Review

Development of Mental Health Care in Sri Lanka: Lessons Learned

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Abstract

Background: Sri Lanka is a multi-ethnic country with a rich cultural heritage and biodiversity. Sri Lanka has a population of 21 million with an annual population growth rate of 0.76%. **Methods:** The authors explored the evolution of mental health care, life-cycle approach to psychiatric disorders, addressing resource limitations in a developing country, and the dilemma of reducing the treatment gap while maintaining standards and quality of care. This review was based on the analysis of related literature, as well as through work experience. **Results:** As a result of continuous effort, Sri Lanka has more than 110 psychiatrists, practicing in all districts of the country. Academic psychiatry has flourished over the years. Measures to improve mental health literacy, training of allied disciplines, and targeted approaches to improve services for vulnerable groups are taking place at a reasonable rate. The psychiatrists employed throughout Sri Lanka, the Sri Lanka College of Psychiatrists, the Board of Study in Psychiatry, and Postgraduate Institute of Medicine, have taken initiative to improve quality of care, by joining hands with the Ministry of Health and other stakeholders. **Conclusion:** Sri Lanka has achieved quality mental health-care outcomes despite having considerable limitations in resource allocation. Mental health services need to be consistently revamped, giving priority to face ongoing challenges to provide quality as well as equitable and efficient service to all the citizens in this beautiful country.

Key words: developing country, mental health services, mental health system, psychiatry

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Introduction

Demographic factors

Sri Lanka is an island nation, which is known as the "pearl of the Indian Ocean" since ancient times because of its rich cultivation, scenic beauty and cultural heritage. Ancient travelers and merchants also knew it by many names such as Thambapanni, Taprobane, Serendib, and Ceylon. It is currently known as the "Democratic Socialist Republic of Sri Lanka" following the constitution of 1978 [1]. Historically, there is evidence of human settlements dating back 125,000 years, which was in the early Iron Age [2]. The country's documented history, however, spans back to about 3,000 years, where several great rulers have since reigned.

Sri Lanka is the 57th most-populated nation in the world with a total population of 21 million and an annual population growth rate of 0.76%. The country has a birth rate of 15.2 births/1,000 and a death rate of 6.2 deaths/1,000 (the World Factbook at www.cia.gov/library/publications). Population density is highest in the western province in and around the capital city, Colombo, which is considered the economic and political "hub." When considering the age structure of the population, men and women of working age (15–64 years) make up the majority. However, recently, there has been an increase in the proportion of older population above 65 years of age due to improved life expectancy secondary to expansion of health-care services. This has posed many challenges on the economy and medical services of the country.

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According to the World Factbook (www.cia.gov/library/publications), the majority of the population in Sri Lanka are Sinhalese, which constitute 74.9% of the total population, whereas other ethnic groups such as Tamils and Moors form 15.4% and 9.2% of the total population, respectively. Other minorities include Burgher, Malay, and indigenous people known as "Veddas" who add to the ethnic, linguistic, and cultural diversity of the island. Buddhism, Hinduism, Islam, and Christianity are the main religious views embraced by Sri Lankans. Buddhists comprise 70.2% of the population (www.cia.gov/library/publications). The Buddhist philosophy and its related moral values and cultural traditions have had a vast influence on Sri Lankan families and social structure for centuries. Hinduism is the second most common religion with its Indian origin and is prevalent in northern, eastern, and central parts of the country mostly among Tamil nationals.

Psychiatric disorders

Psychiatric disorders account for about 13% of the global burden of diseases. Nearly 80% of people with mental disorders live in low- and middle-income countries [3]. Increased mortality is seen in individuals with mental illness, with suicide being the major reason for years of life lost due to mental illness [3]. According to the Mental Health Atlas published by the World Health Organization in 2011, annual per capita mental health expenditure varies largely among different income groups. This ranges from US$ 44.84 in high-income countries to US$ 0.20 in low-income countries [3].

Bridging the mental health gap is an issue for many countries in the world. Accessibility to high-quality mental health-care services for those who need them, improving mental health literacy, providing coordinated care to masses, and addressing low priority given to mental health by policymakers are common issues faced by many countries. Even a developed country with high health-care expenditure does not necessarily mean good mental health outcomes for its citizens. In low- and middle-income countries, a multitude of factors including social stigma, human resource shortages, fragmented service delivery models, and lack of research capacity for the implementation and policy change contribute to the current mental health treatment gap [4].

Mental health in Sri Lanka

Sri Lanka is a middle-income country, which has faced 30 years of internal armed conflict and devastated by natural disasters. But, contrary to expectations, this country has shown satisfactory mental health outcomes for many decades.

The current psychiatric care offered by the Ministry of Health in Sri Lanka showcases the influence of the British allopathic system on psychiatric care. It also reflects rapid upward shift in the development of services, training of personnel in psychiatry and allied disciplines, education of gatekeepers, public education, and provision of community mental health care. This became a reality despite having limited resources and low resource allocation for mental health and psychiatry with a limited number of trained personnel in the mental health field.

While coping with natural and anthropogenic disasters, political unrest, and economic hardships, major reform of the mental health system took place within the last two decades. The current level of service provision shows an upward trend in providing basic care across the country. General public has shown an interest in the allopathic system of psychiatric care, with an increasing trend in the use of resources.

Psychiatrists contribute to service development, training, public education, combating stigma, and call for resource allocation. Although the number of psychiatrists per population is much less than the WHO recommendations, they have taken measures to fill the treatment gap island-wide through the use of available resources. This has enabled patients and families to receive basic care closer to their homes. Acute care units, outpatient clinics, and liaison services at hospitals, as well as outreach clinics and depot programs, have contributed to this. At present, varying needs of patients are addressed by medical officers, nurses, counselors, and volunteers under the guidance of psychiatrists. But, there remains a relative lack of appropriate multidisciplinary teams in the peripheries. Although public awareness is more and stigma is less, still the peripheries of the Island suffer from low resource allocation and relative lack of priority given to mental health.

