

## PSYCHIATRY IN SRI LANKA: AN OVERVIEW

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Sri Lanka now has a population nearing 13.5 million, the majority of whom are Sinhalese (72 per cent). The other major ethnic groups are the Tamils (27 per cent) and the Muslims (7 per cent). The religion of most of the Sinhalese people is Buddhism and that of the Tamils is Hinduism (67 per cent and 17 per cent of the total population respectively). Christianity (8 per cent) is the religion of a minority of Sinhalese and Tamil people. Free and compulsory education has resulted in a high literacy rate (84 per cent of those below 30 years and 80 per cent of those below 60 years of age). Eighty-seven per cent of the people are classified as living in rural areas (Census of Population, 1975).

Since independence from British rule in 1948, there have been changes in the political, social and economic spheres in the country. The impact of Western influence has eroded the traditional system of roles. Restratification of the communities into a small westernized elite and the traditional village peasant population, and in general, a move towards industrialization and urbanization are some of the changes which may have a bearing on the mental health of the people.

### *Mental Health Services*

The health services are organized like the British system with funds coming from the central government via the Ministry of Health. The majority of the money is spent on Western medicine based on hospital and preventive services, and Mental Health receives about 8 per cent of the allocation. In addition there is the traditional Ayurveda system of medicine practised by Ayurvedic medical graduates, mainly in a private setting and in a few Ayurvedic hospitals. Many other 'unqualified practitioners' practise, specially in rural areas. In addition to these 'medical personnel' there are the folk healers and priests who see a large number of mentally ill patients, and they use various charms, magic invocation of divine intervention, exorcism and anti-witchcraft measures in their attempt to cure the sick. In a cohort of first admission 'psychotics' (W.H.O./IPPS 1973), 90 per cent had been to traditional healers before seeking Western treatment (Chandrasena, unpublished) and it is estimated that 60-80 per cent of people take other modes of treatment before seeking Western medicine (DHS/1966).

There are 3,587 mental hospital beds, the majority of which are in a large mental hospital founded in 1870 in Colombo and three other small mental hospitals in Jallna, Galle and Colombo, the remainder

of beds being in general hospital psychiatry units. There are about 1.2 consultants (or a total of 3 psychiatrists) per million population. The nursing staff with psychiatric training constitute 1.7 per million population and the majority of nursing staff are untrained. Psychiatric social workers number 0.17 per million population and there is only a single trainee clinical psychologist in the country.

### *Training and Practice of Psychiatry*

Medical students receive about 4 weeks' clinical training in the general hospital psychiatry units attached to the two medical schools. Most prospective psychiatrists, after about 3 years clerkship in general psychiatry, proceed abroad for further training. Most of them work as registrars and senior registrars in the UK before returning to take up posts as consultants, Membership of the Royal College of Psychiatrists being a prerequisite for obtaining such posts. The practice of psychiatry is medication-orientated and a rapid turnover of patients is necessary to cope with the demands. Admissions are usually restricted to those patients suffering from major psychoses and diagnosis and prescription is very similar to that in the UK. The majority of the wards in the country are locked, physical methods of restraint are not uncommon and ECT is administered in most centres without anaesthesia. The psychotherapy practised is of brief and supportive nature. The psychiatrist is essentially a jack-of-all-trades having to cope with any referral. Patients usually have opportunity to partake in cultivation of crops in the hospital premises and help in the ward chores but otherwise very little organized occupational therapy is carried out. Patients are discharged to the care of the relatives at the earliest opportunity and advised to attend out-patient clinics thereafter. However, follow-up in the community is hardly ever done.

The practice of psychiatry, on the other hand, in the units attached to the medical schools at Colombo and Peradeniya is of a much higher standard and they enjoy a much higher staff/patient ratio and facilities.

The majority of nursing staff in psychiatry units are 'floating members', and only one or two senior nursing staff have long years' experience in psychiatry. Psychiatric social workers are attached to only a few units.

