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What Government Mental Health Services Can Be Accessed By the Civilian Population of Sri Lanka Following the End of the Civil War: A Literature Review

Tanvi Khetan*, Tharanika Ahillan*

***Abstract*— Introduction: Sri Lanka, a lower middle-income country in South Asia, has experienced a devastating civil war, with unique mental health needs following the end of the civil war in 2009.**

Methods: A literature review was conducted to examine what government mental health services can be accessed by the civilian population following the end of the civil war.

Results: Following the end of the civil war, mental healthcare within Sri Lanka can be structured around six principle aims as outlined in the Mental Health Policy of Sri Lanka 2005-2015: to provide mental health services at primary, secondary and tertiary levels, to provide services of good quality where and when they are needed, to provide services that will be organised at community level with community, family and consumer participation health, to ensure mental health services will be linked to other sectors, to ensure mental health services will be culturally appropriate and evidence-based and to protect the human rights and dignity of people with mental illness. It lists various services that have been provided, as well as the importance of non-governmental organisations (NGOs) and indigenous healers and practices in providing the gaps in these services.

Conclusions: A greater focus on primary healthcare and community healthcare is needed, whilst continuing existing measures such as training more mental health workers and psychiatrists, and providing integration of services through the multidisciplinary team and education sector. Finally there is a necessity for increased integration and coordination between the medical system and traditional sector to provide culturally sensitive mental healthcare, and increased research in this area and the effectiveness of the services to better inform future policies.

***Index Terms*—Mental health, Sri Lanka, Literature review, Civil war**

I. Introduction

Sri Lanka is a lower middle-income country in South Asia with a population of 21 million[1]-[2]. A multi-ethnic country, it comprises of the Sinhalese (predominantly Buddhist) majority, and the Tamil (mostly Hindu) and Muslim minorities[3]. Sri Lanka experienced almost three decades of a civil war from 1983 until May 2009[1]. These armed conflicts took place between the "Liberation Tigers of Tamil Eelam (LTTE)", a pro-independent militant Tamil group, and the Sinhalese-dominated Sri Lankan Army[4]. Much of the war occurred in the north and east of the island, where the Tamil minority largely reside[1]. An estimated 100,000 people died and nearly 800,000 were displaced within Sri Lanka[5].

Sri Lanka has a free-of-charge health care system, heavily subsidised by the government, with private health care also being readily available[1]. The improvement of basic health in Sri Lanka despite the prolonged conflict, has been hailed as a success story by the World Health Organisation (WHO)[6].

In contrast, the country's mental health services are considered sub-par. The burden of mental health in Sri Lanka is substantial: in 2015, depressive disorders was the fifth-leading cause of years lived with disability in Sri Lanka. With around only 48 psychiatrists throughout the country, the gap between demand and supply is evident[1], [7]. Following the 2004 Tsunami, this need was recognised by the government of the Sri Lanka: a report was commissioned by the Ministry of Healthcare addressing the Mental Health Policy of Sri Lanka from 2005 – 2015[7]- [8].

Sri Lanka is currently in the post-conflict stage, which has been theorised to affect mental illness[9]. An expansive study in Sri Lanka reported a stepwise increase in symptoms of depression associated with an increase in the affected conflict zones (minimal, moderate and severe conflict zones respectively)[10]. Previous research in low-income countries which have experienced prolonged civil wars, such as Uganda, have identified an increased occurrence of suicidal ideation among individuals associated with increased psychiatric disorders, particularly post traumatic stress disorder (PTSD) and depression, seen post-conflict[11].

Following the end of the war, the mental health needs related to suicide are theorised to be very different to those of the population in peacetime; as a result, these needs should translate into the provision of effective mental health care.
This literature review will explore what government mental health services can be accessed by the civilian population following the end of the civil war.

Tanvi Khetan, Department of Psychiatry, North East London Foundation Trust, London, United Kingdom
Tharanika Ahillan, Department of Emergency Medicine, Newham University Hospital, London, United Kingdom
*Co-first authors: these authors provided equal contributions to the preparation of this manuscript

II. Methods

A. Databases used

The initial literature search was conducted in February 2018 used PubMed, OVID Global Health, PsycArticles, Google Scholar and Sri Lanka Journals Online. This was supplemented with grey literature including reports and policies from the Sri Lankan Ministry of Health, the National Institute of Mental Health (hereby referred to as NIMH), WHO and any related news articles.

