

Challenges in Developing Community Mental Health Services in Sri Lanka

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There are several issues to be faced in developing mental health services in South Asia if they are to be culturally and socially appropriate to the needs of the communities in the region. The meanings of mental health relevant to culturally appropriate service development can be obtained by exploring local notions of well-being, systems of care available to people and current practices among those seeking help for mental health problems. Participatory research carried out in communities in Sri Lanka affected by prolonged armed conflict and by the 2004 tsunami clarified the nature of well-being as perceived by communities themselves. Subsequent development of mental health services for Sri Lanka can be based on community consultation, using methodologies and interventions that involve the participation of the communities and their local institutions, and adapting relevant western approaches to the Sri Lankan context.

Introduction

The World Health Report 2001 (WHO 2001) proposes a public health approach to mental health, reiterating the World Health Organisation's (WHO)

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definition of health as 'a state of complete physical, mental and social well-being' (2001: 3). This report supports the importance of understanding and integrating local knowledge and, in the case of African and Asian countries, 'working with traditional healers' (2001: 58). However, it should be noted that there are so-called traditional healers practicing what is referred to as 'folk-ethnopsychiatry' in many other parts of the world including the US, European countries and Latin America (Blue and Gaines 1992). The strategy for South Asian countries suggested by the WHO Regional Office for South-East Asia (2008) emphasises the need for community based mental health programmes that are 'culturally and gender appropriate and reach out to all segments of the population, including marginalised groups' (2008: 1). However, it is left unspecified how the goals of cultural appropriateness and social inclusiveness can be achieved. First, there are basic questions about the nature of 'mental health' in diverse cultural contexts in which services are required. Then there is the challenge of engaging communities and groups that are often socially and politically disempowered, a problem that is particularly severe for women. Finally, there are issues of power and discrimination that are almost inevitable when (as is commonly done) notions of mental health and well-being are applied through the imposition of western categories and concepts of diagnosis and treatment—a problem sometimes referred to as 'category fallacy' (Kleinman 1977: 4). Developing mental health services in South Asia or other non-western settings is not a simple matter of transferring established strategies and systems commonly used in high-income countries of the west. Mental health is not just a *technical* matter but is tied up with ways of life, values and worldviews that vary significantly across cultures. More directly, notions of 'madness' and 'abnormal psychology' on which mental health systems in the west are based are linked to *western* ways of thinking; and these conflict frequently with worldviews of non-western cultures (Fernando 2002; Parker et al. 1995).

Today psychiatry is under criticism as a basis for mental health service development in the United Kingdom (Ingleby 2004; Ramon and Williams 2005; Tew 2002); and serious problems are evident when psychiatry is applied in a multi-cultural and multi-ethnic society without adequate attention to culture and context (Bhui 2002; Bhui and Olajide 1999; Fernando 2003; Fernando and Keating 2009). It would be regrettable if western models (and the ideologies that go with them)—largely based on biomedical psychiatry—are applied in South Asia without thorough cultural assessment and modification. But this could easily happen if local

agencies fail to challenge the power structures in the world partly—if not mainly—wielded through the economic interests of the pharmaceutical industry. There are signs of the uncritical acceptance of the dominance of biological and pharmaceutical approaches to mental health in the document issued by the WHO Regional Office for Southeast Asia (2008: 2): In discussing ‘acceptability’ of services, the document downplays the importance of indigenous forms of illness explanation, therapy and indigenous healing systems and advocates the ‘education [of South-East Asian populations] ... about the nature of neuropsychiatric illnesses’—implying that western notions of mental health and illness should supplant indigenous ones; and the only therapies mentioned as ‘essential’ are ‘medications’ (that is, drugs from pharmaceutical companies).

