework that will utilize them appropriately. This will also help define the specific competencies and knowledge that CAs should develop in each area, with implications for pre-service and in-service training content and approaches.

CAs are largely satisfied with their counselling and psychosocial work. However, the content of this work is stressful and distressing at times, and they feel the absence of a support mechanism to sustain them both professionally and personally. There are warning signs visible for 'burn out' of CAs if this is not provided, which will likely have negative consequences for the individual CAs and also their clients. It is necessary to recognize that this area of work carries an inherent risk of psychosocial impacts on workers, and this needs to be addressed in both pre-service and in-service training and most importantly in the systems for managing CAs in the field.

CAs also expressed a need for a framework for professional advancement, within their current post/role and more broadly within the field of counselling and psychosocial work. In the light of issues of 'burn out' it is worth considering also the need for options for lateral movement away from direct support work, where CAs are unable to continue effectively in this role. The CAs also identified a need for greater recognition vis-a-vis other officers working at the DS level, and expressed a dissatisfaction with their 'assistant' title.

There are several practical challenges that most CAs experience in their daily work, most importantly lack of access to a private room for counselling sessions and limited transport facilities to enable them to access community-settings.

Overall, the study reveals the CAs actively deal with many serious psychosocial problems at a community level and that they are committed to their own professional development and improving the services they provide. The issues identified by the study also provides an

opportunity to develop systems that support them professionally and personally and also maximizes their contribution to improving the psychosocial wellbeing of individual and groups in the communities they serve.

CHAPTER 8

Recommendations

- Clarify and define the strategic role of CAs in responding to psychosocial problems at a local level, especially in relation to specific issues and in relation to other existing service providers.
- Establish technical supervision and support mechanism to maintain quality of service, support management of challenging cases and further develop skills of CAs. Where possible, this should use supervisory resources within the CA's own area of work – to reduce costs and facilitate access and continuity of support.
- To provide in-service training and technical support to CAs in implementing evidence-supported interventions for common psychosocial problems encountered at a community level (i.e. family and marital problems, educational problems, mental illness and psychological distress, etc.).
- Inclusion of the following subject areas is suggested:
    a. Counselling skills related training, including supervised practice in community and clinical settings
    b. Community-based psychosocial support skills related training, relating to common problems identified through this review and other studies.
    c. Knowledge on mental disorders and clinical psychological conditions
    d. Skills related to mobilizing and collaborating with groups or organisations
    e. Management or organizational skills related to implementing psychosocial interventions and counselling services.
    f. Skills for conducting effective psycho-education and public-awareness training for children and adults
    g. Skills in using information and communication technology (ICTs) to access knowledge (for professional development and learning) and also to engage with clients and target populations in an effective manner.
    h. Training in relaxation and self-care methods for themselves as well as for use with clients

- There is a need to clarify the roles and coordinating mechanisms between the different parallel services that exist at sub-district and district level within different Ministries (and provincial departments) in relation to issues relevant to counselling and psychosocial support – to avoid confusion about responsibilities and to maximise benefits from these human resources.
- Prioritise the development of a national policy regarding counselling and psychosocial support, a service minute and establish a career structure. Awareness regarding the roles played by the CAs of MSS needs to be disseminated and created among high-level officers in all relevant departments and Ministries, as well as amongst those in strategic positions to facilitate cooperation between CAs and other frontline service providers.
- To link the CAs with an appropriate professional body (or if none is suitable to establish one) to support ongoing professional development and standards.
- Establish a workable and systematic mechanism for personal support to address the risks of 'burn-out' inherent to this area of work. Incorporating better training on self-care within existing and future courses is also a priority.
- The service deals inter alia with patients with medical conditions which may necessitate regulation by the Sri Lanka Medical Council. A suitable amendment may be necessary to the Medical Ordinance for this purpose. It is necessary to define clearly the role of CAs in relation to the treatment and support of persons with mental illness, other disabilities or relevant medical conditions.
- Develop and strengthen infrastructure for the following: establishing counselling rooms, improving transport facilities, provision of computer facilities with internet access and facilitate access to technical resources (i.e. journals, communities of practice, etc).
- The user-friendly GIS map to be used to prioritize placement of the future recruits for equitable distribution of CAs by geographical region. It is also possible to add "layers" to the system to help human resource development and to reflect psychosocial needs of geographical areas, for prioritization of deployment of future batches of CAs, if data is generated by suitable research.

CHAPTER 9

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CHAPTER 10

Annexures

Annexure I: Duty list of Counselling Assistants of the Ministry of Social Services and Counselling Officers of the Ministry of Child Development and Women's Affairs under the National Counsellig Service Programme

1. Detection and analysis of psychosocial problems at the community level, affecting social development of Sri Lanka
2. Detection of causes for such problems by scientific analysis
3. Development and implementation of solutions and programmes based on appropriate psychological principles to address these issues at community, village and Divisional levels
4. Detection of persons suffering from mental and behavioural problems and recording of information pertaining to them
5. Detection of persons vulnerable to mental and behavioural problems and recording of information pertaining to them
6. Gathering of data and rehabilitation of families that are disrupted, have behavioural issues, are a threat to the community, based on accepted psychosocial principles.
7. Referral of identified psychiatric patients for necessary psychiatric treatment and provision of required counselling to the families of such patients
8. Education of community leaders and government officials regarding detection, prevention of mental health problems, and the role of counselling in these situations

Annexure II: Sinhala and Tamil Versions of Self-Administered Questionnaire for COs &CAs

IHP
INSTITUTE FOR HEALTH POLICY

ශ්‍රී ලංකාවේ උපදේශන නිලධාරීන් / උපදේශන සහකාර සේවයේ නිලධාරීන් පිළිබඳ සමීක්ෂණය 2013

- උපදේෂණ සහකාර සේවයේ නිලධාරීන්ගේ සේවය වැඩිදියුණු කිරීම සඳහා සෞඛ්‍ය අධ්‍යයන ආයතනය (IHP) විසින් මෙම සමීක්ෂණය ක්‍රියාත්මක කරයි.
- ප්‍රශ්නාවලිය සම්පූර්ණ කිරීමෙන් පසු මේ සමග එවා ඇති මුද්දර කවරයේ බහා තැපැල් කරන්න.
- කරුණාකර මෙම ප්‍රශ්නාවලිය 2013 ජුනි මස 10 වෙනි දින හෝ ඊට පෙර තැපැල් කරන්න.

අංකය :

මේ පිළිබඳ වැඩිදුර විස්තර අවශ්‍ය නම් පහත සඳහන් අය අමතන්න.

වෛද්‍ය රෙජී පෙරේරා
ජ්‍යෙෂ්ඨ උපදේශක
සෞඛ්‍ය ප්‍රතිපත්ති අධ්‍යන ආයතනය
සෞඛ්‍ය පෝෂණ හා සමාජ සුභසාධන අමාත්‍යාංශයේ හිටපු ලේකම්
72, පාර්ක් වීදිය, කොළඹ 02.
දුරකථනය: (011) 2314041/2/3/5: දිගුව (101) ජංගම: 0777411745
ෆැක්ස්: 011- 2314040
විද්‍යුත් තැපෑල: reggie@ihp.lk

කාර්යාලීය ප්‍රයෝජනය සඳහා

රහසිගතයි
මෙම සමීක්ෂණය මගින් එකතු කරනු ලබන සෑම තොරතුරක්ම රහසිගත ලෙස සලකනු ලැබේ. පුද්ගලයින්ට අදාල තොරතුරු අනාවරණය නොකෙරේ.

අ. ප්‍රතිචාරකයාගේ මූලික තොරතුරු

1. වයස: _____

2. ස්ත්‍රී/පුරුෂ භාවය: 1 පුරුෂ ☐ 2 ස්ත්‍රී ☐

3. උපදේශන සහකාර/නිලධාරි පත්වීම් ලත් දිනය: ☐☐☐☐ ☐☐ ☐☐ (වර්ෂය / මාසය / දිනය)

4. ඔබගේ වත්මන් තනතුර:
   - i උපදේශන සහකාර ☐
   - ii උපදේශන නිලධාරි ☐
   - iii වෙනත් ☐ (කරුණාකර සඳහන් කරන්න) _____

5. ඔබ සේවයට වාර්තා කරන කාර්යයාලයේ නම සහ ලිපිනය: _____

6. ඔබ රාජකාරි කටයුතු කරන වෙනත් කාර්යාල හෝ ස්ථාන තිබේද:
   - i ඔව්
   - ii නැත *(නැති නම් ප්‍රශ්න අංක 8 ට යන්න)*

7. ඔව් නම් ඒ ස්ථාන නම් කරන්න _____

8. රාජකාරිය පිළිබඳ තොරතුරු:
   a. ඔබ රාජකාරී කටයුතු වාර්තා කරන අධීක්ෂණ නිලධාරීන්ගේ තනතුරු:
      - i. නිලධාරී 1: _____
      - ii. නිලධාරී 2 (අදාල නම් පමණක්): _____
      - iii. නිලධාරී 3 (අදාල නම් පමණක්): _____

b. ඔබට සේවය කිරීමට පැවරී තිබෙන ප්‍රදේශ පිළිබඳ තොරතුරු

i. එම ප්‍රදේශයේ ජනගහණය: _____

ii. ජනගහන දත්ත මූලාශ්‍රය: _____

iii. එම ප්‍රදේශයේ විශාලත්වය වර්ග කි.මී. වලින්: _____

iv. ප්‍රාදේශීය ලේකම් කොට්ඨාශ ගණන: _____

v. ග්‍රාම නිලධාරී වසම් ගණන: _____

ආ. සේවා සැපයීම පිළිබඳ තොරතුරු

9. පුනි මස 3 සිට 7 දක්වා සතිය තුල ඔබ විසින් සිදුකල සේවාවන් පිළිබඳ විස්තරයක් පහත වගුව ඇසුරින් ලබා දෙන්න. අවශ්‍යය නම් මෙවැනි වගුවක් වෙනත් කොලයක් ඇඳ තොරතුරු ලබා දෙන්න.

දිනය	කාර්යයේ ස්වභාවය කෙටියෙන් දක්වන්න	ස්ථානය	එම කාර්යය කොපමණ වේලාවක් පැවතිද? (පැය)	ඊට සහභාගී වූ සංඛ්‍යාව	මනෝ උපදේශන කාර්යයේ නියැලුනේ නම් එම දිනය තුල සැසි කියක් පැවැත්වුනිද	එම කාර්යයට මුදල් වැය වුණි නම් දළ වශයෙන් කොපමණද	ඊට සම්පත් දායකත්වය සැපයූ වෙනත් ආයතන සහ පුද්ගලයින් (ස්වේච්ඡා සේවකයින් ද ඇතුලුව)

10. පසුගිය **මාසය** තුල ඔබගෙන් මනෝ උපදේශන සේවාව ලබා ගත් සේවාලාභීන් සංඛ්‍යාව දක්වන්න

    a. පුරුෂ : _____
    b. ස්ත්‍රී : _____
    b. ළමුන් (වයස 18ට අඩු) : _____

11. පසුගිය **6 මාසය** තුල මනෝ උපදේශන සේවාව සඳහා ඔබ වෙත පැමිණි සේවාලාභීන් වැඩි පුරම සඳහන් කළ ගැටලු අවම වශයෙන් 3 ක් සඳහන් කරන්න (ඔබ සතුව දත්ත ඇත්නම් ඒ එක් එක් ගැටලුව සඳහා පැමිණි සේවාලාභීන් ගණන සඳහන් කරන්න)

	ගැටළුව	සේවාලාභීන් ගණන
i	_____	_____
ii	_____	_____
iii	_____	_____
iv	_____	_____
v	_____	_____

12. පසුගිය **6 මාසය** තුල මනෝ උපදේශන සේවාව සඳහා ඔබ වෙත පැමිණි සේවාලාභීන් විසින් ඉදිරිපත් කෙරුණු ගැටලු අතරින් ඔබට වඩාත්ම අභියෝගාත්මක වූ, නොඑසේ නම් ඊට සහාය සැලසීමට ඔබගේ දැනුම හා හැකියාවන් තවත් වර්ධනය කර ගැනීම අවශ්‍ය යැයි සිතුන ගැටලු අවම වශයෙන් 3 ක් සඳහන් කරන්න.