B. Search terms

The key concepts in the question were "Sri Lanka", "mental health disease", "mental health care" and "civil war": these were used in various combinations to maximise the results. These concepts and their related terms are detailed in Table 1.

The definitions of mental health disorders were taken from the International Classification of Diseases (ICD), 10th revision[12].

C. Inclusion and exclusion criteria

No limits were placed on publication dates. Civilian population was defined as "persons who are not members of the armed forces" which was extended to also exclude emergency forces and Sri Lanka police force[13]. Refugee populations living outside of Sri Lanka but with a Sri Lanka origin were also excluded, as suggested in a paper by Siriwadhana and Wickramage, in order to keep the focus on affected populations within the country. In addition, non-English literature was excluded[1].

D. Search strategies

To answer this literature review appropriately, the following search strategy terms were used (Table 1). The concepts of Sri Lanka AND Conflict were applied in all sections, combined with "mental health disease" or "mental health care" to answer appropriately.

Concept	Search terms	PubMed	Ovid Global Health	Psyc- Articles
Sri Lanka	Sri Lanka OR Ceylon OR Tamil Eelam OR Jaffna OR Kilinochchi OR Point Pedro OR Mannar OR Vavuniya OR Mullaitivu OR Ampara OR Batticaloa OR Trincomalee	11,843	2,029	299
Conflict	war OR conflict OR civil war OR conflict-related OR internal displacement OR disaster	271,005	9,796	32,077
Mental Health Disease	mental health OR mental illness* OR mental disorder* OR mental disease OR psychiatric disorder* OR psychological disorder* OR anxiety OR post-traumatic stress disorder OR PTSD OR mood disorder OR depression OR depressive disorder OR mania OR bipolar disorder OR suicide OR suicid* OR self-killing OR self-harm OR psychotic disorder OR psychotic illness OR psychosis OR schizophreni* OR schizoaffective disorder	1,640,915	7,783	70,920
Mental Health Care	mental health care OR mental health policy	109,663	24	3,185
Sri Lanka AND Conflict AND Mental Health Disease		154	8	142
Sri Lanka AND Conflict AND Mental Health Care		36	0	11

Table 1: Search strategy

III. Results and discussion

A. Sri Lanka's Mental Health Care in Sri Lanka

In Sri Lanka, Mental Health Care comprises of Western medical care provided by the government, which we shall call "Government Mental Health Care" and traditional care, such as spiritual practices, which has been labelled as "Other Mental Health Care"[14].

B. Government Mental Health Care

There is a limited amount of official statistical data on mental health care in Sri Lanka. Therefore the authors have structured their response to this question through the Mental Health Policy of Sri Lanka 2005-2015 (hereafter referred to as MHP), using estimations from several studies. Government healthcare was structured around six principle aims outlined in the MHP; these are the subheadings of the below sections[8].

i. To provide mental health services at primary, secondary and tertiary levels

Traditionally, government-funded mental health services were limited to tertiary-care institutions, mostly specialist hospitals such as the NIMH in Colombo[7]. After the 2004 tsunami, greater political commitment to mental health led the greater role of primary healthcare in improving mental wellbeing[7]. This commitment was consolidated in the MHP, providing mental health services at primary, secondary and tertiary levels[8].

Nevertheless, although a physician trained for mental health is supposed to be appointed to each district in primary care, one study looking at post-conflict reconstruction of health systems in the Northern Province found no such quota being met[15]. Instead, it was left to NGOs with limited resources to provide much of the psychological support at this level[15]. The methodology in this study is rigorous: it compared both quantitative governmental data and qualitative questionnaire data to survey the unmet needs in this area with less bias than previous studies[15]. Therefore, it shows that an imbalance continues with most mental health services still only available at tertiary and secondary-care institutions, and primary care mental health services remaining scarce[7].

ii. To provide services of good quality where and when they are needed

A key indicator of quality in a mental health service is the ratio of mental health care workers to patients in the population. Existing data from WHO shows that there were 0.36 psychiatrists per 100,000 population[16]. While this ratio offers a straightforward estimate of the density of psychiatrists in Sri Lanka, it does not indicate the difference in workload of a psychiatrist between a low-middle income country and high income country[17]. Also, this figure does not consider the improvements in mental health care which may show themselves in the future. For example, the Ministry of Health's programme to train medical officers in mental health would show its effects on national mental health care in a few years[7].