Recent experience in carrying out participatory research into well-being among Sri Lankan communities exposed to armed conflict and the 2004 tsunami (Weerackody and Fernando 2008; Weerackody et al. 2008) has demonstrated to us the usefulness of accessing community perceptions of well-being in understanding people’s perceptions of mental health needs. In January 2008, training workshops were held at Angoda Teaching Hospital (near Colombo) with the participation of faculty from the Division of Social & Transcultural Psychiatry of the Department of Psychiatry at McGill University and the Douglas Mental Health University Institute, Montreal, Canada. The workshops covered aspects of cultural and social psychiatry, emphasising the central role of social structure and cultural belief systems in shaping mental illnesses and the response to trauma, and the potential for engaging family, community, indigenous healing and religious systems to support rehabilitation, social integration and recovery. Participants at the workshops included mental health professionals working in the statutory sector as well as community workers attached to non-governmental organisations (NGOs) and some members of local medical and social sciences faculties. Feedback from the participants indicated a positive effect of the training in enhancing their ability to understand the mental health needs of local communities. It is against this background that we examine the problems of developing mental health services in Sri Lanka in this article.

We believe that imposing models of service provision based predominantly on western notions inherent in biomedical psychiatry is not the best way forward for Sri Lanka. We see three key challenges: First, development of mental health services should be concerned primarily with needs and aspirations of local communities; therefore, community consultation should be the starting

point for service development in the mental health field. Yet knowledge derived from western sources has a role to play too because (a) indigenous systems of therapy and care have been severely under-developed for several hundred years; and (b) for many people, having accessed both government-funded western healthcare systems and Ayurvedic systems often concurrently (Amarasingham 1980; Waxler 1984), their ideas about health and illness are a hybrid mixture of explanatory models. The challenge is to integrate in a meaningful and culturally sensitive manner those aspects of western 'expertise' (contained largely within western psychology and psychiatry) that are suited to local conditions with local knowledge and expertise, including traditional ways of dealing with mental health problems. Second, capacity within the country, particularly at a local level, should be built up, if necessary with help from foreign agencies, but ensuring that the latter do not impose models of care and therapy that are culturally and socially inappropriate. Finally, as local services are developed, they should be integrated into larger networks of service delivery. In order to meet these challenges, we suggest that participatory community consultation supported by information derived from western systems of social and transcultural psychiatry is a model for North-South collaboration in mental health development—a 'global partnership for development' in the words of the 8th United Nations Millennium Goal (UN 2005).

Meaning of Mental Health

Understandings of mental health are largely determined by the meanings people give to their experiences and feelings in a context of broader worldviews about the nature of the human condition—much of which is culturally determined (Fernando 2002; Gaines 1992; Kleinman 1988a and 1988b; Marsella and White 1982). Although generalisations carry the risk of being reductionist, they provide an indication of the dimensions along with cultural differences occur. For example, Kakar (1984: 272) postulates that the 'Indian emphasis [with regard to mental health] has been on the pursuit of an inner differentiation while keeping the outer world constant ... [while] ... the notion of freedom in the West is related to an increase in the potential for acting in the outer world and enlarging the spheres of choices, while keeping the inner state constant to that of a rational, waking consciousness from which other modes of inner experiences have been excluded as deviations'. The tendency to see problems in terms of internal psychological processes

rather than faults in life situation, described by Triandis (1995) as a difference between so-called individualistic and collectivistic societies, may differentiate many Asian cultures from western ones. The broad variation in cultural concepts of the person is another dimension that needs to be considered in determining mental health categories and concepts (Kirmayer 2007).

In pursuing a definition of mental health that is workable across cultures, Sudhir Kakar (1984: 3), a psychoanalyst trained in Europe who has worked in India for decades, uses the term as 'a rubric, a label which covers different perspectives and concerns, such as the absence of incapacitating symptoms, integration of psychological functioning, effective conduct of personal and social life, feelings of ethical and spiritual well-being and so on'. WHO (2008: 1) states that 'mental health refers to a broad array of activities directly or indirectly related to the mental well-being component included in the WHO's definition of health'. The study of well-being as a way of accessing the meaning attributed to mental health is a fairly recent development justified on the grounds that well-being: (a) is based on standards and values chosen by people themselves; (b) reflects success or failure in achieving norms and values that people themselves seek; and (c) is dependent on fulfillment of basic human needs that include people's ethical and evaluative judgements of their lives (Diener and Suh 2000). Well-being at a personal level is a positive state of affairs brought about by satisfaction of personal, relational and collective needs (Prilleltensky et al. 2001). When we access community perceptions of well-being, these individual components are added to by 'the synergy created by all of them [i.e. individual components] together' (Nelson and Prilleltensky 2005: 56). Community perceptions of well-being have been elaborated through qualitative research involving community development (Chambers 1997). And the components of well-being (norms, values, ethical and evaluative judgements, etc.) are constituted within cultural meaning systems.