i _____
ii _____
iii _____
iv _____
v _____

13. ඔබට උදව් / සහාය අවශ්‍ය වූ විට ඔබට යා හැකිවන්නේ කා වෙත ද? එම පුද්ගලයාගේ තිලය හා ඔහු/ඇ සමග ඔබට ඇති සම්බන්ධතාව (උදා: ඔබේ උපදේශක, සහෘද්ද සේවකයෙක්, පවුලේ අයෙක්) කුමක්දැයි දක්වන්න.

a. සේවාලාභීන් සම්බන්ධ කාර්යයන් පිළිබඳ පරිපාලනමය ගැටලුවකදී සහාය ලබා ගැනීමට:

_____
_____

b. මනෝ උපදේශනයට අධාල නිපුනතා සම්බන්ධ ගැටලු හා අධීක්ෂණය සඳහා සහාය ලබා ගැනීමට:

_____
_____

c. ඔබේ රාජකාරී කටයුතු හා බැඳුණු ඔබේ චිත්ත වේගාත්මක ගැටලු සඳහා සහාය ලබා ගැනීමට:

_____
_____

d. වෙනත් කිසියම් ගැටලුවක් සඳහා සහාය ලබා ගැනීමට:

_____
_____

සුදුසුකම් හා පුහුණු වීම්

14. ඔබගේ ප්‍රථම උපාධියද ඇතුලුව, ඉන් අනතුරුව ඔබ විසින් සහභාගී වී ඇති පුහුණුවීම් හා ලබා ඇති අධ්‍යාපනික හා වෘත්තීමය සුදුසුකම් මොනවාද? ඔබගේ වර්තමාන රැකියාවට අදාල කෙටි කාලීන පාඨමාලාද සඳහන් කරන්න.

පාඨමාලාවේ නම	කාල සීමාව	පත්තිය තුල ඉගැන් වීම් හා දේශන පැය ගණන	ප්‍රායෝගික පුහුණුවීම් පැය ගණන	සහතිකය පිරිනමන ආයතනය	පරිනැමුන සහතිකය, ඩිප්ලෝමාව හෝ උපාධියේ නම	ඔබගේ වත්මන් රාජකාරීන් ඉටු කිරීමට මෙම පුහුණුව / පාඨමාලාව මගින් ලද දැණුම හා හැකියාව කෙතරම් ප්‍රායෝජනවත් දැයි දක්වන්න (1 = කිසිම ප්‍රයෝජනයක් නැත; 2 = සුළු වශයෙන් ප්‍රයෝජනවත්; 3 = සාමාන්‍යයෙන් ප්‍රයෝජනවත්; 4 = බොහෝ සෙයින් ප්‍රයෝජනවත්; 5 = ඉතාමත්ම ප්‍රයෝජනවත්)

15. ඔබගේ භාෂා ස්වාක්ෂරතාව පිළිබඳ ස්වයං ඇගයීමක් කරන්න: (1- නොහැකි, 2- සුළු වශයෙන් හැකි, 3- හොඳයි, 4- ඉතා හොඳයි

භාෂාව	කථනය	තේරුම් ගැනීම	කියවීම	ලිවීම
සිංහල				
දමිල				
ඉංග්‍රීසි				

16. ඔබගේ රාජකාරී කටයුතු වඩාත් හොඳින් කරන්නට ඔබට වඩාත් ප්‍රයෝජනවත් වේ යැයි ඔබට සිතෙන පුහුණුවීම් / පාඨමාලා මොනවාද?

a. .....
b. .....
c. .....
d. .....
e. .....

ස්තුතියි !

IHP
INSTITUTE FOR HEALTH POLICY

ஆற்றுப்படுத்துனர்/ஆற்றுப்படுத்தும் அலுவலர் தொடர்பான ஆய்வு 2013

- உதவி ஆற்றுப்படுத்துனர்/ஆற்றுப்படுத்தும் அலுவலர் சேவை மேம்பாற்டிட்காக சுகாதார கொள்கைகளுக்கான நிறுவனத்தினால் (IHP) நடாத்தப்படும் ஆய்வு.
- தயவுசெய்து கருத்தாய்வு தாள்களை இத்துடன் இணைக்கப்பட்டுள்ள விலாசமிடப்பட்ட கடித உறையினுள் இட்டு அனுப்பவும்.
- நிரப்பப்பட்ட கருத்தாய்வு தாள்களை ஜூன் 10ம் திகதி 2013 க்கு முன்பதாக அனுப்பிவைக்கவும்.

மேலதிக விபரங்களுக்கு தொடர்பு கொள்ள:
வைத்தியர் திரு றெஜீ பெரோரா
சிரேஸ்ட ஆலோசகர், சுகாதார கொள்கைகளுக்கான நிறுவனம்
இல. 72, பாக் வீதி
கொழும்பு 02.
தொலைபேசி: (011) 2314041/2/3/5 (நீட்சி-101)
கை தொலைபேசி : 0777411745
தொலைப்பிரதி : (011) 2314040
மின்அஞ்சல் : reggie@ihp.lk

ரகசிய தகவல்
இந்த ஆய்வில் பெறப்படுகின்ற அனைத்துத் தகவல்களும் ரகசியமாய் பாதுகாக்கப்படும். சுய தகவல்கள் வெளியிடப்படமாட்டாது.

இந்த ஆய்வுக்கு விருப்பம்/விருப்பமின்மையை தெரிவித்தல்

பெயர்: _____

நான் இந்த ஆய்வுக்கு விருப்பம்/விருப்பமின்மையைத் தெரிவிக்கிரேன்.

கையொப்பம் : _____ திகதி : _____

A. பங்குபற்றுநரின் அடிப்படை தகவல்கள்

1. வயது: _____

2. பால்நிலை: i ஆண் ☐ ii பெண் ☐

3. நியமனம் கிடைத்த திகதி/உதவி ஆற்றுப்படுத்துனர்/ஆற்றுப்படுத்தும் அலுவலராக (CA/CO) கடமையாற்ற ஆரம்பித்த திகதி. ☐☐☐☐ ☐☐ ☐☐
YYYY MM DD

4. தற்போதைய பதவி: i உதவி ஆற்றுபடுத்துனர் ☐ ii ஆற்றுபடுத்தும் அலுவலர் ☐
iii ஏனையவை (குறிப்பிடவும்) _____

5. கடமையாற்றும் நிலையத்தின் பெயரும் விலாசமும்: _____
_____

6. நீங்கள் அறிக்கை சமர்ப்பிக்க வேண்டிய வேறு ஏதாவது கடமையாற்றும் நிலையங்கள் உள்ளனவா?
i ஆம் ☐ ii இல்லை ("இல்லை" எனில், வினா இல.8 இற்கு செல்லவும்) ☐

7. "ஆம" எனில், தயவு செய்து அலுவலகம்/கடமையாற்றும் நிலையத்தின் பெயரை குறிப்பிடவும்
_____
_____

8. நீங்கள் கடமையாற்றும் பிரதேசம் மற்றும் பணி தொடர்பான அறிக்கைகள் சமர்ப்பிக்கும் விபரங்கள்
a. உங்கள் பணிகளை அறிக்கை செய்யும் நபர்(கள்) இன் பதவி (நேரடி) முகாமையாளர்:
i. அலுவலர் 1: _____
ii. அலுவலர் 2 (இருந்தால் மட்டும்): _____
iii. அலுவலர் 3 (இருந்தால் மட்டும்): _____

b. நீங்கள் கடமையாற்ற நியமிக்கப்பட்ட பிரதேசத்தின் புவியியல்/நிர்வாக அமைப்பு எத்தகையது?

i. நீங்கள் கடமையாற்றுகின்ற பிரதேசம்: _____

ii. பிரதேசத்தின் சனத்தொகை என்ன? _____

iii. தகவல் எங்கிருந்து பெற்றீர்கள்: _____

iv. பிரதேசத்தின் பரப்பளவு (சதுர Km இல்): _____

v. பிரதேச செயலாளர் பிரிவுகளின் (DS)எண்ணிக்கை: _____

vi. கிராம அதிகாரிகள் (GN) பிரிவுகளின் எண்ணிக்கை: _____

B. சேவை வழங்குதல் பற்றிய விபரங்கள்

9. மே மாதம் 27ம் திகதியிலிருந்து 31ம் திகதி வரை எவ்வாறான செயற்பாடுகளை மேற்கொண்டீர்கள் (கீழே தரப்பட்ட அட்டவணையை பயன்படுத்தவும் - மேலதிகமாக தாள்கள் பயன்படுத்தப்பட்டால் தயவு செய்து அனைத்து பகுதிகளையும் நிரப்பவும்).

திகதி	செயற்பாட்டின் பெயர் மற்றும் விபரங்கள்	இடம்	செயற்பாட்டிற்கு எடுத்துக்கொள்ளப்பட்ட நேரம்	செயற்பாட்டில் பங்குபற்றியவர்களின் எண்ணிக்கை	ஈடுபடுத்தப்பட்ட ஏனைய வளங்கள் (அதாவது, ஏனைய அலுவலர்கள், தொண்டர்கள், வெளியார்ந்த வளங்களிலிருந்து உதவிகள்)

10. கடந்த மாதத்திலிருந்து ஆற்றுப்படுத்தலுக்கு எத்தனை துணை நாடி வரும் நபர்களை (Clients) சந்தித்தீர்கள்?

	18 வயதுக்கு கீழ்பட்டோர்	18 வயதுக்கு மேற்பட்டோர்
ஆண்		
பெண்		

11. தயவு செய்து கீழே தரப்பட்ட அட்டவணையை பூர்த்தி செய்யவும். மே மாதம் 27ம் திகதியிலிருந்து 31ம் திகதி வரை ஆற்றுபடுத்தல் சேவை வழங்கப்பட்ட நபர்களின் குறிப்பிட்ட விபரங்களை சேகரிப்பதே இதன் நோக்கமாகும். தரவுகளை சுருக்கமாக நிரப்பவும்.

திகதி	துணை நாடி வந்த நபரின் வயது	துணைநாடி வந்த நபரின் பால்நிலை	துணைநாடி வந்த நபரின் பிரச்சினை	பிரச்சினை (உங்களுக்கு விளங்கிய வகையில்)	இந்த துணை நாடி வந்த நபருடன் இது எத்தனையாவது சந்திப்பு?	மீண்டும் சந்திப்பதற்காக உடன்பட்ட ஓர் திகதி உள்ளதா? (ஆம் எனில், தயவு செய்து திகதியை குறிப்பிடவும்)

12. உங்களுடைய துணைநாடி வரும் நபர்கள் முன்வைத்த பிரச்சினைகள்/விடயங்களில் நீங்கள் ஓர் ஆற்றுபடுத்துநர் என்ற வகையில் கையாண்ட மிகவும் சவாலாக அமைந்த 3 பிரச்சினைகளை குறிப்பிடவும்.

