Decentralizing provision of mental health care in Sri Lanka

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Abstract

In the past, mental health services in Sri Lanka were limited to tertiary-care institutions, resulting in a large treatment gap. Starting in 2000, significant efforts have been made to reconfigure service provision and to integrate mental health services with primary health care. This approach was supported by significant political commitment to establishing island-wide decentralized mental health care in the wake of the 2004 tsunami. Various initiatives were consolidated in The mental health policy of Sri Lanka 2005–2015, which called for implementation of a comprehensive community-based, decentralized service structure. The main objectives of the policy were to provide mental health services of good quality at primary, secondary and tertiary levels; to ensure the active involvement of communities, families and service users; to make mental health services culturally appropriate and evidence based; and to protect the human rights and dignity of all people with mental health disorders. Significant improvements have been made and new cadres of mental health workers have been introduced. Trained medical officers (mental health) now provide outpatient care, domiciliary care, mental health promotion in schools, and community mental health education. Community psychiatric nurses have also been trained and deployed to supervise treatment adherence in the home and provide mental health education to patients, their family members and the wider community. A total of 4367 mental health volunteers are supporting care and raising mental health literacy in the community. Despite these important achievements, more improvements are needed to provide more timely intervention, combat myths and stigma, and further decentralize care provision. These, and other challenges, will be targeted in the new mental health policy for 2017–2026.

Keywords: community mental health, decentralized care, mental health, Sri Lanka, tsunami

Background

Sri Lanka is a lower-middle-income country with a population of 21.3 million.1 The country performed strongly in the Millennium Development Goals, as evidenced by the excellent indicators for neonatal, infant, under-five and maternal mortality.2 As is the case throughout the World Health Organization (WHO) South-East Asia Region, despite continuing threats from communicable disease, such as dengue, the burden on Sri Lanka’s health system has shifted towards noncommunicable illness. This is occurring in parallel with a very rapid demographic transition – Sri Lanka has one of the fastest-ageing populations in the world – and changing social structures, including erosion of traditional support structures such as the extended family.3

With respect to mental health, data from the Global Burden of Disease study in 2015 indicate that depressive disorders were the fifth-leading cause of years lived with disability in Sri Lanka, in both 2005 and 2015. Likewise, for the same years, self-harm was the second-leading cause of premature death.4 Mental health services in Sri Lanka have a long history of progressive development but in the past have failed to meet the needs of the majority of the population, as reflected in the large treatment gap.5 In 2011, a project supported by the WHO Regional Office for South-East Asia was undertaken in Uva province, to assess the level of utilization of services for one disease (psychosis), as a proxy for the level of utilization of services for mental and neurological disorders. Based on this work, the treatment gap was estimated to be 67.6%.5

The reasons that have contributed to this failure to provide adequate care coverage have included centralized service provision; hospital-based services; disease-oriented services; and a lack of trained staff for basic diagnosis and referral of people with mental health conditions. Nevertheless, there have been significant developments in mental health care in Sri Lanka since 2000, key elements of which are reviewed in this paper.

Policies to decentralize a centralized service

In Sri Lanka, government-funded health services are delivered at the level of tertiary, secondary and primary care. Until 2000, mental health services in Sri Lanka were limited to tertiary-care institutions, namely specialist hospitals such as the National Institute of Mental Health (NIMH), teaching hospitals affiliated to medical faculties, and provincial general hospitals. Owing to factors such as lack of awareness, stigma associated with
mental disorders, and challenges to accessibility, only a small proportion of those in need benefited from these centralized services. A further weakness was the lack of active follow-up, continuity of care or rehabilitation of patients discharged from hospital, leading to a high incidence of discharged–relapsed–readmitted inpatients. This was reflected in hospital admission statistics showing that most hospital admissions for mental disorders were readmissions.

The evolution of the current mental-health-care provision started in 2000, and integration of mental health services with primary health care was at the core of the new approach to service delivery. In parallel, emphasis was placed on the need for services to move from the medical model to a biopsychosocial model of care. Political commitment to mental health changed markedly after the 2004 tsunami. A national plan of action was developed to deliver mental health services to tsunami-affected districts. The emphasis was on work at the primary health-care level, with use of psychosocial approaches to improve mental well-being. Activities were then extended to districts outside the tsunami zone.

The response to the tsunami created momentum for change in Sri Lanka’s mental health system. Various initiatives were consolidated in The mental health policy of Sri Lanka 2005–2015, which called for implementation of a comprehensive community-based, decentralized service structure. The main objectives of the policy were to provide mental health services of good quality at primary, secondary and tertiary levels; to ensure the active involvement of communities, families and service users; to make mental health services culturally appropriate and evidence based; and to protect the human rights and dignity of all people with mental health disorders.