Mental Health/Well-being in Sri Lanka

Several studies have examined indigenous notions of (mental) health and healing in Sri Lanka (e.g., Kapferer 1983; Obeyesekere 1977; 1981; 1985; Vogt 1999) but there is little reliable information on how they relate to the use of services for the alleviation of mental distress or relief of what Sri Lankan people may perceive as emotional or mental problems. Clearly the psychological and social worldview of Sri Lankans, the ways in which they

understand problems of the 'mind' and the local idioms of distress are all very different from those represented in biomedical western psychiatry. It is beyond the remit of this article (concerned primarily with developing mental health services) to discuss these in detail. For example, Obeyesekere (1985: 145) argues that what is designated as the illness of depression in biomedical psychiatry 'is given a radically different form of cultural canalization and expression' in a Sri Lankan cultural context. In the view of the authors, the 'diagnoses' which underpin much of (western) biomedical psychiatry are not always appropriate terms for encompassing the feelings and behaviours identified as problematic in a Sri Lankan context. In this situation, it is necessary to examine how the people of the island deal with the broad range of concerns that may be interpreted as mental health problems.

Systems of Care

Mental healthcare based on western-type institutions was first introduced in Sri Lanka by the British colonial government in the 1840s. The mental asylum located near Colombo that opened in 1926 (Uragoda 1987) is still in operation and is currently being upgraded and remodelled as the Angoda Teaching Hospital. Today, statutory mental health services are based mainly at this hospital and two much smaller hospitals (all located near Colombo) as well as small psychiatric units at provincial general hospitals, which include out-patient clinics. The education of psychiatrists is largely based on western biomedical models. The services for mental health problems in the statutory sector are informed by western (allopathic) medicine, although government supported indigenous medical centres have been developed in some areas. The forms of therapy used within psychiatric care in Sri Lanka are strongly influenced by British systems and are no different from those found in western countries except that psychological therapies play an insignificant part in government hospitals which rely heavily on electroconvulsive treatment (ECT) and psychotropic medication.

Ayurveda, literally 'the science of life' (Sharma and Dash 1983: xxi) is the most popular system of indigenous medicine in India and Sri Lanka, serving, according to a recent survey (Higuchi 2002), about 50 per cent of the healthcare needs of Sri Lanka. Ayurveda became institutionalised during the 20th century when Ayurvedic institutes with standardised systems of training were established in the 1950s. Today, there are two principle Ayurvedic educational institutes—the Institute for Indigenous Medicine attached to

the University of Colombo and the Gampaha Wickramarachchi Ayurvedic Medical College at Yakkala attached to the University of Kelaniya (Higuchi 2002). Apart from practitioners trained at these institutes, who are recognised officially as indigenous medical practitioners (IMPs), there are numerous other medical practitioners using variations of traditional Ayurveda often practicing out of their homes (Nordstrom 1988). A recent review of the use of Ayurveda in Sri Lanka (Kusumaratne 2005) suggests that (what the author calls) the 'Indigenous Medical System' (IMS) is widely used by many people across the country. The IMS in Sri Lanka currently recognises nine branches including *mānasika roga vedakuma* which can be translated as 'psychiatry'. The extent to which people seek Ayurvedic treatment for mental health problems is not known. And in any case, people who (in western psychiatric terms) suffer from serious mental illness may well access ritual healing.