சந்தர்ப்பம்	1 ஆற்றுப்படுத்துனர் 2 ஆற்றுப்படுத்தும் அலுவலர் 3 நண்பர் 4 குடும்ப அங்கத்தவர் 5 வேறு சிலர்	வேறு சிலர் இருப்பின் தயவுசெய்து குறிப்பிடவும்
a. நபர்களின் பிரச்சினைகளுக்கு முகாமைத்துவ உதவி புரிந்தவர் :	1 2 3 4 5 →	
b. ஆற்றுப்படுத்தல் மற்றும் மேற்பார்வைக்கு உதவியவர்:	1 2 3 4 5 →	
c. வேலைப்பளுவினால் ஏற்பட்ட மனவுளைச்சலுக்கு உதவியவர்:	1 2 3 4 5 →	
d. வேறு ஏதாவது பிரச்சினைகள் -	1 2 3 4 5 →	
ஆம் எனில் உதாரணத்தைக் குறிப்பிடவும்: →		

C. தகமைகளும் செயலமர்வுகளும்

13. உங்களுக்கு உதவி தேவைப்படும் சந்தர்ப்பத்தில் உதவி நாடி யாரிடம் செல்வீர்கள்? (அந்நபரின் பதவி மற்றும் உங்களுடனான அவரின்/அவளின் உறவுமுறையை குறிப்பிடவும் உம் : மேற்பார்வையாளர், சகபாடி, நண்பர், குடும்ப அங்கத்தவர்)

செயலமர்வின் பெயர்	சாண்றிதல் அளித்த நிறுவனத்தின் பெயர்	சாண்றிதல் பயிற்சி/ டிப்லோமா/ பட்டப்படிப்பு	காலம்	விரிவுரை அளிக்கப்பட்ட மணித்தியாலங்கள்	செயற்பாட்டு நெறிக்கான மணித்தியாலங்கள்	உங்களது அன்றாட வேலைகளுக்கு எவ்வாறு பயனளிக்கின்றது 1 - பயனளிக்கவில்லை 2 - சிறிதளவு பயனளிக்கின்றது 3 - பயனளிக்கின்றது 4 - மிகும் பயனளிக்கின்றது 5 - தேவையாயுள்ளது
						1 2 3 4 5
						1 2 3 4 5
						1 2 3 4 5
						1 2 3 4 5

14. மொழி திறன் (1- இல்லை, 2- குறைந்தளவு 3- நன்று 4- மிகவும் நன்று)

மொழி	பேச்சு	கிரகித்தல்	வாசித்தல்	எழுதுதல்
சிங்களம்				
தமிழ்				
ஆங்கிலம்				

15. இந்த செயலமர்வு அல்லது கற்கை நெறி எவ்வாறு பயனளிக்கின்றது என்பதை தயவுகூர்ந்து விபரிக்கவும்?

a. .....
b. .....
c. .....
d. .....
e. .....

நன்றி !

Annexure III: Transcripts of in-depth interviews

In-Depth Interview 1

35 year old female. Travels from her home close by to office.

The services provided are counselling and awareness raising. Monday and Wednesday are spent in the office where counselling services are offered. During the other three days she goes on field visits, for awareness raising activities and to the following places.

1. xx alcohol and drugs rehabilitation centre (12 bed facility): twice a month
2. Minors' remand home (around 20): twice a month
3. Elders home (21 beds): once a month.
4. MOH meetings at the two MOH offices: once a month each

She gets clients mainly through the connections she has made and referrals from the Social Care Unit staff (social service officers, women's development officers, child right promotion officers). School teachers and pre-school teachers refer children for counselling if they notice any need. Parents tend to bring children if they notice difficult behaviours or school withdrawal symptoms. The main problems presented by parents as problems of children are exam related stresses and phobias. The other is problems with anger management and stubbornness.

Referrals are to the MOH and the psychiatry unit at the teaching hospitals and Community Mental Health Resource Centre (CMHRC). She takes part in the monthly district MH conference, which is either held at the hospital premises or the CMHRC.

The clients who came to see the CA during the last month are as follows.

Male: Most male clients who come for counselling need psychiatric assistance. (one with schizophrenia, three with depression, one with a sexual problem, five substance abuse/ misuse clients (came with their wives), and one anger management client).

Female: Five stressed out with husbands' behaviour, one with special needs children – depressed, two young adults after relationship break ups, one chronic depression, and one with obsessive compulsive behaviour

She is confident about skills and knowledge for long term counselling care for clients. When in doubt, phones the senior counsellors in the province for advice.

She gets to meet the DS about once a week. If there is an administrative issue, she can talk to the DS or the Admin officer at any time. They have a monthly meeting with GN officers,

Samurdhi officers, MOHs, police, school principals, bank managers and PHIs. This is very useful for making contacts with various officers in the areas.

She is satisfied with her job – 100 % satisfied with counselling work and very much satisfied with the psychosocial work. The transport allowance of Rs. 2,000.00 is sufficient for the monthly travel.

She has a Sociology degree and a 1 ½ year counselling diploma from the NISD. In addition, they get training from the Ministry for at least nine days a year. These trainings are organised in three-day blocks and they are very useful. She engages in self-learning at home. The knowledge received during trainings and studies are sufficient to help people with some problems. However, it is not sufficient regarding some other key problems;

- assessing and helping children who suffer from IQ related issues, and children with special needs
- substance misuse
- clinical issues

All Counselling Assistants can talk to each other free of charge as there is a phone package given to them that allows free outgoing calls within the group. She has supportive colleagues to work with and could talk to her managers at any time if there is any issue, and the Director in the Ministry directly if needed. She gets peer supervision from her university batch mates who also joined as Counselling Assistants.

Main constraint is the absence of a counselling room and this is a key problem. Transport facilities to rural areas (may be a Scooty pep), will be very useful because she is spending long hours on the road to reach some GN areas. Computer with internet access would also be very useful. Apart from that she emphasized the need of more training programmes. Line managers are not well aware of the role of the counsellors. CAs need approval from the DS to get involved in some issues and sometimes the police cannot act promptly. When there are legal problems, the women are therefore directed to 'Women in Need' (WIN). She feels that awareness raising among higher level officers about mental health related problems, including magistrates and high-court judges is important. She shared an example regarding this, where a child with delusional problems had been sent to remand prison by a court order and how there was no way of getting the child for treatment to a mental health clinic from the remand prison. Talking about the specific issues to the CA service she mentioned that having proper job titles and a proper promotional ladder in the service is important. At the moment they are receiving a very small annual increment and there are no promotions. She is now in a permanent position because she has completed the efficiency bar (EB) after she completed three years in service.

In-Depth Interview 2

30 year old female. Stationed at the home town—and her home is one hour's travel time away from work. The area has 131 GN divisions and two MOH areas. She shares office with four other officers, thus there is no privacy for counselling. Social services in this DS division is presented through the Social Care Centre with two social service officers, one child rights development officer, two women's affairs officers and one counselling assistant.

Service: stays in office on two days- Mondays and Wednesdays - to see clients. During the rest of the three days, is involved in awareness raising and home visits, according to the information received from Teachers, GNs and Samurdhi Officers. Till two months ago, visited the Mental Health clinic at the district hospital, but has now stopped as the clinics do not happen regularly. When there are clients who need medical care and possibly medication, she refers them to hospitals or the CMHRC. When patients from her service area are seen at the hospital they are referred to her. Attends to about 15 – 20 clients a month. Most commonly seen problems are 'family problems'. During the last month, the list of clients who received counselling services are: nine women – of which five were with family problems (they came with their husbands) – two were separated from their husbands and came for their socio economic and low mood related problems, and two came to talk about their children's problems. Five men came along with their wives regarding their family problems. A 15 year old boy with ADHD was referred by the school. A 17 year old girl with depression was referred from the hospital. 'Family problems' are the most common and they get referred by the GN's and the police. Stigma is a big problem in this area, like everywhere else. Most of the time, parents do not like to bring their children to the MH clinic or for counselling. One recent example is a son of a school teacher showing delusional symptoms, whom the mother preferred to take to Colombo rather than to get treatment from the MH clinic.

Conducting school level programmes have been very useful. Children phone and SMS her for problems they have. These include developmental issues as well as exam stress related matters. She has links with the two MOH officers and attends the monthly meetings held in both areas. She has links with the police, education department and the schools principals and school counselling officers. There is one local NGO (Kaanthaa haa Lamaa Rakawarana Madyastaanaya) and she has contacts with them too.

She is very satisfied with her job as she gets to do a lot of service functions. The Divisional Secretary is the line manager, who can be approached for administrative support. For counselling related issues she phones the senior counsellors in the province. She is the sole counsellor in the district. There are some social service officers who have followed Prof.

Ranawaka's counselling course. Talking of job satisfaction she added, it would be nice to have better recognition and designation, and also a better pay scale. Lack of promotional prospects causes frustration.

As for educational qualifications, she has a psychology (first class) pass from the University of Peradeniya and has followed Prof. Ranawaka's counselling course. During the degree programme she has also completed a six months placement at the Community Mental Health Resource Centre (CMHRC), Katugastota. She has been receiving training from the Ministry of Social Services, for nine days per year in blocks of three days. Out of the trainings that she has received the abnormal psychology modules have been very useful. The training programmes organised by the Ministry were very useful. Apart from that, she uses the internet at home to improve her knowledge. When focusing on the gaps in her training, clinical assessment and treatment planning in counselling was mentioned. She stated that "it is very useful to have refresher courses on assessment, formulation and treatment planning".

Main problem is lack of supervision. There have been discussions on peer supervision, but it has not yet materialized. Another problem in the area is lack of psychiatric facilities and the lack of a psychiatrist. Considering the facilities in her work place, the most noticeable one is the absence of a counselling room. Also, she (like all other CAs) only gets Rs. 2000.00 for travel. She serves a large area and it is not adequate to do the home visits as there are 131 GN divisions to cover. She emphasized that this is more of a psychosocial workers role, than just counselling. She sometimes talks to clients over the phone as traveling is not practical. She added, "the counselling that we learned in books does not exist over here". It would be better if she had better communication with the PHIs and also with the adjoining district as most of the administrative facilities are over there.

In-Depth Interview 3

40 year old male. Works in his home town, travels to work from home.

Service: he believes that the term social care expresses his role as he is involved in psychosocial development activities. He spends Monday and Wednesday in office while the other three days are spent in the field. He visits the prison on the second and fourth Tuesdays (of the month). On Fridays he goes to the mental health clinic in the district hospital. He assists clients who do not like to go to the MH clinic by accompanying them. Sometimes he hears from the GNs, Samurdhi officers, etc. about patients who do not take their medication. In such situations he does home visits. For example, last week he visited a single mother with two teenage daughters diagnosed with schizophrenia and one son who attends school, as she was lost as to what to do and had been isolating herself from the rest.

These instances go beyond the counselling they were taught. But in real life situations like this, he stated that they need to be more proactive as there is a great shortage of psychiatric social workers. He intervened with the Ministry to get the Rs. 3,000,00 donation for people with mental disabilities. In most cases only the physically disabled people manage to get this. He worked with other officers in the DS in December 2012 to build a house for a person with a mental disability. He was a businessman before. With past experience in agriculture, he trained a group of 25 women on growing flowers. This was done with the Ministry of Child Development and Women's Affairs. They funded this project with Rs. 100,000.00. Now this has grown and they have made links with some NGOs too. Also, the membership has now grown to about 75, and men too have joined the group. Two months ago he, with the help of other officers, found a school for an eight year old boy, who lived in the bus-stand with his mother who is a sex worker. These are the things that help prevent future mental health and social issues. The CA and the other officers, were trying to get a scholarship for the child's education, but it was not possible because they did not have bank accounts, and a bank account cannot be opened because they do not have a permanent address. These are problems that a CA cannot help by limiting the service the counselling room.

This area has about 40 % of Tamil speakers. But this CA does not speak Tamil. So they do not come to the CA and even if they do, there is very little he can do. What he does do is send them to a CA in another DS division who can speak Tamil. The latter CA came to the area only two months ago and prior to that they did not have support for Tamil speakers. In the area of this Tamil speaking CA, about 70 % of the population speaks only Sinhala and the CA is not very good in her Sinhala. Thus, there is a problem in that area too.

Insights into people's problems:

People have economic problems. Most people get stressed out because of difficulties in managing their day-to-day lives. Some cases presented are:

1. A mother came seeking help on behalf of her married daughter who was considering divorce. The problem as she explained was that they have not had sexual intercourse even once. The mother has agreed to visit with the daughter and if possible her husband too next week. However they have not yet visited.
2. 30 year old man visited complaining of extreme sleepiness. After the discussion, the client has agreed to go to hospital.
3. Seven years old boy had visited with the mother. The child had a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and had left three schools as he had problems with teachers. He was referred to the MH unit in the hospital.

4. 18 year old girl referred by a GN for bad behaviour in the house. She was living with her uncle and aunt. The mother was abroad and the father had left them. The girl had two married elder sisters. There was no news about the elder brother and the younger brother was living in a temple (not a monk). They last visited two weeks ago—it had been her third visit while the uncle and aunt had seen the CA twice. Now the girl has been referred to the MH clinic and she is been treated for some delusions and hallucinations she is having.