Thus, greater emphasis is now needed in collaborative work and partnership with other stakeholders to provide meaningful, quality care island-wide. This is a common problem faced by many countries. Psychiatrists need to strengthen their leadership skills, capacity to mobilize support, while continuing to provide technical leadership. The Sri Lanka College of Psychiatrists and the Board of Study in Psychiatry at the Postgraduate Institute of Medicine (PGIM), in addition to imparting state-of-the-art discipline-based education, need to focus on these areas, as well as giving guidance to develop infrastructure and training need of multidisciplinary team members.

Evolution of Mental Health Care in Sri Lanka

The care of patients with mental illness has been recorded in Sri Lanka over many centuries. Ayurveda, Siddha, and Unani treatment models had a significant influence on health care. It is important to know that, in Ayurvedic medicine, psychiatry is considered as a core component [5]. Renowned Ayurvedic physicians such as Charaka (the third century BC) described the phenomenology and also attempted to formulate the etiological classification of mental illness based on the principals of Ayurvedic medicine [5]. Charaka recognized three origins of mental disease: those produced by imbalance in bodily doshas, those produced by mental doshas, and those produced by a combination of the two. Thus, Charaka classified five types of insanity: Vata born, Pitta born, Kapha born, that born from a combination of all three doshas, and that which is accidental [6]. He suggested that treatment for psychiatric illness should be by an expert of that field [6].

Mahawansa, a chronicle on the history of Sri Lanka, records that since the 4th century BC, hospitals have been in

existence in Sri Lanka [5]. Sri Saddharma Saratha Sangrahaya, an Ayurveda medical record written by King Buddhadasa (362–409 AD), describes the prevailing treatment of that period including treatment of mental illnesses. The Buddhist doctrine was influential in the treatment of mental illness, which has been described at length by King Kirthi Sri Rajasinghe (1747–1782 AD) [5].

Citizens were empowered to care for their mentally ill kinsmen and neighbors inclusively in their own homes using traditional treatment methods, which was a comprehensive "community care model" owned and administered by the locals themselves. During those time, health-care services were available to locals at the village level, in which a traditional doctor provided an honorable service to village men, women, and children.

The impact of cultural believes on indigenous health care was apparent in the common use of demonological and astrological remedies in the treatment of mental illnesses. Robert Knox in his Historical Relation of the Island Ceylon explained the belief of supernatural influence on such disorders in detail. Traditional healers carried out "Bali and Thovil" (traditional dancing rituals to heal mentally disturbed people), which were designed to expel demons possessing the mentally ill people [5]. The event involves participation of the whole village [7]. The mentally ill were helped those who showed abnormal behaviors and those who continued to have illness despite treatments were accepted in the society with tolerance. Thus, until colonization of Sri Lanka by the West, there was no segregation of those suffering from mental illness from the society at large [5].

The model of psychiatric care had a paradigm shift following colonization by the British. In 1839, an Ordinance was enacted, providing the legal framework for civil commitment. The prevailing laws at that time only addressed insanity in the context of contracts and maintenance [5].

Following Western influence, people with psychiatric disorders were initially imprisoned along with criminals and later institutionalized with leprosy patients [5, 7], before they were committed to asylums. The first asylum was built in Hendala, which was later moved due to overcrowding, and in 1926, it was finally relocated to Angoda, a suburb in Colombo [7].

Despite the initial aim of institutionalization of those with mental illness was to segregate them from the community, with time it became evident that these patients required care and attention. As patients led a sedentary life, employment was offered, to improve both mental and physical well-being. This laid the foundation for occupational therapy for patients with serious mental illness [7].

Edward Mapother, Medical Superintendent of the Maudsley Hospital in London, visited mental hospitals in South Asian countries, which were under colonial rule in 1937. After a thorough review of the Angoda asylum, he made several recommendations, for the improvement of provision of mental health services including complete revision of the existing laws [5].

Mapother recommended the establishment of a specialist service and in 1939 three Sri Lankan doctors traveled overseas to receive specialist training in psychiatry in London, and by 1940 there were two Sri Lankan psychiatrists. The return of practitioners who had been trained in psychiatry over the next few years resulted in an attitudinal shift toward mental health and positively impacted the expansion of mental health services.

An outpatient clinic was first established in the general hospital, Colombo, in 1939, and this progressed to commencement of psychotherapy and follow-up clinics by 1941 and neuropsychiatric clinics by 1943 [7]. New treatment modalities including insulin shock therapy (1940) and later cardiazol convulsive therapy (1948) were introduced. Treatment of mental illness was revolutionized in the 1950s with the introduction of psychotropic medications. Lithium and depot neuroleptic drugs were introduced through the 1970s [7].

The Mulleriyawa Mental Hospital was commenced in 1958 as a 1,000-bed unit. The foundation for this hospital was laid following the bombing of the Angoda asylum in 1948. In addition, at the district level, more psychiatry inpatient wards and clinics were built over several decades, fulfilling Mapother's recommendation for decentralization of mental health services [7].

Since the late 1990s, there was renewed interest and revamping of services leading to rapid decentralization and service development mainly as a result of training Board Certified Consultant Psychiatrists by the PGIM, Sri Lanka, which was established in 1976. The latter part of the 20th century saw the development of academic psychiatry in place of infrastructure development [7]. Only centers in the cities of Colombo, Kandy, and Galle had full-fledged psychiatric services. To cater to growing need of psychological treatment methods, several private organizations trained counselors with low standards. To counteract this, the author commenced the first counseling diploma course offered by the Faculty of Medical Sciences, University of Sri Jayewardenepura, in 2000.

As new faces came into the training and service, more numbers took up psychiatry as a career and returned to Sri Lanka after completing the overseas component of training. But, attrition was a continued problem due to more economic and personal reasons as well as low priority given by policymakers to specialists who return home to practice psychiatry in remote areas.

The devastating tsunami of December 2004 had a major impact on the well-being of the people of the affected areas. This brought about many local and international organizations together who assisted in the development of psychiatric care in Sri Lanka. The active use of funds and volunteer force led to improved capacity of staff and some service development [8]. The Sri Lanka College of Psychiatrists played a pivotal rôle during this era in coordinating care with the Ministry of Health.