Indigenous Healing Practices

The use of healing rituals predates Ayurveda in the Indian tradition. People suffering from mental health problems (usually accompanied by their carers) tend to consult and obtain help from a variety of professionals apart from physicians practicing Ayurveda or western (allopathic) medicine; they include specialists in exorcism and other forms of healing (Amarasingham 1980; Kusumaratne 2005; Vogt 1999; Wijesekera 1989) as well as astrologers, who provide what Pugh (1983) calls 'astrological counselling'. Vogt (1999) identifies three forms of healing rituals commonly used in Sri Lanka: (a) *Pirit* is a monastic ritual, sometimes also conducted by lay persons, performed at significant events (such as burial or birth preparations) as well as illness; (b) In *puja* (offering ceremony) a group (of family, friends or well-wishers) offers a ritual act of generosity towards (for example) a monastic community or towards gods; and (c) The *tovil* is a public healing ritual held in the house of a patient that involves dancing and drumming. It may also incorporate a *puja* to the gods. Forms of medicine and healing rituals are used by most people without experiencing any conflict, one merging into the other in practical terms (Amarasingham 1980; Waxler-Morrison 1988). Spirituality is important in all forms of healing and often central to the explanatory system of the healer. Kusumaratne (2005) describes the practice of a healer—*kattadi mahattaya*—practicing exorcism (who incidentally also practices as a physician specialising in the treatment of snakebite) in the hamlet of Homagama. It

seems that this person dealt with 25 cases of witchcraft, 50 cases of demon possession and 60 family disputes during three months in 2005 using various types of *tovil* ceremonies.

Conclusions

Ayurveda and western allopathic medicine exist side by side in Sri Lanka, sometimes with a considerable degree of overlap (Waxler-Morrison 1988). However, in the case of mental health problems, many people probably seek various types of help, mainly those that come under the heading of 'healing rituals'. We believe that mental health services that are being developed in Sri Lanka should be appropriate to the cultural beliefs and practices of Sri Lankan societies; and should take on board the current behaviour of the people of the country in seeking help for mental health and well-being. Moreover, since most Sri Lankans live in rural environments in villages and it is the rural population that is most lacking in mental health services, priority should be given to service development for rural communities.

Community Well-being

The post-tsunami history of Sri Lanka provides clear evidence that planned interventions aimed at improving the well-being of affected communities have not always succeeded mainly because they were not sensitive to the social and cultural settings of those communities (Haug and Weerackody 2007). Consultations with communities on how to improve their overall well-being were rare or non-existent; interventions planned in such a vacuum often brought unintended consequences for the communities—sometimes resulting in unhappiness, frustration, grief, anger and conflicts between individuals and groups—which may well have had negative effects on the mental health of people in the affected communities. Since May 2007, one of the authors (CW) has been leading a study of adaptation and resilience among communities in Sri Lanka affected by conflict and/or disaster.

To date (October 2008), affected communities in three districts have been studied using tools adapted from Participatory Rural Appraisal (PRA) (Chambers 1997). The research focused on exploring community perceptions of well-being, that is, the criteria used by the communities themselves for defining well-being, and the perceived changes in well-being before and

after the conflict or the tsunami. The aim was to consult the communities concerned about ways in which they have dealt with changes in well-being and the usefulness (or negative impacts) of agencies that have delivered services to them. The participatory process ensured that women and other marginalised sections of each community were adequately represented in the consultations.

A preliminary analysis of studies in two locations shows that perceptions of well-being are composed of several elements that are experienced as inseparable as far as the communities are concerned. In other words, subjective feelings and external circumstances are all experienced as a 'whole'—'holistically'—and not as separate 'factors'. In a community in the south of the island that had been disrupted by the tsunami of December 2004, the elements identified represent social, psychological, spiritual and material aspects of people's lives; and in this community there had been an increase in religious practices after the tsunami—a change seen by the community as an improvement in their collective well-being (Weerackody et al. 2008). In the case of a refugee community that had been displaced in 1990 as a result of the conflict in northern Sri Lanka, the material aspects of well-being include having sufficient cash incomes and access to adequate land and good housing, while caring and providing good education for children, having unity and cooperation within community and access to recreation and services represented social dimensions of well-being; and feeling secure both physically and psychologically was another major aspect of well-being desired by the refugee communities. The physical, mental and moral aspects of well-being encompassed living in good health, an inner sense of happiness and harmony; living in harmony with the neighbourhood, maintaining good moral behaviour and living with courage, self-initiative (rather than dependency) and drive (Weerackody and Fernando 2008).