5. 70 year old mother had come asking for a job for her 20 year old daughter. The mother mentioned that the daughter was going through a divorce and that she was separated from her husband. She had refused to come to the CA's office and when the CA visited, he had observed signs of depression. Then she was referred to the MH clinic and had been diagnosed with depression. Now she is attending the MH clinic and has made two visits to the counsellor too. It is now two months since the first visit.

6. The other group of people whom I try to work with is the Education Sector including the school principals and school counsellors who have minimal training. They sometimes try to sort out problems and create even more serious ones. Therefore, further training for them and awareness raising is vital. For example, in the case of an 11 year old girl who was abused by her grandfather and was pregnant, I do not feel the school and the police department handled the situation in the best interest of the victimized girl.

7. About 70 % of the problems are sexual. This does not refer to the act itself. But mostly to the lack of understanding of the other person's body and needs. The cases are not directly presented and they come as aggression within the family unit and divorce, etc.

8. Another major problem, especially in the estate sector is alcoholism. This is largely linked with violence, economic problems, abuse, and mental illnesses too.

Social-Care Unit

The social-care unit of the DS office has seven Officers—one Social Service Officer, one Social Service Assistant, one Elders' Rights Development Officer, one Early Childhood Rights Officer (stationed outside the SCU), one Child Rights Officer (stationed outside the SCU), one CA and one Human Resources Development Officer. Currently, out of the seven officers, six are occupied and one is vacant (a Social Service Officer). The CA emphasized that it is important for all these officers to be in one unit because problems seem to involve most. In addition, the CA also has links with the GNs, Samurdhi Officers,

and the other field officers who are about 20 in number. There are also volunteers such as community leaders and monks.

Job satisfaction

CA is about 60 % satisfied. He claimed that it is not a very stressful job. He enjoys helping people, but sometimes it is not very satisfying and quite stressful because he knows what is needed but there is nothing he can do.

Support mechanisms

He gets to meet his line manager, the DS whenever he wants. Sometimes he may talk to him about 2 – 3 times a week (last spoke to him on Friday). He also talks to the Director of Counselling at the Ministry. However, it is also frustrating as there are no supervisors or counsellors for them. Sometimes he gets very stressed and disturbed after sessions. But there is no one he can talk to. He does not intend to be in this job till retirement.

Education and Professional Trainings

- Graduated from the University of Peradeniya with a Psychology special in 199x
- One year diploma at the Ranawaka institute in 200x
- On-the-job trainings provided by the Ministry is very useful. However, none of them have provided him skills to handle some cases

The four year degree has given him the knowledge to understand the clients and the problems they present from a theoretical perspective. The counselling training from the Ranawaka institute is also useful. The quality of trainings from the Ministry has deteriorated. They need to also look into the well-being of the counsellors.

Gaps in training:

- Lack of clinical knowledge
- Training on how to understand the clinic card. i.e. what are these medications for? How do they work? What are the likely side effects so that they can explain things to the clients with confidence
- No knowledge in clinical assessment.
- Knowledge relevant to psychosocial work including networking is required
- Knowledge about other religions would be very useful when dealing with clients from diverse backgrounds. It will be useful to add this to the Higher National Diploma course too if possible.

- He has found that some knowledge about para-psychology is also important for counsellors when working with some clients.
- Another important area is self-care.

In addition to the local issues he also mentioned some national level issues.

- Top level administrators should be made aware of counselling
- Training the education department administrators and also teachers
- The language problem has to be dealt with. For example: have Sinhala and Tamil counselling officers in areas with mixed populations.

The main gaps in the field are as follows.

- Inability to get peer supervision
- lack of resources: no counselling rooms in most areas, lack of travel funds (only Rs. 2,000.00 per month)
- No support for the counsellors' personal problems. He has noticed that some CAs have messed up their lives in some way. This may be because they don't have adequate support and also have not got training in self-care and protection of own self.

In-Depth Interview 4

37 year old male, lives 36 km away from work place. Travels daily by motorbike and it takes around 45 minutes to reach the work place.

Service

On Wednesdays is at the DS office (if new clients come he sees them if not does office work); on Tuesdays - at the Social Care Centre (meets clients, helps the WDO if required to do home visits, sometimes the GS would also request, plans awareness raising programs); On Mondays, Thursdays and Fridays - at MHU (On Monday mornings and Thursday afternoons at clinic, on Friday afternoons at family support clinic and other times meets clients from the medical ward – mostly attempted suicide cases and a few clients with stress or depression or family conflicts); visits villages along with the Psychiatric Social Workers (PSWs); does awareness raising activities – in villages for parents, police, RDHS and GA's office staff. The Ministry of Social Services provided Rs. 25,000.00 (for Deyatakiruala events) and Rs. 20,000.00 (for the mental health day celebration). Has also, conducted various activities with the support of NGOs. Apart from the above funded activities helps the CRPOs and MHU staff to implement their related activities.

He spends around 30 – 40 minutes with a client. Per day, he meets four clients; and does eight hours of counselling sessions or a little more during a week. Currently sees: eight adult clients (five females and three males). (Personal details are with the Counsellor in his personal note book).

He works under the MSS and under the direct supervision of the DS and the Psychiatrist. At the DS office the relationship is of an administrative nature and at the MHU it's collaborative and technical. Has access to the DS and the Psychiatrist at any time and can call them whenever necessary.

At the MHU, sees patients and family members who access other social services and students referred by the Probation Officers. The common problems of clients are – attempted suicide (mostly females – young girls), anxiety, depression, somatic problems, Obsessive Compulsive Disorder, aggression, and PTSD. The clients are asked to come once a week initially, later on twice a week and are later terminated (may meet once a month). Some come even after the termination. He also gives the phone number if asked. He can deal with most of the problems of client groups; but finds it difficult to talk to children under the age of 10 (referred to MHU nursing staff, Angela). Also finds it difficult to talk or work with alcoholics.

Job satisfaction

Has self-satisfaction when clients say that it helps them. Is satisfied a lot with his work!

Training and skills

Holds a bachelor's degree in psychology; a diploma course in human rights; followed the NISD diploma for 18 months; and has followed the various trainings the Ministry has conducted from time-to-time. They are helpful but the trainings conducted by the Ministry are in Sinhala and the translation is poor. Some more content needs to be included in the training e.g. sex education and topics on MH. Training on diagnosis and treatment (for mental illness e.g. schizophrenia); communication skills; and how to conduct case conference could help him to be more effective in work. He talks to the psychiatrist or the nursing counsellor; does relaxation (for sleep at night) and talks to friends and colleagues outside xx. He does these things to take care of himself and foster wellbeing. He benefits from the training organized by NGOs, MHU, etc. He reads books to update his knowledge and feels the need to learn English.

Resources

Has good working space at the DCPU office, the MHU, and Social Care Centre to meet with clients.

Gaps and recommendation

More team work; working with the MHU (for wider exposure); and a recognized course by the MSS on clinical psychology could make him more satisfied. He was entrusted to work as the District Coordinator but the designation is not yet given.

Interview with Divisional Secretary

In this region prevalence of poverty is very high. As this region suffered from long-term war, rebuilding hope among the people is a long felt need. On the other hand there are ongoing stressful situations too. Despite this the development work is taken forward. There are problems related to family breakdowns, unemployment, alcohol addiction and etc. There is a growing problem of people falling prey to the financial service companies, with some of them even going to the extent of committing suicide. In xx there is good networking and coordination of services; which is helpful and effective. There is lack of human resource. The staff too needs self-care support; staff care should be made more formal and should be mainstreamed to benefit all government staff.

In-Depth Interview 5

33 year old male. Wife lives in Colombo (visits her during the weekend), and he stays 15 km away from work and comes by motorbike (takes 20 minutes to travel to office).

Service

Supervisors are DS and Assistant DS. On Mondays and Wednesdays is at the office; on other days in the field. Visits the Qazi courts and on the third Thursday of the month meets clients at the MHU. Has an office room and a separate room for counselling sessions. Clients are referred by the SSO, WDO, GS, Samurdhi Officers, Social Developments Assistants, Probation Officers and other officers and the MHU. Has been asked to give reports e.g. the probation asks for suggestion and opinions (in case of a child in a family having problems). On Mondays and Wednesdays he meets clients at the office, and on the other days he visits them at their homes (follow up).

Once in three months the Ministry provides around Rs. 20,000.00 or above for awareness raising activities. Apart from funded activities, organizes various awareness raising activities through the DS, GS and Samurdhi Officers at village and school levels. These are not funded so ensures that these activities are conducted within an hour or two (if it exceeds then refreshments have to be provided). These are part of the list of duties to be reported monthly. These events are for Samurdhi, PAMA (public assistance for monthly allowance) beneficiaries and the members of the elders and women societies. The respective officers do the logistics and coordination. As this centre is a Social Care Centre, there is team work;

all the relevant officers are here (SSO, WDO, SDS, the counsellor, program assistants for each program, and every Wednesday the probation officer visits). The awareness raising activities are conducted on Tuesdays, Thursdays and Fridays. Gets referrals every day and on some days it will be more (for instance on the days after the Qazi court cases gets more referrals – the courts takes place every month). The Qazi courts send people to the Counsellor to "settle the matter and reach a consensus among the husband and wife to live together". To get more information may have to organize a Family Group Conference. He organizes case conferences for complicated problems (if many services are to be met). Not only provides counselling but follows up with the rest of the problems as well – functions as a "psychosocial worker"!

Clients with depression, stress (in appearance person is extremely sad or inactive or going through some severe difficulty like violence, sleeplessness, talks abnormally that he is possessed by "jinn"); in those cases he assess the individual and the family context and refers them to the MHU. There are also people with schizophrenia. There are other psychosocial problems like poverty, family disputes, husband addicted to alcohol, victims of domestic violence, child victims to sexual abuses, etc. Some clients just come to meet – as they feel they are being listened to or in expectation that they might be provided with material assistance or services! He makes it a point to meet with a client around three times a month. On every third Thursday meets the MHU patients as individuals or in groups. He teaches the clients breathing and relaxation exercises, helps people to assess their stress environment and how to deal with that. Does family counselling (in the case of husband and wife conflicts), motivation for drop outs and befriends people with severe mental illness.

Job satisfaction

He feels satisfied about his work. He is able to do many more things than designated responsibilities—for instance he introduced "quick maths" for the students. Searching and self-learning helps him to be satisfied. Has written three abacus books (mental arithmetic methodology), which are expensive but given free of charge. He is invited as a resource person for other staff's programs, which gives him a lot of satisfaction and feels he is resourceful. The DS and the ADS are the two managers; has rapport with both of them. The DS is available during the office time and can be contacted over the phone. When he goes beyond counselling (practical support that makes changes in the life of the client) for instance when a child is able to show performance in studies because of his support, he is satisfied! When he learns new things and has some new techniques to offer he feels he is able to help people.

Training and skills

Has completed the NISD diploma in 200x (one and half year course). The Ministry has also been providing training over the last five years. Every six month there is a residential training for three to five days. These are mostly conducted by psychiatrists, psychologists, senior counsellors and social workers and other resource persons. Apart from this, there are various trainings within the DS division both by the government and NGOs related to Human Rights, GBV, mental health, disability and etc. Most of the training is relevant to the work and they are released by the Ministry to attend same. He gains relevant and new knowledge. But the trainings are not very practical – class room and theoretical based programs. But the Ministry has had yoga, relaxation exercises etc. which were useful. Does self-learning, and takes the initiative to attend workshops (he is very motivated). He has not learned much approaches and techniques of delivering services. They do peer support on a monthly basis and district coordinators are met by the Ministry coordinator once in three months. Technical supervision is not there. He refers the difficult cases to another counsellor who may be an expert in that field.

Resources

The support of the team members (Social Care Centre team), the office space, travel allowance, and the personal contacts with senior counsellors are resources. Communication facilities and increased transport allowance and trainings (hypnotism, etc.) are useful.