Renewed interest on mental health continued, and the first mental health policy was developed in 2005 to establish a comprehensive service at the community level. The National Mental Health Action Plan was established by the Mental Health Directorate (MHD), the NIMH, and the SLCPsych in

2005 and revised in 2010, according to the vision of the Mental Health Policy [8].

Life-cycle Approach to Mental Health Care

Individuals are faced with diverse challenges throughout their life cycle. Therefore, the authors felt that it is important to emphasize the unique challenges faced at each stage.

Child and adolescent mental health disorders are on the rise and include substance abuse and disruptive behaviors including violence and increasing addiction to devices. Apart from these, depression among children, teenage pregnancies, exposure to sexually transmitted infections, deliberate self-harm, and various forms of child abuse have been increasingly noted as needing urgent attention. Psychiatrists are faced with the challenge of not only effectively handling these issues but also with endeavoring to provide interventions to prevent them. In this context, cooperation with significant stakeholders and education of vulnerable groups and gatekeepers is of great importance.

Working-age adults have a different set of problems, such as managing different rôles within their families and work, not having quality personal and family time, losing the traditional family structure and support networks, exposure to different types of social stressors, and effects of addictive behaviors and violence. Alcohol abuse and domestic violence are two significant issues that are on the rise. Substance abuse in the families has led to offending behaviors; marital disharmony; financial difficulties; and neglect of vulnerable women, children, and elderly, thus affecting mental health of all members of the society. Deliberate self-harm and depression are common among this age group. The number of patients living with major psychiatric disorders in the community has increased and thus requires greater rehabilitation services and affordable psychiatric care in the community. Promoting recovery in working-age adults affected by major mental health issues is a current burning need that is being addressed in Sri Lanka. Detection and developing a strategy to reduce maternal deaths due to suicides has also received attention through a public health approach.

The World Bank has recently rated Sri Lanka as having the fastest growing aging population in South East Asia. It is predicted that the population over 60 years of age will double in < 20 years with the percentage of people over 60 years rising to 18% in 2020 and 27% in 2040. The needs of the elderly with mental health issues are diverse and costly. Mental health comorbidities in the elderly include dementia, delirium, and depression, which greatly reduces the quality of life and add to the caregiver burden. The incidence of suicides, especially in elderly males, is also on the rise. Caring for the elderly in the community poses several difficulties as their offspring are burdened with their own issues. Recent research evidence shows that elder abuse by their offspring is common. Optimal caring for the elderly in the community calls for a multidisciplinary approach, with the involvement of health-care professionals, social services, and family members. Some specialized centers cater to the elderly psychiatric patients with special needs. A psychogeriatric postgraduate subspecialty curriculum has commenced training postgraduates in this subspecialty.

Challenges That Have Impacted Mental Health

Another major cause for mental illness in Sri Lanka was the internal armed conflict that had lasted for over two decades, resulting in over 60,000 people losing their lives and causing significant hardship to innocent civilians of all ethnicities throughout the country. At present, there are several organizations that provide services to those affected. They include the Ministry of Health Rana Viru Surakum Ekakaya, Department of Social Services, Directorate of Rehabilitation of Sri Lanka Army and Family Rehabilitation Centre.

In the internal armed conflict, a considerable proportion of militants recruited by rebel groups were children, who were forcefully conscripted to fight as child soldiers. The whole range of psychiatric conditions was found among the children exposed to the war [9]. In a survey of children in north eastern Sri Lanka, 92% stated that they had experienced severely traumatizing events during the internal armed conflict, such as combat, shelling, bombing, and witnessing the death of loved ones, and 25% had symptoms of post-traumatic stress disorder [10].

In addition to that, tsunami was a natural disaster (2004), which caused enormous psychological impact on the entire nation. People who lived in coastal areas lost their loved ones and their properties. Apart from war-related violence, tsunami was a tragedy which increased the risk of mental health disorders in the severely affected communities [11].

Labor migration is common in Sri Lanka with a significant number of females traveling to the Middle East to work as housemaids. Financial gains for families and enhancement of the national economy were seen at the cost of negative health and social effects on the families left behind. Migration of a parent for a certain period of time may affect family relationships and functioning as well as social and psychological development of the child. Recent research showed socioemotional maladjustment and behavioral problems, as well as learning disabilities may occur among these children in the absence of a caring parent [12].

Current Health Vital Statistics of Sri Lanka

When considering mental health in Sri Lanka, 0.7% of household members are receiving treatment for some kind of mental illness. When considering the age, higher percentages tend to be concentrated among the adult population, 20 years and older (www.statistics.gov.lk/page.asp). Among people being treated for mental illnesses, the most common mental illness is depression (37%), followed by psychosis (17%). A greater number of females have depressive disorders, anxiety disorders, and psychosis (www.statistics.gov.lk/page.asp).

In 34% of households, at least one member smokes tobacco and another 29% use smokeless tobacco. The percentage of

"ever use to smoke tobacco" by sector of residence is higher among rural residents. In 37% of households, at least one member currently consumes alcohol and less than 1% have used either cannabis (0.4%) or heroin (0.1%) (www.statistics.gov.lk/page.asp? page = Health).

High suicide rate has been a challenge faced by Sri Lanka for several decades. Both cultural and social reasons for these high rates have been studied extensively [13]. When considering suicide, by residence, the rural sector has the maximum percentage of 0.6% of households, in which at least one person has tried to commit suicide, compared to only 0.3% among those residing in urban or estate sector (www.statistics.gov.lk/page.asp).

Maternal mortality in Sri Lanka has shown a reduction with 1,700/100,000 live births in 1948 and 33.8/100,000 live births in 2016 (www.fhb.health.gov.lk/web/index.php). The maternal suicide rates have shown an increase from 0.8/100 000 in 2002 to reach a peak of 12.1/100,000 in 2010 and declined to 8.4 in 2017 [14]. The Psychological Autopsy Tool for Maternal Suicides was introduced to analyze the maternal suicides in the country and is operative since January 2016. The psychological autopsy is carried out preferably within 14 days of maternal suicide, by a team lead by the consultant psychiatrist in the area [14].