The MHP also stressed that at least two community psychiatric nurses should be allocated to each district[8]. Subsequently, in 2010, a 6-month programme was introduced at the NIMH to train 55 nurses as community psychiatric nurses, providing more care at the primary level[7]. The result is 2.74 nurses working in the mental health sector per 100,000 population[16]. This strengthened treatment adherence and provided mental health education in the community, enhancing the service quality[7]. An unpublished study by Minas highlighted these benefits; findings from three districts in southern Sri Lanka revealed community support officers were responsible for referring more than half of all inpatients[18].

However, the actual quality of care despite the improvements in human resources is lower than expected: for example, there is still a significant delay in recognition of mental illness by medical professionals[7]. A project by the WHO Regional Office for South-East Asia estimated the treatment gap in the provision of mental health services to be as much as 67.6% in parts of Sri Lanka[19]. The tendency for patients to be taken elsewhere to services which do not provide effective treatments can also be seen as an indicator of insufficient quality of services for patients[7].

iii. To provide services that will be organised at community level with community, family and consumer participation health

The Sri Lankan government has chosen to promote community mental health care in Sri Lanka with the support of NGOs[7]-[8]. The reason for this can be explained by the balanced care model which suggests that low to medium-resource settings need to focus on providing treatment in the community, with the development of general adult services such as outpatient clinics and community mental health teams; Sri Lanka has started to do just this recently[20]. However, the global balanced care model is self-admittedly overly simplistic, with no differentiation between the types of services in different countries[20]. Therefore there needs to be an attempt to assess how feasible this model is in a country such as Sri Lanka.

Fernando, Suveendran and de Silva did this by providing basic training for community care workers in detecting mental disorders early, seeking appropriate help when applicable and caring for mentally ill people in the community[7]. The result has been positive, with 80 community volunteer organisations island-wide, 4361 volunteers and activities coordinated under the Consumer Action Network Mental Health Sri Lanka.

Likewise, another small scale study by Samarasekere, Davies and Siribaddana. emphasised the benefits of a community focus into order to combat the stigma around with mental illness within Sri Lankan communities, working with the patients' families too[21]. Stigma is a barrier to seeking mental health services, and is particularly relevant when seeking care following a suicide attempt or in suicide prevention. However, the study only had nine participants picked from two districts of Sri Lanka through non-random sampling, leaving the risk that these subgroups were not representative of the population[21]. As a result these findings may not be transferable as community mental health workers in other districts may have different experiences[21].

iv. To ensure mental health services will be linked to other sectors

The MHP stressed the provision of care via a multidisciplinary team, to ensure linkage to other sectors[8]. Before this, mental health care in Sri Lanka followed the medical model where social issues were often overlooked[8]. However nowadays, a gold standard multidisciplinary team in Sri Lanka includes community psychiatric nurses, psychiatric social workers and occupational therapists, showing a shift towards a psychosocial model of mental health care[7].

Mental health has also been linked to the education sector thorough the introduction of a 'life-skills programme' since 1998 in secondary education, helping young people build up a solid foundation in which to cope with life events and reduce the 'peak' in youth suicides[22]. With particular reference to suicide rates, interventions available include the promotion of resilience in school children through the curriculum and awareness programmes on study techniques, anger management and coping with stress[22]. This holistic approach also improves follow-up of children diagnosed with mental disorders[3].

Nevertheless, whilst programmes linking mental health services to other sectors exist, the vast majority of care seems to be focused on medical approaches, with pharmacotherapy still taking priority over psychotherapy in the treatment of the mental health needs in post-war Sri Lanka[3].

v. To ensure mental health services will be culturally appropriate and evidence based

Mental health services in post-war Sri Lanka are more likely to be sustainable if they are tailored specifically for the local health system and socio-economic situation[23]. Existing mental health services have attempted to do this, for example through the introduction of a hotline for counselling to help prevent suicides which was subsequently expanded to each district[24]-[25].

However, often much of the most culturally appropriate care is provided via spiritual healers and religious figures[3]. The tendency to seek help from such figures before resorting to psychiatric services indicates that official governmental care is not as culturally sensitive as it aims to be[3]. This can contribute towards delayed presentations of mental illness and stigma associated with depression, both of which can serve as substantial barriers to care[3]-[25]. As a result, this has been identified this as a mental health need.

vi. To protect the human rights and dignity of people with mental illness

Sri Lanka's archaic mental health care legislation from 1873 is still in operation today[26]. This restricts progress in

the area: for example involuntary treatment should only occur at the NIMH, meaning much of the population cannot access such treatment[26].