Gaps and recommendations

The rest of the staff members (at the social care unit) do not have adequate knowledge about the counselling work and its benefits (they walk inside his room during the counselling sessions, giving the feeling that they do not respect the work done!) The counselling room is sometimes taken by the DS for various other purposes. Lack of general understanding about counselling that it is confidential shows that the therapeutic aspect is not acknowledged. He finds it difficult to show the achievements of his work! Others are able to show the outcomes which are measurable!! What is the use of a home visit? - how to prove if someone asks!

Interview with Assistant Divisional Secretary

The CA is an active staff member and good at his work (the ADS has also done a counselling diploma certificate at the South Eastern University). He attends the case conferences at the DS office, which I coordinate often. His services are very much needed in the area. There are a lot of problems due to the effects of disasters and the war. Women headed households, child labour, children dropping out from school, and parents migrating to the Middle East for employment and leaving the children with the rest of the family members

and relatives is very common. Counselling support helps to raise awareness among the people. Particularly, it is a very helpful approach to resolve family problems. There are also people with depression, stress, and trauma and with other mental health difficulties. Often, they are referred to the MHU. Counselling becomes supportive to other social care services too. The CA would need resources like a computer (for documentation and data maintaining purposes), travel facility and a separate permanent space for his work (as it requires safety and confidentiality both for the counselling sessions and to maintain the records).

In-Depth Interview 6

37 year old male. Lives ½ km away from office. Travels by a three wheeler in the morning and returns home with a brother of his.

Service

Basically, four types of work is done; individual counselling, group counselling, family counselling and awareness raising activities. For individual counselling the clients are referred by the GS, mid-wife, PHI, SSO, WDO, CRPO, PO and PA (SSO); clients rarely come on their own for counselling support. Group counselling is done mostly for the students. When notified of drop outs I conduct group counselling for those who dropped out or students who are about to drop out. There are many children's homes in the area and certified schools too (comparatively most number of homes in the Jaffna region is found within this DS division). Family counselling is offered to couples who are referred by the WDO and the rest of the above mentioned service providers. I conduct awareness raising activities and workshops for youth (career guidance, alcohol related, etc.). I do safety related awareness for the girls working in the shops (commercial sector). At office on Mondays and Wednesdays (meet clients, have office meetings, planning, documentation, etc.). On Tuesdays, Thursdays and Fridays in the field (visit schools, follow up with clients and groups, do awareness raising activities, home visits etc.) I refer patients to the MHU. I work under the Ministry of Social Services and am based at the DS office. My direct supervisor is the DS. I am under the Ministry of Social Services; hence the relationship with the DS is a mandatory administrative relationship. With the MOH I have a mutual coordination relationship; I participate at the case conferences, do referrals and support whenever needed for joint activities. My relationship with other staff within the Social Care Unit is regular and we do coordinate well. The other officers within the DS office and outside are supportive, for instance work with the Probation Office (the office is within the same premises and next door), and with the Education Department. Whenever I am invited to programmes I help them, and we invite them for our programs as well. Did MH awareness and stress management programme for the DS staff, pre-school teachers and etc.

There are families with problems such as young couples or individuals who have difficulty to adjust with parents, parents unable to adjust with children, conflicts, domestic violence, and family separation or those who have initiated the process for divorce; parents say that the children are deviating with regard to marriage arrangements, parents and guardians bring alcohol addicts and etc. Elderly persons face problems such as being neglected; living without basic facilities and seeking assistance to go to a home and etc. Young people have problems related to love affairs; young girls come and say that the parents are opposing their love affairs and etc. There are MH related complaints too; somatic related problems, anxiety, severe depression etc. and I refer them to the MHU. After they started using drugs we talk to them about other difficulties like practical support. I do teach relaxation, anger management etc. Some come regularly (around 20%) and for others we do follow up in the field. We ask the clients to come to the office once a month or if necessary weekly—it depends on the nature of the problem. I am able to build good relationships with the clients and get their cooperation within one or two sessions. I get a lot of support from the other officers too. I have people to support me - my friends and office colleagues accompany me if I have to do field visits. I feel confident (he was an assistant lecturer – temporary at the Jaffna University and later did an NISD diploma)—I started practicing counselling support from 2009. I do documentation using brail, and I have a special computer software at home. At office my friends help. I refer the clients to the MHU if I cannot help them.

Job satisfaction

I am satisfied about this work as a) I am able to earn b) I am able to support the public. When there is a change in the life of a client and they are happy I find that happiness and share that in my life too. The DS is my line manager. At any time I can meet or even call him. He is very supportive towards me. I get whatever I need; at least the DS and the officers try their level best to fulfill my needs. For instance the rest of the staff gives their space if I have to meet with a client. My satisfaction could be scaled as average 65%. I use the available resource to the maximum and am able to see the outcomes, which gives me the satisfaction to continue to do the work. I go out for programs (organized in relation to my work or even with family outings), go to temples, participate at my children's events, participate at my association (a centre for social resource of differently-abled of which I am the current president) – these are some of the ways I manage my stress and foster my wellbeing.

Training and skills

I hold a BA (Hons) psychology degree and have done the NISD diploma. I have been following other regular trainings of the Ministry and other NGOs. I have also applied for the Australian scholarships program (have problems about sitting for the IELTS as I am visually handicapped). The trainings have imparted knowledge and exposed me to

a variety of topics. The trainings by the psychiatrist gives me the knowledge to at least assume (I am unable to diagnose the MH difficulties) the nature of the problems of the client (MH illness) and I am able to understand and help if possible or make referrals to the MHU. These trainings also have helped to work (coordinate) with other services (psychosocial approach). Other than these I gain the practical knowledge while in work. I read, browse (on you tube I listen to the counselling sessions, lectures and talks), I have support from my other colleagues (when meeting and calling each other we do discuss about problems and new approaches) – these are the ways I keep myself updated. Most of the training by the Ministry has been conducted by Sinhalese resource persons and we have difficulty in understanding (often our peers are asked to do the translation and it would be good to have professional translators); but recently they conducted two separate programs in Tamil, which was convenient for me. Overseas experiences would help to improve my English language skills and give exposure particularly to differently-abled, education approaches, and learning advanced skills in counselling would be helpful to build my capacity further.

Resources

My colleagues, family, head of the office (DS) and managers who are supportive, NGOs (which assist my clients whenever I make referrals for livelihood) and other friends who are working in the same field are my resources. Transport facilities (I do work mostly over the phone at the office - and I have also been given my personal number to some people who need urgent and regular follow up assistance), a computer with the software for visually impaired persons (which will make me more independent to do my documentation), and advanced trainings etc. would be helpful for me to be more effective.

Gaps and recommendations

I find it difficult to visit the field as I have no transport facility, I cannot do documentation at the office as there is no computer with software for visually impaired person and I do not have a separate space for counselling sessions to meet with the clients. There is social stigma everywhere; I will feel more satisfied if we could work to create a grass root level awareness about mental health and wellbeing. I am currently designated as "Counselling Assistant"; but it would be good to have the designation as "Counselling Officer" as we do the work like other related officers and our status and benefits are not compatible. We are in the same structure of an officer e.g. like the WDO, etc.

Interview with Divisional Secretary

The CA is a good person and he works in coordination with the rest of the staff in-charge of various services within the Social Care Unit. He is a sincere staff and capable

in his field of work. The counselling service is necessary in this context and particularly within my Division as there are a lot of people with livelihood problems, facing child abuse, domestic violence, elderly persons facing a lot of problems and etc. Education is not the worst problem but poverty; people need personal assistance like counselling to understand and guide them. The family system and support has broken down due to displacement and war related effects. We do not have enough space to offer the CA for his work (particularly to meet with the clients in private). He also needs transport facilities to make field visits (a three wheeler would be helpful).

In Depth Interview 7

A 33 year old male, lives at the quarters (just behind the office), and goes home once or twice a week (not yet married).

Service

I do three types of work: 1) individual counselling: I get referrals from the schools (child abuse related cases and behaviour problems); I support adults, among whom there are PTSD problems (now moderate), emotional problems, addiction to alcohol, relationship problems, domestic violence (large number of family cases and it's on the increase), depression, and anxiety; and I do referrals to the MHU, and also get referrals from the probation and other field staff such as, GS, WDO, NCPA and etc. 2) family counselling: get referrals from the magistrate, legal aid commission and police too 3) group counselling: I conduct awareness raising activities and workshops! I select target groups – I coordinate and work together with the NCPA and Probation. These programs happen to be one-day events but if necessary we do follow ups regularly. I work with schools too and there is good cooperation.

On Mondays, Wednesdays and when necessary on Fridays I stay at the office and meet clients. Whenever requested I attend the MHU clinic at the hospital. On Wednesday afternoons I go to the courts and meet the clients. On other days, I visit the field if there are default cases or if there is a need to do the family assessment I do it on those days. I do prevention counselling in relation to domestic violence, sexual/child abuse, parenting skills, alcohol and substance abuse, SGBV and etc.! When NGOs approach me to be a resource person I do so and we do invite the NGOs whenever activities are organized by us. We get limited funding support from the Ministry to conduct activities. I am attached to the MSS and am based at the District level. I work closely with other government related services providers like the MHU, schools and etc. I am under the GA and my other relationships are mutual and need based. The clients come to meet me at the office. Sometimes they even come from very far.

Constraints

I feel I need to improve on family counselling skills. I am able to deal with minor problems – minor depression, anxiety and phobia. I don't do therapy. If there are complicated problems I refer them to the MHU. I do refer to the clinical psychologist as well. I feel there is a lot of need for counselling work, but there are lack of resources; for instance, human resource – I am the only permanent counsellor for the district! Those at the DS levels are temporally appointed but they get other appointments and go away! I get a lot of referrals but am unable to meet with the demand. I have created a format with the support of the clinical psychologist to document the sessions (there is no standard format as such). I have a file for each client. There is no comfortable space for the clients to wait and meet (sometimes they stop coming when they find it difficult to sit or wait here); I was not given any transport facility by the Ministry but use the Kachcheri vehicles and my travel allowance, which is not sufficient as the geographical area is very large. We are also not given any allowance for accommodation too. I am designated as a Counselling Assistant and it doesn't give status for us. It would be good to be designated as a Counselling Officer, as this is a professional work like the rest of the officers in the same section. A proper designation, a space on our own and transport facilities would make my work much easier. I am doing the work without frustration despite all these things because of the support received from the management, like the GA and the ADS.

Supervision

My line manager is the Assistant District Secretary. GA's meeting happens on every Wednesday and there are sector updates/progress meetings I have to participate in. Whenever necessary I do meet the ADS and I can phone her too. For technical support I talk to the Clinical psychologist and MO Psychiatry. I also attend DCDC and hospital case conferences—they invite me to get my opinion. Technical supervision is a gap (we only talk over the phone with our colleagues and known people for support) — we don't have systematic supervision and it will be good to have peer supervision.

Job satisfaction

I am satisfied as my capacity is utilized; I can see the benefits e.g. prevented a lot of divorce cases!

Training and skills

I have a BA in psychology and have done the NISD diploma as well. I worked with an NGO for a year (worked as a counsellor after the Tsunami) and later at another NGO (worked as a PS trainer for two years). The Ministry conducts trainings and workshop under various topics as part of on-going capacity development for us. The trainings refresh our skills.

They are more complementary to the work that we have already been doing. E.g. suicidal related training (how to work with someone who has suicidal thoughts) and alcohol. These have been helpful. I update myself by reading books, referring to websites and talking to peers. The trainings are generally conducted for two or three days! But it should be regularized and ongoing with practical exercises and coaching.

I would need further trainings to focus on alcohol related issues, family counselling, and how to work with abused children (how to get them out of the effects – what are the contents for immediate response).

Resources

I have space for counselling sessions, office space and receive cooperation from other staff. I am using a space given by the Kachcheri but there are lot of things stored inside the office too and I need to have a model space for work (a room where the client would feel comfortable to sit and talk and even to put up some charts or pictures too) for the work. Need a space to keep the records confidentially and I use my own lap top. The human resources needs to be increased. I talk to my friends and peers but it does not help to systematically deal with my personal problems. I also listen to music and watch movies.

