Historical background

The concept of mental illness is an ancient one found in Ayurvedic medicine that prevailed in Sri Lanka and India over 2000 years. Organic and supernatural causes were considered as aetiological factors of mental illnesses and the treatment methods were based on those causative factors (Neki, 1973).

After the British colonized Sri Lanka in 1796, they recognized the need for a modern western system of approach for mental illness and in 1839 Governor Mackenzie introduced an ordinance to establish lunatic asylums. The mentally ill patients were housed in a leprosy asylum in Hendala during this period. A building of a separate asylum in Borella close to the city of Colombo was started in 1846 (Wambeek, 1866) and patients from Hendala Leprosy asylum was transferred to Lunatic asylum Borella in 1847. As this hospital was overcrowded, soon many mentally ill people were imprisoned in jails throughout the island. The asylum provided protection and occupational therapy as the main mode of treatment.

The Borella asylum became increasingly overcrowded over the years and was an extremely unhealthy environment for the habitation of the mentally ill. Even though the need existed for a long period, addition of new accommodation or building a new asylum were delayed due to many barriers under the British colonial administration. After much debate steps were taken to build a new asylum in Cinnamon Gardens Colombo. The new asylum which was opened in 1884 became overcrowded within a period of one year (Carpenter, 1988).

At the beginning of the twentieth century the overcrowding was so much that the asylum was occupied by double the number of persons it could accommodate. Together with overcrowding, standards of all other facilities enjoyed by the inmates had gone down drastically and need for a new and bigger asylum arose. As a result, a foundation stone was laid at Angoda to build a new asylum with facilities to accommodate 1800 patients. Although it was meant reduce the problems faced by the patients at Cinnamon Gardens asylum, the colonial government spent an inordinately long period of time building this new asylum.

Mental Hospital Angoda was opened in 1926, eight years after laying the foundation, providing facilities for 1728 patients. The environment and the treatment regime at Angoda were no different from the previous asylum as the new asylum was also overcrowded and new treatment modalities were not available. Prof Edward Mapother, who had a good understanding of mental hospitals in England and India came from England to conduct a comprehensive survey of the Angoda asylum and to make recommendations to the Colonial government. It is worth noting here how he described the Angoda asylum.

“The floor, roof and walls of each cell consist alike of drab cement without any attempt at colouring or decoration. High up in one wall is a small window with stout iron bars. In the floor is a large hole into which the patient may pass his motion and urine. These cells are incompletely divided from one another by a partition which does not reach the roof so that the noise and stink from any one cell may reach at least all the others of the same row. Into these empty cells I was informed that the most noisy and troublesome patients in the hospital; were turned at night completely naked. The doors of the cell contain no observation window, and considering the violent character of many of these patients there is every ground for believing that the doors are rarely opened in the night by the solitary attendant on duty. It needs little imagination to picture the suffering of any patient in an early stage of bodily
illness passing a night under such conditions, a situation which must frequently arise. I am told that the noise proceeding from this building is like that on a bad night in a menagerie” (Mapother, 1928).

Following his observation Mapother made extensive recommendations including starting a specialist medical service, decentralization of psychiatric services, amending of the Ceylon Lunacy ordinance etc. The Mapother report was a landmark study of the mental health treatment system of Ceylon resulting in several drastic changes in the system. The first outpatient clinic was started in Colombo General Hospital in 1939. The first Ceylonese Psychiatrist started treating patients in 1940 and the Pelawatta mental hospital was started in 1944 with 60 patients. Ceylon lunacy ordinance written originally in 1873 was revised in 1940 and in 1956.

Decentralization of mental health services

Following his recommendation, the first child guidance clinic was established in General hospital Colombo in 1947. The first 24 bedded acute psychiatric unit outside the asylum at Angoda was opened at General hospital Colombo in 1949.

Modern day Psychiatry in Sri Lanka

Introducing mental health care into primary health care settings is the practical and accepted mode of bridging the ‘treatment gap’ in low and middle income countries with resultant better health outcomes (World Health Organization, 2008).