Training the mental health-care workforce

In 2000, the Ministry of Health initiated a new programme to train medical officers in mental health. Training takes 12 weeks, with 6 weeks centrally at NIMH and the balance 6 weeks at the periphery, under the supervision of the regional consultant psychiatrist. These trained medical officers, designated as medical officers (mental health), are stationed at secondary-care institutions, namely the district general hospitals and base hospitals. This programme now has 205 trained medical officers (mental health) working in secondary-care institutions and some primary-care institutions such as divisional hospitals. The mental health services delivered by medical officers (mental health) include outpatient care, domiciliary care, mental health promotion in schools, and community mental health education. The medical officers (mental health) work in collaboration with the primary health-care teams functioning under the medical officer (mental health), community psychiatric nurses, who were allocated to psychiatry units across the island. Their primary role was to extend mental health care beyond the hospital to the community, with active follow-up of patients to encourage treatment compliance. The community psychiatric nurses also provide domiciliary mental health-care service. During a domiciliary visit, a community psychiatric nurse supervises treatment adherence; administers treatment, including depot injections as per instructions from medical staff; and provides mental health education to patients and their family members. These specialist nurses also provide mental health education in the community, in collaboration with primary health-care teams. Community psychiatric nurses also act as links to improve the referral system. This newly established connection between the psychiatry unit and the patient and their family has not only strengthened treatment adherence but also helped to improve mental health literacy in the community.

Shift from a medical model to a biopsychosocial model

Mental health care in Sri Lanka traditionally operated using the medical model. This was not a comprehensive approach and psychological and social issues affecting patients with mental disorders were often overlooked, especially when examining patients in overcrowded clinic and inpatient settings. When the medical officers (mental health) and the community psychiatric nurses started providing domiciliary care, improved assessment of the psychological and social needs of patients and their families became possible.

A cadre of psychiatric social workers was included in the extension of mental health care from a hospital setting to community settings. In 2005, with the support of WHO, 42 unemployed university graduates underwent 6 months of training in psychiatric social work and were deployed as development assistants across the country. Of the original 42 trained, 32 remain in service. In 2015, the Ministry of Health appointed a further 27 new recruits with formal Bachelor of Social Work qualifications. The psychiatric social worker is able to facilitate establishment of a link between a patient and their family and the relevant social agencies. Typically, care is provided via a multidisciplinary team, comprising the medical officer (mental health), community psychiatric nurse and psychiatric social worker. In some circumstances, an occupational therapist may also join the team. This multidisciplinary approach allows assessment of the medical, psychological and social needs of patients and their families in their own homes in the community.

Involving the community

In the past, mental health care was provided mainly by medical personnel in institutionalized settings; patients and their families were passive recipients of the care and there was no partnership with the community. The community had no ownership of the mental health care provided, and received whatever was given...
has still not happened island-wide. Availability of mental health services in tertiary- and secondary-care institutions. To provide an mental health services in Sri Lanka remain mostly available and delay in treatment. ill persons are violent. This also leads to unnecessary suffering mental illness and its treatment are also prevalent. Common in treating individuals with mental illness. Many myths about non-effective treatments. These practices add to the delay there is considerable delay in seeking effective treatment. This occurs at both patient and family level, as well as at medical health services. For example, compared with physical illness, challenges and issues related to mental illness and mental health care in Sri Lanka since 2000, notably in the aftermath Substantial progress has been made in improving mental being The unfinished agenda for mental well-being

Substantial progress has been made in improving mental health care in Sri Lanka since 2000, notably in the aftermath of the 2004 tsunami. Nevertheless, there remain major challenges and issues related to mental illness and mental health services. For example, compared with physical illness, there is a delay in recognizing mental illness. This delay occurs at both patient and family level, as well as at medical professional level. Even after recognition of a mental illness, there is considerable delay in seeking effective treatment. This is because many patients are first taken to agencies providing non-effective treatments. These practices add to the delay in treating individuals with mental illness. Many myths about mental illness and its treatment are also prevalent. Common myths include that mental illness is lifelong; that there are no treatments; that mental illness is contagious; and that mentally ill persons are violent. This also leads to unnecessary suffering and delay in treatment. Despite the concerted push to decentralize care provision, mental health services in Sri Lanka remain mostly available at tertiary- and secondary-care institutions. To provide an effective mental health service, further efforts are needed to shift the availability of services to the primary-care level. This has still not happened island-wide. Availability of mental health services in primary care is only just beginning, and, at present, is highly dependent on the personal interest of mental health professionals. The services available are mostly medical interventions. To provide a good-quality primary-care service, psychological therapies have to be available and mental health professionals who are competent to provide psychological therapies are needed. In addition, despite the creation of the new mental health cadres, demand outstrips supply and fuller integration with primary health care and expansion of qualified personnel are needed. For example, during a train-the-trainers programme, medical officers (mental health) graphically described their daily pressures. These challenges ranged from excessive patient numbers to shortage of essential medicines in clinics, and cultural stigma towards psychiatric staff and their patients. Stigma and associated discrimination are present at individual, family, community and professional level. They are encountered during an illness, as well as after recovery, and are directed at patients, their families and the community. The distress caused by the stigma and discrimination is sometimes more than the distress caused by the illness itself. Low mental health literacy persists in Sri Lanka, signalling an urgent need to educate the public on mental health and related issues The Ministry of Health is in the process of developing a new mental health policy for 2017–2026, which focuses on new developments in mental health services and addresses the unfinished agenda in mental well-being, in alignment with the Sustainable Development Goals and other global health agendas.

Source of support: Nil.

Conflict of interest: None declared.

Authorship: All authors contributed equally to this paper.


References