Interview with Medical Officer for Mental Health at MHU

The counsellors at the DS and GA's office are given support for the administrative part of their work. There is less technical supervision and management. The CA comes to the MHU clinic at the hospital two days a week. Other Counsellors (temporally appointed at the DS level) do come and help during the outreach clinics in the respective DS areas. They concentrate more on probation and court related cases; and not so much on mental health (illness) related problems. Mostly, they work on motivation, problem solving and family related conflicts. However, they are a complementary support towards mental health! I am not certain about their training background. There is no mandatory coordination between their services and the MHU's. In one division the CA doesn't come to help at the clinic. There is lack of coordination. Further, most of these CAs or even other staff members are from out of the area and they work for a short period; they are transferred often. When, counsellors are appointed there is no consultation with the health sector and it will be good to make decisions along with the health sector when appointing personnel for mental health related work. It should apply to others as well (WDO and other staff attached to the social care services).

In-Depth Interview 8

32 year old female. Lives 1.5 hours travel time away from place of work.

Service

I work with the team in the GA's office and assist in all of their programmes apart from counselling. In the past year I have done the following programmes:

a. Worked on women's development projects

b. Helped agricultural programmes especially the disaster relief programmes after the floods, helped to conduct survey and needs assessment, and have gone from house to house helping in administrative functions like relief fund disbursement. We also helped to organize donation ceremonies for beneficiaries. I spent three months on this work. Though this disaster relief work gave me an idea of who has been affected, it was not possible to do counselling for them at that stage when we visited their homes. If we invited them to come to the office often they wouldn't, due to the distance and travel expenses involved.

c. I also helped in distributing disaster relief to schools.

d. Planning new year festivals

e. Raising funds

f. Blood donation campaigns

g. **Counselling for individuals** who come to the office: I do about 12 hours a week which can be a bit less or more in some weeks. I would see about 5-6 people a week sometimes. Other times very few come. Of these 12 about three may come more than once. I may spend 2-3 hours with them. It's mostly young people who come with their parents and sometimes they come with their friends.

The multidisciplinary team in the Social Services Care Centre: I work on a daily basis with all colleagues in this team, involving myself in all of their activities. We support each other generally. We are all supervised by the Assistant District Secretary (ADS)

- Social Services Officer
- Social Development Assistant
- Women's Development Officer
- Elders Rights Protection and Development Officer

Government Departments:

- Probation Office
- The district courts
- Police: The Children and Women Bureau desk
- Health department: collaborating with MOH, PHI and family health worker
- The child protection committee

Other NGOs

- Try to get help from legal aid organizations
- We make referrals to hospitals
- A Buddhist NGO dealing with disability and appliances

Nature of these relationships

- Though some make referrals and try to utilize the counselling service many don't really have much confidence and are not able to recognize the need and also do not understand clearly what counselling can achieve. So they are half-hearted in their support and collaboration.
- If my boss contacts their boss and asks for help or collaboration then based on his rapport with them they are very corporative.
- **MOH, PHI, and FHW:** Some don't seem to have the authority on the ground level to make a decision with confidence to work with me or refer to me. They say they have to ask their boss. This may be just particular officers I have met (e.g. the MOH and Family Health Worker), and not all.
- The police was very open for me to come to the police station and work alongside them. However the environment is not at all conducive to having confidential chats (it was extremely public) and the clients thought I was also a police officer so the relationships with me were coloured by that. Also the style the police use to solve problems and our style as counsellors are very different. Even our goals and agendas are different so I didn't see how I could continue working within the police stations but asked them to send clients to our centre.

What sort of clients do you get to meet in your work and what are the common problems?

- **Women** who suffer some impact of either drugs, alcohol, or related violence in the home and in society in general. These are beach (tourist) areas and there is a lot of substance abuse and other types of abuse.
- **Children / young people** who have had problematic love relationships : " going astray", dropping out of school due to substance abuse, sexual exploitation and abuse, children suffering in dysfunctional homes where parents are not present (migrant workers children), and petty crimes.
- Elderly people: abandoned, neglected and depressed, and no one to care for them. Too much family responsibility taking care of their children's children and unable to cope.

How do you deal with such clients/cases? Have you got the capacity to support them? If not, what do you do?

I deal with these cases by

- Getting practical help from the other relevant officers in the multidisciplinary team
- Sometimes I speak with them and advise them and their parents/family.
- Sometimes I refer them to other departments / organisations

I know there is a lot more I can do but it is not easy as they don't come often, sometimes it is too dangerous for me to go alone to some of these problematic households and neighborhoods, so I have to go with a male presence (usually my supervisor the Assistant District Secretary). I have to wait to go with someone else. Sometimes due to the confidentiality of the case I can't even speak with my colleagues in the team. Then it becomes a real stress for me.

Case studies illustrating how respondent works

1. A child was brought to the centre by anxious parents who said they were upset that the child always spoke of a previous birth and was withdrawn fearful and depressed. I wasn't sure at all what to do with the child and was wishing we had some training in this regard. But I met the child anyway and started to play and talk to the child about his concerns and fear. I watched the child closely and listened to everything he said and suddenly it was apparent to me that he was talking about his sister who was his playmate and who had left home to go to boarding school, and he was

grieving for his sister as he didn't have any one to play with any more. I told the parents to give him time with his sister and explain to him that she was not gone for good.

2. A Muslim husband had a mental illness (schizophrenia) and regularly beat his wife. I referred this to the police for action as he was uncontrollable, but they weren't interested or found it too difficult because they were Muslim. I felt I did not have sufficient authority in this case to make any significant change

3. I was told of an elderly woman who was trying to cope with looking after her migrant daughter's children. The father of the children was an alcoholic and would come home and make life very difficult for her, the grandmother, and for the children. I visited the home, and then I got the kids down to the centre. They didn't speak. When I asked them if they had any problems with their dad they said nothing. I think they are ok but I am not sure. We told the police to warn him.

   Observations of researcher: CA needs training in identifying abuse and distress in children. The training needs to also cover how to work with high risk and high vulnerability children. Also needs skills in knowing how to support and empower primary care givers of children.

4. I also worked with the father of a 26 year old girl, who was incapable of going anywhere on her own or doing things on her own outside the house, ever since she lost both her mother and brother to the tsunami. Her father came to see me. He had been content to keep her inside the house looking after her sick grandmother and never encouraged her to leave the house as this was convenient for him. Now he was forced to help her become independent as he was trying to give her in marriage. I visited their home. I advised him to start helping her to do small things on her own as she was unable to function without him. I asked him to bring her in for counselling and started to speak to her encouraging her to, over a period of time, come for counselling all on her own. She has started to come half way with her father and alone the rest of the way.

What is your self-evaluation, where do you receive supervision and administrative support from?

Earlier when I started I felt I couldn't do much but now I think I would score myself 75% as I feel I handle things better. I also feel I need to learn a lot more:

What do you need to be able to work more effectively?

I am unhappy about the way we have to sometimes abandon cases due to:

- Lack of access (no transport) limited resources and limited trips can be done. Have to wait for a van which isn't always available.
- Security reasons. I can't go alone to some areas, have to wait for someone to join.
- No phone facility from which to call clients. They can call in but we can't call them so I can't follow up. Line was cut after two months of operation.
- Tough situations like drug and alcohol abuse and child abuse where I can't intervene.
- Need a formal procedure to make sure other GOs work in collaboration. I am just a "counselling assistant" I don't seem to have the authority to make a referral and if I do, sometimes it isn't taken seriously.(see case study 2)
- It will help if we are given more authority in our title and also in the formal procedures, making us a formal link.

Supervision

I am supervised by the Assistant District Secretary, who comes every Wednesday or Tuesday and provides our whole team with administrative support and gives us encouragement and professional help to make links and referrals.

We do not have any one for technical subject related supervision. It is expected that we provide peer supervision and we do this. But since my colleagues are from different fields I can't always share everything. I am also unable to share things which are confidential some times.

So I have made my own team (other CAs) from other areas. I also talk to a senior counsellor. But this is not a formal arrangement. We do it whenever we want or can.

Training and skills

What sort of training (in detail) you have received?

I have studied the counselling diploma with Dr. Ranawake. We also have on the job trainings, about three per year, to refresh our knowledge.

How do you evaluate the relevance and impact of the training you've received?

There is a lot more we need to learn as the cases we handle are very complex and many of them are subjects we have not covered in our courses.

What are the gaps you see in your training? What are the areas that you feel the need for further training?

- Learning to identify illnesses and to know how to respond in the case of Mental Illness. We need some knowledge of clinical issues and Mental Illness.
- Social problems like substance misuse and other abuses. How to identify victims and know the issues in intervening with them
- How to manage our own stress and keep ourselves healthy
- Providing and receiving supervision, as is done with counsellors. Technical supervision.
- How to use IT for our work and for educating general public about psychosocial problems and counselling so they will not be so dismissive of it.
- How to make and keep records. We have a format given to us but we don't always use it.

Resources

What resources and support do you have right now? What will help you to be more effective?

- We have a very good centre and good facilities
- We need to be able to use a phone to contact and follow up clients
- We need resources to travel to the field when needed
- An official acceptance by other departments and organisations—formal links with other structures
- Authority and acceptance
- Technical support and supervision as there are so many cases which are difficult and sometimes we feel very helpless
- Opportunities to meet other counsellors and be further trained
- Resource materials in Sinhala and ways that we can keep learning in the Sinhala medium

- We have only one computer and it's hard to get it to access the internet and get material
- We need to be able to educate the general public and we need resources
- Directories of services of both GO and NGO so we can confidently refer people and also make links with these organisations.

How do you manage your wellbeing and stress? Who supports you?

- Gain relief by chatting to colleagues
- Husband very supportive but I can't always talk about work with him and exhaust him as well
- I tried to start a yoga class in the centre for everyone, but we didn't have resources to pay for it.

Gaps and recommendation

What are the hindrances that you face in your current role?

- Lack of authority ("counselling assistant"), acceptance, and formal links
- Need more training and resources in local languages
- Have to travel three hours a day which is exhausting
- Need technical support

Recommendations

- Other government departments need to be given material that will help them understand this counselling service and how it works and how these officers can make formal supportive networks which are professional and not based on the goodwill and relationships alone.
- A formal referral system needs to be introduced and streamlined; officers in all government departments that deal with social/ human problems need to be included.
- In the case of clients who are willing to come for help but cannot continue due to distance and financial difficulty, standard options need to be discussed at a department level and implemented.
- The general public should be made aware through local and national media about this counselling service; when, how, and for what issues services can be accessed by the public.
- A formal supervision structure which is mandatory and regularly conducted by

senior subject specialists who can advise and monitor our performance and help us, through at least distance supervision regularly.

- On-going training and opportunities to sharpen our skills and receive up to-date knowledge on current issues.
- A structure where we can get promotions and have some kind of career development and a recognition of our seniority.

Interview with the Assistant District Secretary (supervisor to respondent)

- These girls are very dedicated and don't work for the money.
- They need much more training and regular skills development as they are not able to sometimes work with violent clients and cultures (fisher folk).
- They need to be given technical advice about methods of managing some issues
- Since she is a woman she can't go to some areas in the field by herself. There should be more staff so they can work in pairs. At the moment she covers 72 divisions with 77,000 families which is impossible to handle alone.
- I am very satisfied with her commitment and dedication and what they have been able to do but they need much more support.
- They don't get chances to go for workshops or trainings. We can't afford outside resource persons due to the costs but they are very much in need of training.

In-Depth Interview 9

Note: respondent did not wish to be recorded using electronic media but was more comfortable with written records. The report is written primarily in the first person quoting the respondent verbatim.

49 year old female.

1. Service

What sort of work do you do? Counselling for individuals.

I support the work of the social worker in the centre and others in the team. Visiting disaster affected victims in their homes, I help to assess who needs relief. While doing this if I see a need for counselling I do it on the spot, building up their strength by telling them and reminding them "at least you are alive". Clients do not come to this centre (The social services centre – *samaajasathkaaramadyasthanaya*) because it is far away—it's in a lonely place and they find it unsafe. So they come to this office. Most don't come primarily for counselling but for some other need and also see me for advice or when they are referred

to me. There are times when I may see about 4-5 clients a week. But they mostly come on Wednesday the public day.