Still, in truth, patients are cared for in regional facilities at the discretion of the medical professionals[26].This requires the family's help to bypass outdated review procedures, hence why mental health care has shifted towards increased community participation[26].Therefore the need for new law changes may in fact be redundant as the healthcare sector drafts their own common laws.

However, there has been an acknowledgement that new regulations relating to mental health are needed, so that progress in mental health care is not hindered by a lack of supporting legislation[26]. Nevertheless planned new mental health legislations have remained in 'draft' for over a decade, so it is evident that Sri Lanka lacks the political will to address this imbalance[26].

C. *Other mental health care*

Although this review has concentrated on government mental health care, it is necessary to appreciate the role of traditional mental health care.

In Sri Lanka, there are a range of indigenous healers and practices. While not strictly under formal care, they have been increasingly recognised by governmental psychiatrists as important in addressing mental health needs, treating mental illnesses and promoting psychological health and resilience[27].

An example of such a ritual is the relatively common occurrence of possession states in Northern Sri Lanka[28].The role they play in communicating distress could arguably constitute as "mental health care" in Sri Lanka. However, there is a suggestion that abnormal forms of possession states in this culture should suggest a psychotic diagnosis due to the greater negative impact in can have on the individual, including in suicide attempts[28].Therefore there is a need for some kind of intervention within this unofficial mental health care, in order to maximise these benefits and reduce harm[28].

More details of these rituals have been difficult to locate in the literature, suggesting more research is needed in this area considering how widespread the practices are reported to be. The study by Siriwardhana therefore advocates a better relationship between the Western medical system and the traditional sector to ensure more effective care for both patients with serious psychotic illnesses who may need Western medication, and those in government hospitals who need more culturally-sensitive care[28].

D. *Limitations of this paper*

The use of the International Classification of Diseases (ICD) definition of mental health disorders has been criticised for allowing Western interpretations of mental distress to be imposed onto other cultures[29].This seems to be relevant in Sri Lanka, where there are local idioms of distress which may not necessarily be captured through ICD 10, and locally relevant assessments have better success in capturing mental health disorders[30].However the widespread use of the ICD 10 system for classifying mental health disorders around the world led the authors to consider this as a suitable method for coming up with terms for the concept of 'mental disorders'[31].

IV. Recommendations

These statistics of providing more healthcare workers emphasise that the government should continue expanding human resources capacity, but in the settings with the largest treatment gaps[24].

Nevertheless the conclusion from the literature is that more mental health services should be shifted to the community level in Sri Lanka.

V. Conclusion

This literature review established that existing mental healthcare within Sri Lanka can be structured around six principle aims as outlined in the Mental Health Policy of Sri Lanka 2005-2015.

It highlights that there is a greater focus to provide primary healthcare, in addition to secondary and tertiary mental healthcare, in improving mental wellbeing, but that NGOs with limited resources are often deemed necessary to provide this need on a primary level.

It shows that the ratio of psychiatrists and mental healthcare workers in Sri Lanka to the patient population is lower than required, but there has been an increased drive from the government in training more mental healthcare workers.

There is an increased focus in addition on the balanced care model to provide services at a community level, but a reliance on NGOs to provide this care. However services which have been provided on a community level have been met with positive reception, adding evidence to the body to continue such programmes.

Mental health services are increasingly being integrated through the multidisciplinary team, as well as through links in the education sector to promote resilience in school children regarding mental health. Hotlines for counselling have attempted to also provide more culturally appropriate care, but the majority of such care is given via spiritual healers and religious figures. Finally the mental healthcare legislation in operation in Sri Lanka is over one hundred years old, providing a barrier to accessing mental healthcare.

Thus these suggest that the alternative healing system, with indigenous healers and practices, are providing a source of mental healthcare within these gaps which is providing pivotal for the civilian population following the end of the civil war, and a greater coordination between the medical system and traditional sector to provide culturally sensitive mental healthcare is necessary to go forwards.

Overall the main conclusion from this literature review is the need for more research and data regarding mental health systems and policies throughout the country, both governmental and alternative healthcare systems. This will enable an effective analysis of these mental healthcare systems and how they support the civilian population to be

made. Through this more policies can be developed which consider the wider context of mental health in post-conflict low- and middle- income countries, including the role of culture, community and gender. Through such research, we can ensure that there is a more effective response to high suicide rates and mental disorders exacerbated by wars in low-middle income countries.

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