As a measure to detect and treat depression in this vulnerable group, the Edinburgh Postnatal Depression Scale was validated in Sinhala and used in routine MOH clinics to assess depression in postnatal women during the first 6 weeks' postpartum. Recent studies on maternal depression in Sri Lanka showed that the prevalence of antenatal and postnatal depression was 27.1% and 16.2%, respectively. Data indicate that mental health in pregnancy should be a major focus in Sri Lankan maternal health agenda [15].

Available Services

In Sri Lanka, there are over 100 psychiatrists practicing in the Ministry of Health and universities, providing a total coverage of all 24 districts by qualified psychiatrists. The trained psychiatrist of the district leads a multidisciplinary team of the district hospital, conducts outreach clinics, gives leadership to develop services, trains gatekeepers, and conducts programs to improve mental health literacy of the district. To carry out all these activities, a high level of leadership and soft skills is required. This is now being focused on the continuing professional development programme by the SLCPsych [16]. To deliver optimum cost-effective care, political willpower to strengthen facilities and to recruit multidisciplinary teams should accompany these skill development programs.

All medical faculties teach medical undergraduates in the assessment and management of psychiatric disorders and patients with deliberate self-harm [17]. A presidential task force was appointed in 1997 when Sri Lanka was ranked as the country with the highest suicide rate. The strategies that were introduced by the task force assisted in bringing down the suicide rates. SLCPsych and several psychiatrists conducted public awareness programs and workshops for media personnel on responsible media reporting on suicides. All these efforts have led to reduction of youth suicides [17], but there is an upward trend in older male suicides [17], which needs attention now.

A psychiatrist-led multidisciplinary team is serving all teaching and general hospitals and majority of base hospitals. The composition varies, but an occupational therapist and a social worker with a community psychiatric nurse are essential members of this team. At present, no clinical psychologist post in this team exists, as there is a dearth of trained clinical psychologists. Discussions are underway to absorb psychologists who have attained their master degrees in clinical psychology as an interim measure, until fully qualified and trained clinical psychologists are available to be appointed to the Ministry of Health multidisciplinary teams.

There are many nongovernmental organizations (NGOs), which are involved in mental health. Some of them include the National Council for Mental Health Sri Lanka "Sahanaya," Sumithrayo, The Nest, Communication Centre for Mental Health, Women in Need, National Christian Counseling Centre, Alokaya Youth Counselling Centre, Family Studies and Service Centre, Sarvodaya, Centre for Family Services, and Sri Lanka National Association of Counselors. NGOs, which are involved in providing services, related to alcohol and drugs include Alcohol and Drug Information Centre, Mel Medura Alcoholism Information and Rehabilitative Services, Sri Lanka Anti-narcotics Association, and Federation of Nongovernmental Organizations against Drug Abuse.

Psychiatry in Medical Education

Mental health field has made vast strides in Sri Lanka in providing quality training in psychiatry to medical and allied health undergraduates and professionals. Although this effort needs further strengthening, lessons learned are worthy in dissemination.

With the availability of several alternative health-care facilities and native treatment methods for psychiatric care, medical education becomes vital in providing the best possible care to bring about a change in public opinion. Thus, medical education received close attention from academic psychiatrists, which resulted in the development of an undergraduate core curriculum in psychiatry, providing a common platform on essential components in psychiatry, which will be covered and assessed by all eight state medical faculties in the country [18]. Since 2018, all faculties comprehensively assess psychiatry as a final year subject. This is a valuable achievement for psychiatry. Nalaka Mendis was the pioneer in this regard. The principal author led the team of academic psychiatrists in developing the core curriculum in psychiatry for all medical faculties. Undergraduate core curriculum has covered all aspects needed for an undergraduate and has outlined the essential components of the training program and assessment [18]. The institutional objectives are basically similar in all faculties; however, each used a different strategy such as integrated approach, traditional approach, and traditional with some integration [18].

In addition, professional and personal development was considered essential in medical education, which was brought to the medical curriculum at the Faculty of Medical Sciences, University of Sri Jayewardenepura, and was recognized as an essential component of training to impart soft skills, communication, and counseling skills to students. The doctors at different settings now recognize mental illnesses, treat them, provide shared care, and contribute to promotion of mental health.

Postgraduate training in psychiatry is conducted by the Postgraduate Institute of Medicine, University of Colombo, which is the national institute for postgraduate medical education. Senior consultants of the Ministry of Health and academic departments contribute in designing, delivery, and examination process. The Board of Study in Psychiatry oversees the postgraduate training program, which includes postgraduate diploma in psychiatry; medical doctor specialized in psychiatry; and subspecialties such as forensic psychiatry, adolescent and child psychiatry, and old age psychiatry, and contributes to training in other specialties such as medicine in general, family medicine, venereology, emergency medicine, and community medicine.

The postgraduate diploma in psychiatry has a 12-month supervised training program, which includes clinical training in general adult and child psychiatry, a series of lectures, and field visits to rehabilitation centers organized by the Board of Study in Psychiatry [19]. This course was initially designed to bridge the mental health gap due to the limited number of trained and qualified psychiatrists in the peripheries. Each district is currently served by at least one consultant psychiatrist who leads the delivery of mental health care to the district; the objectives of the diploma training program are earmarked for curriculum revision to encompass present and future needs.

The medical training program in psychiatry is a five year program for general adult psychiatry and six years for subspecialties. Entry to the program is by a competitive examination, followed by three-year structured program, which evolves on CanMEDS rôles (an educational framework that describes the abilities that physicians require to meet the health-care needs of their patients, developed by the Royal College of Physicians and Surgeons of Canada) and formatively assessed at different stages and with a summative assessment after completion of three years [20]. This is followed by further supervised higher training in approved local and overseas training centers along with completion of a research component. A trainee is qualified to apply for board certification as a specialist once all requirements are fulfilled. The overseas component of training is to bring new knowledge and skills to the country, but it has also resulted in attrition of psychiatrists. To achieve international standards of examinations, the panel of examiners for specialty psychiatrist examination is appointed by the Board of Study in Psychiatry, which is a university senate approved panel of senior consultants, including one examiner from the Royal College of Psychiatrists in the United Kingdom or Royal Australian and New Zealand College of Psychiatrists.