Mental Health policy of Sri Lanka

A mental health policy drafted by the Sri Lanka College of Psychiatrist has been approved by the Government of Sri Lanka for the first time in 2005 (Mental Health Policy, 2005). The basic objective of the policy is to decentralize the psychiatric services that have been centralized in large mental hospitals in Colombo and establishment of a community mental health service. According to the policy of Sri Lanka the district has been considered as the basic service unit. A minimum of one Acute Psychiatric Inpatient Unit (APIU) should be based in District General Hospital which is the biggest health impatient establishment in a district. Apart from the acute inpatient unit there should be a rehabilitation unit based in each district. Each district is divided into several Medical officers of Health (MOH) areas depending on the population. There is a small district hospital situated in each of these MOH areas. The Policy is to establish Primary Community Mental Health Centers (PCMHC) in every district hospital in each MOH area.

A community mental health team comprising of a Medical Officer of Mental Health (MOMH), Community Mental Health Nurses and a Community Support Officer will be attached to each PCMHC. A medical officer who successfully completes the Diploma training programme will be usefully appointed as the Medical Officer of Mental Health in the community team.

National Institute of mental Health (NIMH)

Establishment of a NIMH is a proposal of national importance included in the Mental Health Policy of Sri Lanka. This NIMH would be the nerve center, providing clinical care for the patients from the Western province of Sri Lanka and offering specialized services such as perinatal mental health services, learning disability, old age and forensic services. Training and research in the national interest with planning of mental health services were the main objectives of establishing a NIMH. With the decentralization of services, downsizing of the Angoda Mental hospital would be inevitable. Therefore it was proposed that the Mental Hospital Angoda be upgraded to NIMH and further structural and administrative changes be made in order to serve the proposed objectives.

Post graduate training

The Post graduate Institute of Medicine (PGIM) of University of Colombo started in 1980 and conducts a 5 year course leading to MD (Psychiatry). Those who successfully complete this programme are certified as specialists in psychiatry. Currently there are certified specialists in Psychiatry in almost all the Districts of Sri Lanka, based at the District General Hospitals.

A large proportion of the senior registrars sent for overseas training however never returned to Sri Lanka (Mubbashar and Humayun, 1999). Thus
the psychiatrist per population ratio remained low with a presence of 1:500,000 to 1000,000 on most occasions. In this backdrop it was decided to train a middle grade doctor with limited competency who would be less attractive for recruitment in high income countries. These doctors were offered a Diploma in Psychiatry by the PGIM, and are usefully serving in the Districts and hospitals where there are no specialist psychiatrists.

**Undergraduate education in Psychiatry**

Introduction of psychiatry as a final year specialty in most medical schools in the island is an important step in the training and competency of all primary care doctors in psychiatry. Previously as in most of India, psychiatry was taught in the third and fourth years with all other medical subspecialties with little emphasis on its importance. The teaching and assessment was minimal, and most medical graduates could qualify with little or no knowledge of psychiatry. The current programmes in all the leading medical schools in Sri Lanka have up to eight weeks or more of full time exposure to different aspects of psychiatry and mental health, and the undergraduates are assessed extensively on par with the other final year specialties – Medicine, Surgery, Obstetrics and Gynaecology and Paediatrics.

**Training of allied specialists**

As envisaged in the national mental health policy, the training of other mental health professionals has to now take priority in Sri Lanka. Foremost among them is the need to train psychiatric nurses and psychiatric social workers with particular focus on the community. These professionals can play a critical role in timely, effective and appropriate services to those with mental disorders (World Health Organization, 2007).

Unlike in the West, the ratio of psychiatric beds for the population has always been low. There have not been widespread mental hospitals and most patients have been cared for in the community by their families (Farooq and Minhas, 2001). Therefore a paradigm shift from institutional to community care is not necessary. The services in the community have to concentrate on strengthening the families to care for those with mental disorders (Linsley et al., 2001).

India perhaps has taken the lead in training a significant cadre of allied mental health specialists. Such a move however is just being initiated in Sri Lanka. This no doubt will be a significant step in supporting the carers and bridging the ‘treatment gap’.

**References**