Who do you work with? Individuals, ministries, departments, units

The multidisciplinary team in the Social Services care centre. We have a team approach here and it's very useful. I support the whole team and join them to the field sometimes

- Social Services Officer (SSO)
- Social Development Assistant (SDA)
- Women's development officer (WDO)
- Child rights protection and development officer.
- Now we also have an early child hood officer.

We go to the field together, make referrals, and offer support when we can. The whole team works together with me and supports me. Having the right personality to galvanize this support is important otherwise a CA can lose the support of this team. Need to learn how to get on with a team and get one's work done collaboratively. The success of this team approach depends on the personality as well. Team skills have to be built since we have been given the concept of a team to work with.

The Prison: 2 days a month.

This is a secure facility for male inmates who are in long term rehabilitation. Many have drug offenses, come from economically disadvantaged and lower educational backgrounds. I am called in to offer some help in reintegrating those who have completed their rehab. and are ready for release. I am required to help them get smoothly back in to society. Some of them are murderers on life terms and they are given parole and we have to work with them before they leave prison and also to recommend their home leave.

School programmes

I introduce myself to schools in the area and speak to the principal and do awareness programmes for children and young adults on "young adulthood". Children are not being brought up well at all. There is no discipline. Teachers have no right to correct children any more. There is no respect at all for teachers. Teachers also label students "idiot" and "fool". It all seems a bit pointless to talk to them as what we need is a change in the value system in the whole of society and that is very hard to see happening. Sometimes we get the teachers down to the centre and conduct training for them in basic counselling and listening skills. They are very poorly selected and come to teach only if they don't get any other job. About

two percent are there because they want to be. We can do this only once for a group as there are no funds. These teachers really need more training.

Government Departments CA works with:

- Probation Office
- The district courts
- Police: The Children and Women's Bureau desk
- The child protection committee

Other NGOs: We do not work with NGOs- they are corrupt and we don't engage with them. We have been told not to do this (when probed she said). There has been a circular in this regard asking us not to work with NGOs.

What is the nature of these relationships you have with other departments

The other departments make referrals and call on our support when needed. It is amicable and supportive generally, if one is able to make and maintain useful relationships with these departments.

What sort of clients do you get to meet in your work and what are the common problems?

- Broken families: many without mothers who have either gone abroad or left with another partner.
- Children with grandparents who can't manage them. Their only influence is media. No other good human influence. Sometimes children are just abandoned.
- Violence in the home: It's in about 90% of all homes I think but it never gets reported, unless and until a crime is committed. Also other types of abuse and sexual abuse within families.
- Substance misuse (drugs and alcohol)
- The fishing subculture along the coast which has integrated all this substance misuse and fragmentation and violence to its culture. It has become part of the subculture here along the coast.
- General observations: Respondent mentions that: *'People don't tell us the real problems they have. They will come to you saying something else when their real problem is different. You have to speak with them and then get it out. People increasingly (especially children) have very poor social skills now. They are so used to spending most of their time watching TV or texting and on*

video games that they don't interact even with their family members. It's as if they don't really know anymore how to engage with others, speak about their needs and resolve issues.

How do you deal with such clients/cases

Case study 1: An older woman brought in her special-needs (disabled) grandchild and told me to find a home for the child because she was not able to cope with caring for the child. She was looking after the child single handed with absent parents. I told her "don't do this. This is what has come to you through your karma, so you have to accomplish it in this life. If you don't do it now it will be a curse for you and keep revisiting you in the next birth. This is a penalty you have to pay for your past sins. When I explain things like this people then understand and go back. This woman went back with the child"

(Researcher: would you generally look in to the practical capacity of a client like this woman to take care of a child?")

Yes we would and we could try to get her the Rs. 250/= a month which a special needs (disabled) child is entitled to.

Researcher Observations: The needs of the elderly client for practical and emotional support was unrecognized. The risks the child is currently in, at the hands of an older care giver unable to provide care was also unrecognized, and the perceptivity of when one may use religious belief positively to support a person and when one uses it negatively to judge or restrain a person has to be developed.

Case study2

I met with a young Muslim boy who had killed 3 people in a family for having abused his sister, and he is looking for a chance to kill the last one also. He says he has been told by his family that he has to protect his sisters' honour by avenging her abuse.

"I told him, your parents are wrong for having told you to kill. You are now in prison, not them. In prison you can't do anything. You can't even protect your sister or earn any merit for yourself. I spoke to him like this for a long while. He told me" you are like a mother to me, if I had met you before I did these crimes I would not have done them".

Case study 3

I was referred another case in prison of a man who had committed two murders but was being considered for parole two years earlier than the end of his sentence for good behaviour. He was to be sent home on leave for a while and I was asked to see if this could be recommended. It was in fact the man's own wife's father and wife's sister that he had killed. But he was asking to go home and see her and was asking if he could have support to be reunited with her. So we did a home visit and spoke with her. We found that the story she told us was very different to what he had been telling the Prisons Dept. We had been asked to try and help unite the two, but when we spoke to her we realized that this would be a dangerous move for her and harmful to the family. So we advised her to stay safe as he was going to be released.

Researcher observations:

It appears that the Police and Prisons Dept. instructed the counsellor in what they should do, *"we had been asked to help unit the two",* instead of the counsellor studying the situation and making recommendations to the Police and Prisons Dept. regarding a prisoner. The respondent was able to clearly identify the risks and dangers to the community and even to her in this case and indicated the dilemma she was in when she had instructions to do one thing but realized this would be harmful. She was unable to assume the professional authority to dialogue with the police and prisons and present an alternate recommendation.

2. What is your self-evaluation, have you got the capacity to support them? If not, what do you do?

I can manage these problems I have the strength. I am more successful that I was when I started. But now I feel it's useless working with these people as they don't want to change. So I have stopped doing awareness for adults. Now I do awareness only for children and young people. If it's not going to be useful to bring change why should I shout for 2 hours? Sometimes I feel very discouraged when I see the changes in society.

I am satisfied with my work but sometimes I am very discouraged especially when people don't respond well and do what we say, and also when we don't see results.*" hoada hoada madey daanawa wagey" ("it's like to wash and wash something and throw it back in the mud again")*

Where do you receive supervision and administrative support from?

Our administrative supervision is done by the Assistant District Secretary and he is our line manager.

We don't have any formal system of supervision from a professional. It would be so good if they appointed some senior people to discuss our cases with and get some guidance. We are alone here. I generally speak with my four friends who are also CAs in four different areas, and we support each other. We discuss cases and advise each other.

What do you need to be able to work more effectively?

- Need to have authority and recognition as an officer. We are all called "assistants" so how ever senior we are that's all we can become.
- There needs to be more counsellors to share the load and also more male counsellors to work alongside us female counsellors and to work in high risk environments
- There must be supervisors or senior counsellors appointed who can be there to support, advise and talk about cases.
- We lack teaching/training tools and materials.
- Need technology that can help us update our knowledge

3. Training and skills

What sort of training (in detail) have you received?

- Graduated in 199x from University of Kelaniya with a degree in philosophy and elements of psychology.
- One year counselling diploma with Dr. Ranawaka
- Sri Lanka Foundation Institute two week residential counsellor training
- On going residential three day trainings by the department held 2-3 times a year

How do you evaluate the relevance and impact of the training you've received?

I use the basic skills I have learnt from all these trainings. However I realize how much more we need because there are real life problems and cases we never prepared for. The ongoing training is a good chance for us to update our knowledge because it is regular. However we need to be trained by professionals who can address the current issues. Sometimes in these ongoing trainings the trainers themselves know the same amount that we do or just a bit more, so we can't get much.

How do you keep up to date with subject knowledge and keep your knowledge fresh?

I talk with my colleagues, we share whatever material we each find, and if one of us goes to a training we share the material with the others. We try to read but there's not much

in Sinhala and there is no access to internet. Those days we used to get new materials on different subjects from other organisations (NGOs) who were specialized in some subjects. Now we don't work with them so we don't even have this.

What are the gaps you see in your training? What are the areas that you feel the need for further training? (this is a combination of the respondents views and researcher recommendations)

- Special training in working with prisoners (offenders) and how to understand their minds and work with their families.
- Knowledge on elders' problems and how to work with elderly people especially now, as they are becoming greater in number and they have more responsibility when families of their children break up.
- How to counsel and prepare young people about to get married and start families.
- Clinical knowledge about mental illness and what we can do to support people with MI
- Knowledge on law, rights and legal systems and procedures related to family problems, drug and alcohol, violence, and offending behaviour.
- Understanding and working with special needs children, identifying them, classifying and knowing how to support their caregivers.
- Working to prevent sexual abuse and how to identify and support victims in the community

4. Resources

What resources and support do you have right now? What will help you to be more effective?

- Earlier we used to get resources and materials from other organizations (NGOs) but now since we have been asked not to have dealings, we don't even have the materials we used to have. Training materials, books and awareness materials. We need materials even if it is from the NGOs.
- There is a phone at the centre and we can use it. We have been given a phone by the Ministry but I don't use it as it is Dialog. We also have a Mobitel package for all government servants and I use that.
- I don't come to the centre often, as you can see, it's far away from the main road and also considered a bit lonely and dangerous. Clients never come here unless there is a special workshop and many people are invited.

- We don't have a computer or internet connection in the centre. There is one computer in the DS office and that's the only one we can use to connect to the internet. We need technology that can help our work. I have to cover 97 divisions in this GS.

How do you manage your wellbeing and stress? Who supports you?

"I am here because of my earlier merit which I have gained. So I want to do good to protect my future births, I talk to my four colleagues regularly. We all worry a lot about our work and the problems we encounter in people's lives. We have a sense of despair some times. *"kalakireemak"* because we try so much but don't see results. I speak with my husband daily and with family friends. I sleep well and gain a lot of support from Buddhism by listening to *pirith*.

5. Gaps and recommendation

What are the hindrances that you face in your current role?

- The lack of authority and recognition from being an "assistant" and the ability to make authoritative decisions and have them respected and adhered to by other professionals

Recommendations (based on the observations of the researcher)

- The centre though well-furnished and located in a peaceful environ is seemingly not being accessed by the general public for counselling but is only used as an office for the multidisciplinary team and for the occasional gatherings/training programmes.
- The need for supportive supervision is felt very keenly. The respondent though possessing strong people helping skills and commitment, exhibits signs of burn-out already after over five years in service. Statements of discouragement and a sense of futility "I think these people don't want to change so it can't be done" demonstrate the need for urgent and regular supportive supervision.
- A formal supervision structure which is mandatory and regular, conducted by senior subject specialists who can advise and monitor their performance and help them, at least through distance supervision regularly.
- The on-going training given by the department is a great chance to sharpen skills form professional attitudes and provide up-to-date knowledge. This training however needs to be undertaken professionally, be based on a well-researched and supported curriculum and conducted by specialized well trained professionals.
- The general public seem to be unaware of the service and only access it in the DS office and only on Wednesdays which is the public day. They may not be aware that

this counselling service is available all through the week. Should be made aware through local and national media about this counselling service; when, how and for what issues services can be accessed by the public and how the officer can be accessed.

- A change of title for more senior counsellors which will give them a sense of recognition and value is needed to enhance motivation and protect their pride in their work. A structure where they can get promotions and have some kind of career development and a recognition of their seniority is needed to safeguard their motivation and drive.
- There are numerous organisations (NGOs) which specialize in certain fields like Mental illness(Sahanaya), prevention of sexual abuse (ESCAPE), prevention of suicide (Sumithrayo), substance misuse (ADIC and others). They each have an area of competence and knowledge, awareness and training materials prepared which can easily be shared with CAs if the system tapped into these resources.
- Ministries should be encouraged to work in collaboration with such organisations and have a mutually supportive collaboration where material resources, contacts and information can be shared for the benefit of society at large.

In-Depth Interview 10

Note: respondent did not wish to be recorded using electronic media but was more comfortable with written records. This is written in the first person as recorded verbatim.

28 year old female. Lives with parents 38 km away from work and travels by bus and by walking.