Trainees attend courses and workshops facilitated by the SLCPsych, PGIM, and the Ministry of Health. Those short courses and workshops are popular among trainees and young psychiatrists as a way of learning new skills. Medical officers appointed to psychiatric units for the first time receive a training course in psychiatry, which consists of basic training to strengthen undergraduate knowledge and skills.

Education about Mental Health/Mental Illnesses for the Lay Public

Consultant psychiatrists of teaching hospitals and district hospitals play a pivotal role in public education and training of gatekeepers. Further, some government and NGO institutions conduct public awareness programs regarding available psychiatric services with the aim of maintaining the mental well-being of the citizens. The SLCPsych had been instrumental in developing leaflets for the public and conducting media campaigns to address stigma attached to mental health. Many publications on mental health problems in the form of books, leaflets, newspapers, newsletters, and magazines are freely available island-wide published by government hospitals and universities. Posters and banners are displayed in government and NGO institutions on different themes such as suicide prevention, prevention of domestic violence, child abuse, and tobacco use. Psychiatrists who have special interest in media write newspaper articles and conduct television talk shows.

As computer literacy increases among the general public in Sri Lanka [21], mental health education through this route is essential (www.Health.gov.lk/mental_health_act).

All psychiatry departments of government medical faculties and psychiatric wards in government hospitals have their own websites to create public awareness of facilities provided and also as a forum for psychoeducation. Young psychiatrists to promote mental health awareness have also initiated YouTube video programs such as the Mental Health Round Table.

Both the government and NGO sectors conduct mental health education programs and mental health promotional activities for the general public and target groups, e.g., Mental Health Meek (October 10–16) and World Tobacco Day (May 31), along with seminars, exhibitions, workshops, and dramas as part of primary prevention. These programs are carried out mainly through the enthusiasm of the individual psychiatrists who are supported by the MHD of the Ministry of Health.

Education of Gatekeepers

As discussed previously, psychiatry is one of the main subjects of undergraduate and postgraduate medical education, as well as nursing and allied health education and training, thus contributing to training of gatekeepers.

Counselors

Several government and NGO institutions offer higher diplomas (www.cmb.ac.lk/index.php/course/diploma-higher-diploma-in-counselling-psychology), diplomas, and certificate courses (www.imhlk.com/certificate-in-counselling-

and-psychotherapy) in counseling, and some courses offer clinical exposure as well (www. medical.sjp.ac.lk/index.php/psychiatry-diploma-course).

Psychologists

Psychology training is also offered at various institutes. In Sri Lanka, to practice as a qualified psychologist, a basic degree in psychology with a master degree in the same field is required [22]. At present, there are no clinical psychologists attached to the government sector, which restricts this service to people who can afford to obtain it from the private sector. At present, measures are underway to recruit clinical psychologists to the government service in future.

Nurses

The 3-year nursing program consists of 1-month training in psychiatry. Senior nurses become eligible to follow a 6-month diploma in psychiatry if they prefer. Nurses who have completed the 6-month diploma can then follow a three-month certificate course in community psychiatric nursing (www.health.gov.lk/moh_final/english/others.php).

Medical officer of health teams

Medical officer of health (MOH) team is a successful model in Sri Lanka. The team consists of MOH, public health sisters, public health inspectors, and family health workers who provide health services to the community at grass-root level, covering the whole island with 342 areas, each having a population of around 60,000. These teams are well accepted by the communities and carry out successful programs in maternal and child health and immunization.

Several measures have been taken to empower the primary care physicians, especially through enhancement of knowledge in psychiatry, e.g., the World Psychiatric Association funded "train the trainers program" to train trainers in primary care in Sri Lanka [23]. Mental Health training of MOH and teams are carried out mainly by district psychiatrists, as attempts to include mental health as a primary objective in their training program brought limited results due to perceived importance and workload in other areas of their service.

Other gatekeepers

Psychiatrists conduct workshops for police officers, preschool teachers, and special education teachers to educate and update their knowledge on common psychological problems.

Legislations and Safeguards in Mental Health and Psychiatry in Sri Lanka

Over the past quarter of a century, there have been advancements in mental health laws in the South Asian region, in countries such as India, Pakistan, and Afghanistan [24]. The prevailing law in Sri Lanka related to mental illnesses is the Lunacy Ordinance, which was enacted in 1873, while Sri Lanka was a British colony. This Ordinance, unfortunately, is not in keeping with the times as it promotes a custodial approach and thus institutionalized care, where the well-being of the society outweighs that of the individual who suffers from mental illness.

In an attempt to remedy this situation, the Ministry of Health together with the relevant authorities is in the process of repealing this archaic legislation, with a view of enacting laws where the rights of individuals with mental illnesses are recognized and protected. To date, however, the current Ordinance remains in place and maintains a centralized admission process, especially in regard to involuntary admissions for patients that do not have capacity to consent to treatment. The draft Mental Health Bill once enacted will address this burning issue through the establishment of decentralized services and programs for the treatment and care by providing the authority to general hospital psychiatry wards to detain patients for treatment if they fulfill the criteria for such an admission [25]. In addition to treatment, provision of rehabilitation and regulation of access to care are other important aspects that will be addressed. However, the mental health bill that had been drafted as a joint venture with the SLCPsych and Ministry of Health could not be enacted due to difficulty in reaching a consensus by different interest groups. This needs closer examination to ascertain reasons for delay and remedial action to be taken. Again, this is an opportunity for meaningful collaborative work to take place involving all stakeholders.

The Mental Health Policy of Sri Lanka is a valuable tool that clarifies the vision for a comprehensive mental health service for the citizens of Sri Lanka based on a community care model. It also promotes the treatment of mental illness holistically and discusses the role of a multidisciplinary team. It proposed the establishment of a National Mental Health Council to ensure that the policy is carried out as planned, with the support of the Directorate of Mental Health, Ministry of Health. It focuses on decentralization through reorganization of services as well as the development of human resources. The Ministry of Health is in the process of finalizing the Mental Health Policy for the next decade to align with its vision of comprehensive, decentralized services to all those in the need of mental health care [26].