Developing Community based Mental Health Services

In our work in Sri Lanka, we have noted that the current institutional approach to diagnosis and treatment of mentally ill people based in government hospitals and clinics is largely biomedical, although changes are being made to promote recovery through integration of patients into the community. At present, care-giving and rehabilitation practices outside hospitals or in other institutional structures are sparse and community based projects are

limited to those conducted by NGOs. Statutory planning for mental health-care does not envisage any place at all for indigenous therapies—notably for Ayurvedic practitioners—or for healing rituals. To advance a broad, culturally appropriate approach to building mental health services in Sri Lanka, we propose three overlapping stages: (i) dialogue and consultation with communities; (ii) capacity building with local mental health workers; and (iii) integration of the system into social welfare and health structures.

Dialogue and Consultation with Communities

People working in the mental health field include psychiatrists, nurses, counselors and social workers as well as community workers and volunteers attached to NGOs that work on psychosocial issues. In order to improve their knowledge and understanding of communities and well-being/mental health-related issues, we propose a 'bottom-up' approach, in which people working in the field are helped to engage in dialogue and consultation with communities. In our view, PRA tools (see Chambers 1997) allow the consultation process that is required. Local temples, churches and mosques can provide the networks and venues for these community consultations. And the same institutions can provide the institutional framework and become the centre-piece for sustaining on-going dialogue and local services as they are developed.

Capacity Building of Local Mental Health Workers

Mental health workers participating in dialogue and consultation need a theoretical and conceptual orientation to understand community/social issues and to achieve their aspirations to develop community based interventions and services. We are currently engaged in a project to develop a 'process tool-kit'—a system for consultation and action that NGOs and statutory agencies alike may use for designing psychosocial interventions. In addition to this tool-kit, we hope to design culturally appropriate interventions suited to the needs of Sri Lankan communities and arrange training in social and cultural dimensions of mental health as funding allows. In addition, it is hoped to arrange locally facilitated on-line web-based training and consultation to reach a wider audience in a cost-effective manner if (as seems likely) access to computers and broad-band services are expanded in the near future.

Integration with Community Institutions

The initial stages of programme development should produce a team of skilled people who will work closely with each of the communities concerned, liaising as much as possible with agencies and universities (in both Sri Lanka and abroad) in a mutually beneficial learning partnership. In the final stage, their knowledge and experience should be transferred into devising a sustainable and effective system of community care linked to the health and social care systems in the district. Its exact nature will depend on the priorities and approaches identified by the community, combined with assessments of feasibility, and consideration of models suggested by agencies and universities. The final outcome in terms of a model for a community care system at a village level will evolve through the process of community development. It may well be that workers or community personnel will be designated as mental health workers; in this case, they would become the links between the community and the outside institutions vis-à-vis mental healthcare. Sustainability will be ensured by linking the system from the start with a community facility.

Conclusions

Mental health services in low and middle income non-western settings should be 'home-grown', suited to the cultural context and needs of the communities themselves, and not based on models imposed from outside. Also, they should be sustainable and supported by the communities they serve. There are serious drawbacks in imposing western biomedical approaches to mental health and illness in toto, but approaches developed in the west may play a part in service development, particularly if they are rethought from the perspectives of transcultural psychiatry. However, it is important that trainers and advisors whose background is steeped in western traditions of mental health (especially those represented in biomedical psychiatry) should reflect on their own subjectivity and position if authentic change is to be accomplished. We propose that by making community consultation the starting point and bringing in western experts as learning partners where necessary, a community development approach to mental health service development can be a way forward for Sri Lanka.

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