1. Service

What sort of work do you do?

I work as a counsellor within the Ministry of Social Services based at the Divisional Secretariat and I am located at the Social Care Centre. I work at the grass root level to meet the needs for counselling and support. Some of the work I do:

- **Community work:** Conducting psychosocial programmes for different groups in the community:
  - Motivation and attitude development
  - Awareness on Mental Health issues, identifying mental illness in the community
  - Making referrals

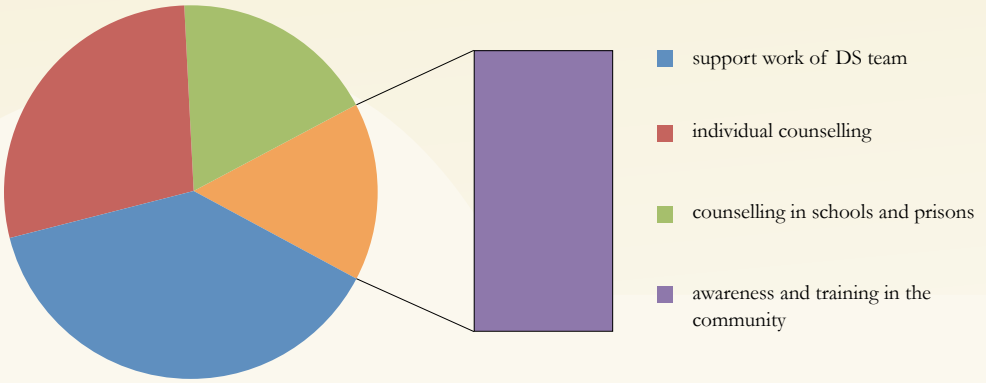
- **Schools:** Visiting schools and conducting "counselling clinics"
  - Educational and emotional support for students
  - Training for teachers
  - Interventions for parents
- **Elder's wellbeing:** Working through grass-root level elder's clubs to enhance wellbeing of elders
- **Prisons:** Working with the prison, two days a month.
- **Acting Counsellor:** Acting as relief counsellor in the adjoining division when the need arises
- **Staff training:** Conducting awareness programmes such as stress management and others for the staff of the Divisional Secretariat (my own colleagues)
- **Supporting the HR Dept.** of the divisional secretariat to conduct welfare activities, new year festivals, and other programmes.
- **Pre-marital** counselling: Teaming up with registrar of marriages and the local midwives to provide pre-marital and marriage counselling.
- **Young adults:** together with the MOH (they do the health aspects) I cover the aspects of
  - Building good Relationships
  - Stress management and simple relaxation
  - Physical and psychological changes in puberty
  - Sexuality
  - Technology and how it can help or harm life

Counselling for individuals

- **Publicity:** We had a leaflet about the service which we used to distribute when we go to the field and this helped people to know what services they can get. It has now run out of print.
- **Access:** they come to the centre but most come to the DS office, as this centre is far away.
- **Referred by:** Clients who come from schools are referred by principals and teachers. Referrals are also by the Gramasevakas, the multidisciplinary team and also from the MOH, Usually after an awareness programme we have lots of clients coming in.

- **Difficulty:** But many clients don't continue to come, unless it's for some other reasons as well, because traveling is costly; they do not like to come all this way "just to talk about problems"

Approximate Time Allocation For The Week



Whom do you work with? Individuals, Ministries, Departments, Units: MoH, midwives, Registrar of marriages, other officers in the DS office, principals of schools in the area, and Prison Grama Niladaari (who makes referrals).

The Multidisciplinary Team in the Social Services Care Centre: I work on a daily basis with all colleagues in this team, involving myself in all of their activities. We support each other generally. We are all supervised by the Assistant District Secretary (ADS)

- SSO- Social services officer
- SDA-Social development assistant
- WDO-Women's development officer
- ECDO - Early Childhood development officer
- CPRO- Child rights promotion officer

It is necessary to work in this team. We make and receive referrals from each other. I always accompany them to the field as there are no issues that don't overlap with psychosocial. We share materials when we get any.

Other NGOs

We work with Sarvodaya and earlier, Saviya. They help to identify clients with MI and to treat them. (When probed by researcher) "No there is no problem about working with

NGOs. There is in fact a section in our duty list requiring us to work collaboratively linking up with other organisations that have expertise."

What is the nature of these relationships?

Relationships are very cordial and supportive with all the departments and organisations mentioned above. But it's with the schools that I have the best relationship. I work with the principals of the schools and introduce programmes and the counselling clinics to them. They are extremely welcoming and support this work very much.

What sort of clients do you get to meet in your work and what are the common problems?

- **School students:** Exam stress, memory problems, disorganization and wanting better study techniques, inability to concentrate, addicted to music/movies/games, fear of certain subjects, and difficult relationships (romantic relationships)
- **Elderly people:** neglect, hopelessness, depression, and suicidal thoughts
- **Family problems:** Alcoholism of father, migration of mother, can't cope with family responsibilities. Children who get into dangerous alliances (relationships) while still in school or underage.

How do you deal with such clients/cases? Have you got the capacity to support them? If not, what do you do?

I use either **an individual counselling approach**, or go as part of the **multidisciplinary team** and offer my interventions together with the others, or sometimes I conduct a **counselling clinic in the school or a programme in** the village; these are the different ways I work.

Case example of multidisciplinary team work -1

The Child Rights Promotion Officer (CRPO) is currently handling a problematic family in which there are issues of bad health practices, malnutrition, and lack of motivation to raise the family well and therefore neglect. She calls up a meeting which is called a "family consultation" *(Pavul hamuwa)*. The family members and some of the relevant members of our team are invited to discuss. I am also invited. I go and see if there are any MI, or relationship or behaviour issues and see how I can support the family as a counsellor or what interventions I can suggest. Later we would go for a follow up visit to the family's home and see what progress has been made.

Case example of collaborative work with NGO– 2

The Women's Development Officer has been working with a woman who is being beaten regularly by her husband who is a drug dependent. While the WDO attends to the offenses and the legal side of this case I try to engage the husband and see if he is willing to get into a rehabilitation programme – at an NGO very skilled in this subject. They also have counsellors so I meet with them and discuss how they can help this husband come off his drug dependence which will hopefully help him stop abusing his wife as well and how we can support the wife better.

2. What is your self-evaluation

I need more knowledge about therapies and working with substance abuse. But for now think I would score myself 70% on the programmes I do and 60% on the individual counselling I give. I generally feel able to handle the cases though I realize there is a lot more I need to learn and keep learning. Since we have a team and we also know other organisations and departments I do referrals of any cases I am not able to handle.

Where do you receive supervision and administrative support from?

We do not receive technical support or substantive supervision to do with our subject officially. We are expected to find this for ourselves. I talk to the team for this kind of support. The Assistant District Secretary had regular weekly administrative supervision at which we can get support and advice from him about procedures and administration. We do not get formal technical support.

What do you need to be able to work more effectively?

- I feel a great need for a senior person like a subject matter specialist or a psychologist who will regularly be available to discuss cases and to troubleshoot when we have an emergency or a crisis and we need advice.
- Also someone who is more experienced and operates professionally and confidentially so we can discuss our personal difficulties which are related to work as well. It's not the same when you talk to colleagues and friends. There's always a risk in sharing with them and also they only know as much as we do anyway.
- A better designation which will allow us to be taken seriously instead of being called " counselling assistants"

- We do not have any career development pathways open to us. However well we do there doesn't seem to be anything better we can achieve or any more recognition than we get now, which isn't a lot. There are no promotions, no developments in view, so this can affect our motivation as time goes on.
- (question from researcher: 'how do you wish to be motivated") Give us regular ongoing opportunities to learn from quality professionals and resources. Give us opportunities to do higher studies in related fields in good higher education institutions.

3. Training and skills

What sort of training (in detail) you have received?

- BA (general) degree (Kelaniya) with Philosophy, Psychology and sociology (3 years)
- Masters in Sociology(Kelaniya)
- PG Degree in Community Development
- Computer science degree
- Dip. in Counselling, Colombo Psychology Institute (Dr. Ranawake)
- Ongoing training by the Ministry of Social services: including:
  - Clinical psychology overview (Dr. Danesh)
  - Childhood psychiatric disorders
  - Family counselling and basic skills
  - Problems of young adults(Health Ministry)

How do you evaluate the relevance and impact of the training you received?

There are many other areas of skills sharpening and training we need but the courses I have done have been useful to the following extents.

- Basic degree- 75% , MA (Socio)- 60%, PG Degree(counselling)- 70%
- Dip. from Colombo Psychology Institute- 75%
- On-going training from the MSS- 65 %

How do you keep up to date with subject knowledge and keep your knowledge fresh?

- When I meet resource persons who come for different trainings I try to talk to them keep in touch and learn from them even after the programmes.

- I also read books whenever I find good ones but they are mostly in English
- I go online at home and I learn off internet

What are the gaps you see in your training? What are the areas that you feel the need for further training?

- Clinical psychology so we can understand and work better with Mental Illness and know what we can do as counsellors for people suffering with MI
- Deeper understanding and skills on working with substance abuse and dependence
- Tools and techniques for working with:
    - Children with special needs (developmental disorders) MR
    - Children at risk (including those abused)
    - Working with clients who have histories of self-harm and suicidal ideation

4. Resources

What resources and support do you have right now? What will help you to be more effective?

We have access to the following equipment and resources:

- Phone, OHP, photocopier, computer, laptop, camera and recording equipment. These are well maintained and there are no breakages.
- We do not have internet access in the centre but have limited access in the DS office.

What will help?

- A list of organisations which do special work on different social and psychosocial issues so we can establish contact and make useful links with them
- Access to up to date material on current issues and new tools, techniques and therapies in managing them, preferably in Sinhala.
- Translated versions of internationally accepted books and journals would be very useful so we can keep abreast with the rest of the world in our work
- Access to good quality training locally, maybe regionally, so we can see how other parts of the country, region (Asia) and the world are handling the same issues and we can learn from them and share our experiences too.
- We do not have sufficient financial resources to do the necessary programmes. We can't sometimes afford to even buy the participants tea, so instead of getting them

down to the centre we go to their villages and meet in temples and school halls. With more resources we could do much more.

How do you manage your wellbeing and stress? Who supports you?

- I enjoy music – classical Sinhala and Hindi
- I read a lot
- Do gardening and cooking for pleasure
- When I feel discouraged I argue with myself and try to figure out why these things happen and try to be rational.
- I speak with my friends for relaxation
- Go out and enjoy
- Spend time with my fiancé

5. Gaps and recommendation

What are the hindrances that you face in your current role?

- People are still not fully aware of the role of a counsellor and what the practice of counselling can actually do. They are not convinced about talking therapies. They have more faith in swallowing medicines.
- We work with the poorer segments of society. They often can't afford to lose a day of work to come in to the office for counselling or for an awareness program or even to pay the bus fare. We have to be able to cater to such people and go when they are free and provide incentives for them as well.
- No technical support to give a better quality service. We can only do the best we can with limited knowledge. No one to ask.
- We need more counsellors to cover the vast areas and large number of divisions and families so that the service will be good quality. We also need more male counsellors often when there is a need for specific issues we have to "import" male counsellors from another district!

Recommendations (This is based on observations by both the respondent and the researcher)

- Well-designed media campaigns and literature advertising this service
- Motivational programmes for staff like us, focused on their wellbeing and stress relief as we deal with problems all the time. Chances to be refreshed and learn something new.

- In the case of clients who are willing to come for help but cannot continue due to distance and financial difficulty, standard options need to be discussed at a department level and implemented.
- A formal supervision structure which is mandatory and regular, conducted by senior subject specialists who can advise and monitor our performance and help us, at least through regular distance supervision.
- Incentives in the form of high quality on-going training and chances to sharpen our skills and receive up to-date knowledge on current issues.
- A scholarship scheme for higher education for those in this service (Masters and Doctorate degrees)
- A structure where we can get promotions and have some kind of career development and a recognition of our seniority
- Urgent need for printed study materials in Sinhala either written in Sinhala or professionally translated subject related books or journals.

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