Research in Mental Health System Development in Sri Lanka

Minas et al. carried out a research to evaluate the mental health system development in Sri Lanka. They found that Sri Lanka is a smart country with good-quality mental health outcomes for many decades, though it is a relatively small middle-income country, which had to face 30 years of civil war and many natural disasters. Despite Western practices becoming predominant over a long period of time, the traditional form of mental health care continues to play an important role. The devastating tsunami, which brought in international support, gave rise to reforms in the mental health-care system, due to the availability of improved technical expertise. This gave rise to decentralization with an establishment of more in patient psychiatry wards in district

general hospitals throughout Sri Lanka with further emphasis on community psychiatry [8, 27].

Ranasinghe et al. conducted a research [28], which analyzed community psychiatry service in Sri Lanka. In the current practice of psychiatry, there is a shift from hospital to community-based care. Although different models are used, the concept of community psychiatry is based on several core principles. In Sri Lanka too, psychiatrists have initiated community psychiatry projects. Weerasundera suggested the use of a practical approach to community psychiatry where the specific advantages and limitations of each locality are taken into consideration when setting up a community practice [29].

Another study conducted to assess community psychiatry, community mental health services, and primary care psychiatry in Sri Lanka, found that Sri Lanka has a well-established primary health-care system, which can be used to deliver mental health care effectively. In addition, it was noted that NGOs contribute through provision of community care, rehabilitation services, and training of primary health-care workers and other gatekeepers. Furthermore, psychiatrists as a body were recognized to play an important rôle in advocacy and health promotion [30].

The Sri Lanka College of Psychiatrists

The Sri Lanka College of Psychiatrists was originally founded as the Ceylon Mental Health Association in 1955, which was a professional body that played an advocacy rôle in furthering psychiatric services in the country. It then transformed to Sri Lanka Psychiatric Association in 1972 and finally in 2003 became the Sri Lanka College of Psychiatrists as it stands today [31]. This organization has grown from 36 members in 2003 to 237 members in 2018 [32]. Members are from those completed medical education in Sri Lanka and those practice overseas also contribute to the development of mental health services in Sri Lanka.

The SLCPsych functions with a vision of promoting the advancement of knowledge and skills in psychiatry, providing advocacy and supporting the conduct of research in the field.

Over the years, the college has contributed to continuing professional development (CPD) of psychiatrists and MOMH, support service development, and engaged in policymaking and advocacy to the Ministry of Health and other important stakeholders. It conducts annual academic session and regional CPD activities. In 2015, it commenced a CPD program for psychiatrists.

To appreciate academic achievements and dedicated service development, as well as, to promote enthusiasm regarding the field of psychiatry, the SLCPsych offers several awards. Bobby Somasundaram Gold Medal is offered for the best performance at the Selection Examination for the MD program, R. Kulanayagam Gold Medal is offered for the best essay in psychiatry by a trainee, Peter and Mabel Cooray Gold Medal is offered for the best research paper presented at the annual academic sessions, and an award is presented for the best poster presentation at the annual academic sessions and psychotherapy essay [32]. Dr. D. V. J. Harishchandra Gold Medal is awarded to the best regional psychiatrist of the year, in recognition of his/her contribution to service development in the periphery. To promote international collaboration, the SLCPsych issues bursaries to members and liaise with international organizations to promote research in mental health field.

Since 2010, the college publishes an open-access, peer-reviewed journal, biannually, *Sri Lanka Journal of Psychiatry*. This contains original research and other scholarly articles relevant to psychiatry and allied sciences. The SLCPsych also issues an annual newsletter. The college published two books on CPD for psychiatrists and medical officers [16, 33] and several information leaflets for the general public to increase awareness on mental health.

The CPD program for psychiatrists formulated in 2015 is on par with national and international standards. It assists psychiatrists to update knowledge under six thematic areas guided by CPD for specialists, set by the Sri Lanka Medical Association (SLMA) and Royal College of Psychiatrists (RCPsych) in the United Kingdoms and Royal Australian and New Zealand College of Psychiatrists [16].

The SLCPsych also facilitates district mental health meetings (Figure 1), provincial mental health committee meetings, and collaborates with the Ministry of Health on educational programs to nurses, nursing students, and other allied disciplines [32].

The members of the college actively contribute to the Board of Study in Psychiatry, Ceylon College of Physicians,

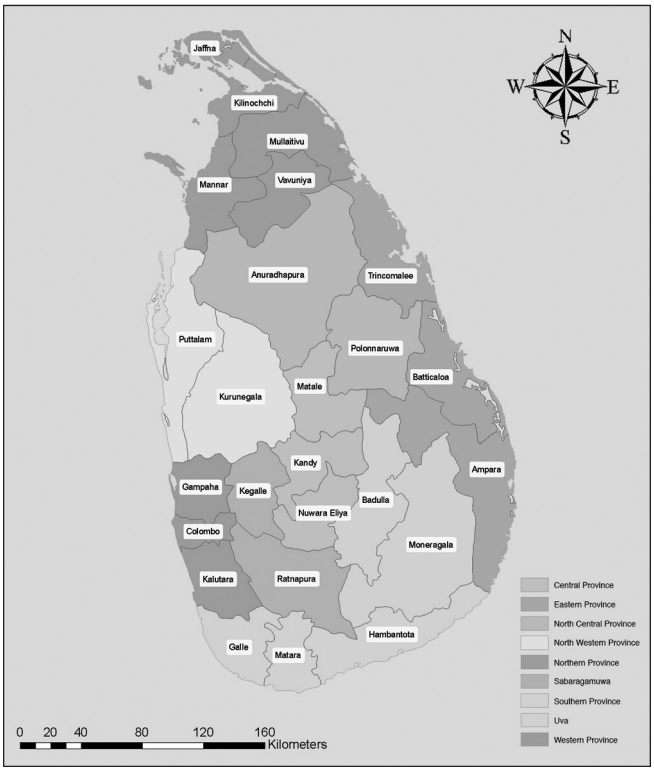

Figure 1. The 25 districts in Sri Lanka where mental health services are available.

SLMA CPD committee, and Medical Expert Committee of the National Medicines Regulatory Authority [32].