### *Epidemiology and Clinical Pattern of Mental Diseases*

A recent epidemiological survey (Wijesinghe *et al* 1978) has shown that the prevalence of mental dis-

orders in Sri Lanka is similar to those estimated in world-wide prevalence rates (Ødegaard, 1970). Wijesinghe *et al* (1978) note that of 94.5 per cent of patients with psychiatric disorders, the majority were neurotic and were not receiving any Western psychiatric attention, and so were 58.6 per cent of schizophrenics. A study of a cohort of first admission psychotics suggests that only 1 in 4 patients gain admission (Chandrasena, unpublished) and that there is a long delay after the onset of illness (Chandrasena, 1979). Although lack of facilities contribute partly to these figures, there are other important cultural barriers which prevent patients from accepting Western treatment. Social stigma of mental illnesses, cultural beliefs that mental illnesses, are due to possession by spirits (Wijesinghe *et al* 1976), 'bad times' due to astrological signs and other beliefs in witchcraft are some of them. As observed by Neki (1973) hysteria seems to be more prevalent in Sri Lanka, but anorexia nervosa, repeated self-poisoning and self-mutilation seem relatively uncommon (Chandrasena, 1977; Chandrasena, 1979). Reactive psychoses also form a sizeable inpatient group (Mahendra, 1977; Chandrasena, unpublished). In spite of poor treatment facilities, and non-availability of depot neuroleptic preparations, the prognosis of schizophrenia in Sri Lanka appear to be better when compared to Western nations (Waxler, 1979). Psychogeriatric patients do not present a problem to the psychiatric services, partly due to the lower life expectancy (only 4 per cent of the population are over 65 years) and also due to well established extended family support systems in the rural communities. Illicit drug abuse is restricted mainly to those culturally accepted, viz cannabis and opium. If facilities are made available, these patients have been shown to be easily amenable to treatment (Chandrasena, 1979).

#### *Current Problems and Future Trends*

I have already drawn attention to the pressure of work on the staff in mental health services, and this is due to many causes. Medical manpower shortage has been an insurmountable problem as many psychiatrists join the brain-drain. This together with unequal distribution of resources has left many peripheral psychiatric units without consultants and even permanent house officers for long periods of time. The medical manpower shortage should hopefully end within the next decade as two new medical schools have been opened in 1978, and by 1984 the present output of 225 doctors should be increased by a further 125. As most Western nations have become self-sufficient in doctors, it is now increasingly difficult for Sri Lankan medical graduates to obtain suitable employment abroad. As the years go by the

health service vacancies in Sri Lanka will be filled and many young doctors will begin private practices especially in rural areas.

The shortage of para-medical mental health staff and other facilities is a reflection of the general shortage of resources in the health service. If the money is made available there should be no difficulty in recruiting this staff. Shortage of drugs is a common occurrence. It is unfortunate that no depot preparations are freely available in Sri Lanka hospitals. Facilities for estimating serum lithium are available only to those hospitals in Colombo.

Although infectious diseases and malnutrition justly receive a large proportion of the health service budget, up to now there has been a general lack of appreciation by the administrators of the need to develop mental health services. It is encouraging to note that in January this year a pressure group of psychiatrists has been organized to make representation at Ministerial level regarding mental health needs of the country. The World Health Organization continues to offer training fellowships to Sri Lanka psychiatrists and also sponsor overseas consultants, research projects and workshops in mental health.

Another major problem is the cultural and social barrier that exists between the psychiatrist and the community. Neki (1973) has observed that modern psychiatry has so far made little dent on cultural beliefs and attitudes of SE Asian communities. Doctors find it difficult to accommodate other cultural beliefs and traditional methods of treatment. Wijesinghe (1971) notes that the practice of an Ayurvedic physician is more appealing to the villager because he has reciprocal support of the community institutions like the priest, the soothsayer, the exorcist and the astrologer, all of whom work in unison. It is unnecessary and unwise to attempt to dispel cultural beliefs as mere ignorance as it is these very cultural beliefs that reduce the 'social labelling process', thus improving the prognosis of schizophrenia (Waxler, 1977; Waxler, 1979). Conflicts between family members resulting in suicidal behaviour are well handled by 'cultural rituals' (Chandrasena, 1977) and 'anniversary suicidal reactions' are uncommon in India and Sri Lanka, possibly due to various mourning rituals (Venkoba Rao, 1969; Chandrasena, 1979).

What then does the future hold for mental health services in Sri Lanka? The establishment of two university psychiatry units and the creation of two chairs in psychiatry has led to considerable improvements in the teaching of psychiatry to undergraduates and also that of psychiatric research. It is hoped that the creation of two further university units in 1979 will result in similar favourable changes.

Urbanization and industrialization and identification with Western culture will bring with them the associated mental health problems. A major contribution to supporting the mentally ill so far, specially neurotics, has been by the extended families and traditional healers. As attitudes towards these modes of support change, more demands are likely to be made on psychiatric services. Drug dependence and alcoholism are likely to follow the trends in developed nations. As people become aware of mental subnormality, more requests for help will be made. If these demands are to be met with some realism, there will have to be increased financial commitment. For the present, consultants should be encouraged to travel to small peripheral hospitals to conduct outpatient clinics.

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