The Sri Lanka College of Psychiatrists maintains an official website and utilizes social media to create public awareness. In addition, the members have developed an educational video series freely available on the YouTube titled "Mental Health Round Table" [32].

The Sri Lanka College of Psychiatrists has contributed to developing national guidelines on responsible reporting of suicide (working collaboratively with the MHD), administration of electroconvulsive therapy, and pre-departure health assessment.

The college has also stepped forward in developing the infrastructure in psychiatry. A common infrastructure blueprint was developed for teaching hospitals and general hospitals that will be useful when establishing psychiatry units. The SLCPsych has also taken steps to develop "Day Centres" for service users [32].

Challenges Faced in Reducing Treatment Gap

Challenges that encountered in the evolution of mental health services in Sri Lanka could be considered under different domains. In a public health point of view and in considering the timeline, these challenges can be broadly divided into that occur in normal times and those occur in times of disaster.

Challenges encountered during normal times include stigma and lack of mental health literacy. Urbanization has led people vulnerable to stress-related disorders and other mood disorders. Changing lifestyle, traditional rôles, and lack of community support mechanisms increase this vulnerability. Thus, improving mental health literacy among the public and reducing stigma to reach out for help become a vital component in improving mental health at all times.

Media portrayal of mental health issues often leads to stigma. Despite efforts, reporting by the media sensationalizing suicide and homicide incidents and plight of mentally ill people lead to distress of vulnerable communities and individuals. Some television programs (such as teledramas) portray people with mental illness with a negative connotation. Keeping a balance between news value and ethical reporting standards has always been a struggle. In this respect, initiatives have taken place to improve responsible media reporting and to reduce stigma. Mental health policy need to address the issue by having a continuous monitoring mechanism and coordinated approach that involves all stakeholders. Education of vulnerable groups and gatekeepers also need to be strengthened by mental health policy.

Natural and anthropogenic disasters pose considerable challenge to mental health service providers. Sri Lanka faced an internal armed conflict, which lasted for over two and half decades. Natural disasters such as tsunami, floods, and landslides caused a negative impact on human lives. These lead to depression, post-traumatic stress disorder, deliberate self-harm, and substance use among those affected. Normalization of trauma and acceptance of distress is a negative social impact that occurs due to unrestricted media reporting on these. An approach dealing with media and strengthening community support should continue with more emphasis given to it by mental health policy. Detection of mental disorders among vulnerable communities, providing community support, managing referrals, and after care need to be strengthened at district level, especially in affected zones.

Considering a life-cycle approach, all common disorders in childhood, adolescence, adulthood, and elderly are prevalent in the community and need to be addressed by a stepped care approach. Children are in a highly demanding and competitive educational system leading to increased levels of stress-related, mood, and anxiety disorders. Lack of parental supervision and increased availability with easy accessibility of substances of abuse and devices also contributed to these problems. Growing elderly population in Sri Lanka poses a significant challenge to unpreparedness in mental health services. Increased longevity associated with greater disability make elderly vulnerable to mental health comorbidities, especially in stressful urban communities which grossly lack sufficient social care provision. Incidence of dementia, delirium, and depression are on the rise, as well as suicides, especially in males. Decline in functional capacity with aging, poor physical health, social isolation, and financial deprivation with retirement are some of the factors contributing to mental health problems in the elderly, which need to be addressed [34]. Again, cooperation with multiple stakeholders providing care at different levels and provision of minimum facilities to mental health units is a responsibility of the Mental Health Unit of the Ministry of Health. Sufficient funding need to be allocated to train gatekeepers, ensure referral system and training MDT, provide minimum facilities to all mental health units, and ensure the development of specialized tertiary mental health care facilities at each province. In this regard, major shift of focus need to occur at the central level to allocate resources to these important tasks. Providing encouragement and facilities to specialist psychiatrists to serve all provinces need to be considered, as retention of specialists in all districts is an important factor in delivering quality care closer to patient's homes. Along with these, emphasis needs to be given to strengthen community care by supporting psychiatrists and teams to conduct outreach clinics, mobile services, and home assessments.

The challenges faced in organizing community mental health care in all districts aligned with the existing health-care delivery framework are multifaceted. Detection of mental health disorders, training of psychiatrists and gatekeepers, and increasing public awareness and addressing stigma had been dealt effectively. The most important challenge now is to integrate mental health services with the existing framework of health-care delivery in the country. In this regard, careful integration with primary care teams such as general practitioners and MOH teams becomes vital, without increasing strain to the existing system. This shift involves working with attitude and prejudice of policymakers, which resonates with the custodial asylum care that developed by the British. Shifting focus to community care has begun

at policy and grass-root levels, but goes through a slow phase of development due to low resource allocation. To make an attitudinal shift, psychiatrists need to develop a healthy dialogue with policymakers and administrators at central and local levels. Skills in collaboration and conflict resolution become important in this regard. The two aspects of mental health services, i.e., provision of effective mental health care at a close vicinity to service users and delivery of mental health promotion programs, need to be carefully integrated. The former should be offered only by a well-trained multidisciplinary team led by psychiatrists and the latter could be delivered by other stakeholders, if proper technical guidance is given by specialists in mental health field. The services offered at the district level require well-developed in-patient units with intensive care facilities in the district general hospitals as well as outreach clinics, mode of transport to these clinics, age-specific and disease-specific community centers (e.g., rehabilitation centers, day units, half-way homes, and long-term care facilities), and community teams. The development of these has occurred in an exemplary manner in certain districts and centers, as a result of the continuous struggle and innovative and collaborative approaches of some futuristic psychiatrists. Agreeing on new mental health policy for 2016–2025 which addresses all these aspects in a comprehensive manner is still in the draft stage due to lack of agreement between stakeholders. This calls for in-depth discussions between policymakers, administrators, psychiatrists, and service users.

Conclusion

Sri Lanka has achieved quality mental health-care outcomes despite having limited resource allocations. Mental health services need to be consistently revamped, given priority to face ongoing challenges to provide quality, equitable, and efficient service to all the citizens in this beautiful country.

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Conflicts of Interest

There are no conflicts of interest.

References

1. Warnapala WA: Sri Lanka 1978: reversal of policies and strategies. *Asian Survey* 1979; 19: 178-90.
2. Deraniyagala SU: Pre and protohistoric settlement in Sri Lanka. *Int Union Prehistoric Protohistoric Sci* 1998; 5: 277-85.
3. Thyloth M, Singh H, Subramanian V: Increasing burden of mental illnesses across the globe: current status. *Indian J Soc Psychiatry* 2016; 32: 254-6.
4. Wainberg ML, Scorza P, Shultz JM, et al.: Challenges and opportunities in global mental health: a research-to-practice perspective. *Curr Psychiatry Rep* 2017; 19: 28.
5. De Alwis LA: Development of civil commitment statutes (laws of involuntary detention and treatment) in Sri Lanka: a historical review. *Medico Legal J Sri Lanka* Colombo 2017; 5: 23.
6. Ramu MG, Venkataram BS: Manovikara (mental disorders) in Ayurveda. *Anc Sci Life* 1985; 4: 165-73.
7. Carpenter J, Mendis M, Samarasinghe D: The History of Mental Health Care in Sri Lanka. Colombo, Sri Lanka: Marga Publications, 1988: 2-80.
8. Minas H, Mendis J, Hall T: Mental health system development in Sri Lanka. In: Minas H, Lewis M, (eds): *Mental Health in Asia and the Pacific: historical and Cultural Perspectives.* New York: Springer, 2017: 59-77.
9. Somasundaram D: Child soldiers: understanding the context. *BMJ Clin Res* 2002; 324: 1268-71.
10. Elbert T, Schauer M, Schauer E, et al.: Trauma-related impairment in children – a survey in Sri Lankan provinces affected by armed conflict. *Child Abuse Negl* 2009; 33: 238-46.
11. Chandradasa M, Kuruppuarachchi KA: Child and youth mental health in postwar Sri Lanka. *BJPsych Int* 2017; 14: 36-7.
12. Siriwardhana C, Wickramage K, Jayaweera K, et al.: Impact of economic labour migration: a qualitative exploration of left-behind family member perspectives in Sri Lanka. *J Immigr Minor Health* 2015; 17: 885-94.
13. Bolz W: Psychological analysis of the Sri Lankan conflict culture with special reference to the high suicide rate. *Crisis* 2002; 23: 167-70.
14. Isuru LL, Gunathillaka KD, Kathriarachchi ST: Reducing maternal suicide in Sri Lanka: closing the gap. *Sri Lanka J Psychiatry* 2016; 7: 1-3.
15. Agampodi S, Wickramage K, Agampodi T, et al.: Maternal mortality revisited: The application of the new ICD-MM classification system in reference to maternal deaths in Sri Lanka. *Reprod Health* 2014; 11: 17.
16. Kathriarachchi ST, Rodrigo A, Waas DA: *Continuing Professional Development for Psychiatrists in Sri Lanka*. Colombo, Sri Lanka: The Asia Foundation, 2016.
17. Kathriarachchi ST. A Review of trends in suicide and deliberate self harm in Sri Lanka. *Vidyodaya J Hum Soc Sci* 2009; Joint Golden Jubilee Issue: 171-84.
18. Kathriarachchi ST, Dharmasena SR: Undergraduate training in psychiatry in a developing country – experience in establishing a new curriculum. *J Ceylon Coll Physicians* Colombo 2002; 35: 4-11.
19. *Prospectus: Diploma in Psychiatry*. Sri Lanka: Post Graduate Institute in Medicine, University of Colombo, 2008.
20. *Prospectus MD Psychiatry and Board Certification in Psychiatry*. Sri Lanka: Post Graduate Institute in Medicine, University of Colombo, 2013.
21. *Computer Literacy Statistics*. Sri Lanka: Department of Census and Statistics, 2017.
22. De Zoysa P: The use of psychology in the administration of justice in Sri Lanka: a point of view. *Int Psychol Bull* 2013; 17: 62-3.
23. Jenkins R, Mendis J, Cooray S, et al.: Integration of mental health into primary care in Sri Lanka. *Ment Health Fam Med* 2012; 9: 15-24.
24. Weerasundera R: Mental health legislation in Sri Lanka: the time for change is now. *Sri Lanka J Psychiatry* 2011; 2: 3-44.
25. Ministry of Health. *The Draft Mental Health Act*. Colombo, Sri Lanka: Ministry of Health, 2007.
26. The Mental Health Policy of Sri Lanka 2005 – 2015. Colombo, Sri Lanka: Mental Health Directorate, Ministry of Health Care, Nutrition and Uwa Wellassa Development, 2016.
27. Fernando N, Suveendran T, de Silva C: Decentralizing provision of mental health care in Sri Lanka. *WHO South East Asia J Public Health* 2017; 6: 18-21.
28. Ranasinghe P, Mendis J, Hanwella R: Community psychiatry service in Sri Lanka: a successful model. *Sri Lanka J Psychiatry* 2011; 2: 3-5.
29. Weerasundera R: Community psychiatry in a Sri Lankan setting: should we rush to push the boundaries. *Sri Lanka J Psychiatry* 2010; 1: 27-8.
30. Rodrigo EK: Community psychiatry, community mental health services or primary care psychiatry in Sri Lanka. *Sri Lanka J Psychiatry*

2017; 8: 1-3.
31. Kathriarchchi ST: Leadership in psychiatry (a presidential inauguration address). *Proceeding of Annual Academic Sessions of the Sri Lanka College of Psychiatrists*. Colombo, Sri Lanka: The SLCPsy, 2015.
32. *Proceeding of Annual Academic Sessions of the Sri Lanka College of Psychiatrists*. Colombo, Sri Lanka: The SLCPsych, 2018.
33. Gunawardhana UP, Seneviratne RM: *Management of Mental Health Problem: A Guide for the Doctors in the Community*. 2nd ed. Colombo, Sri Lanka: The Asia Foundation, 2015.
34. Samaraweera D, Maduwage S: Meeting the current and future health-care needs of Sri Lanka's ageing population. *WHO South East Asia J Public Health* 2016; 5: 96-101.