Elective Report 2013

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What are the prevalent mental health conditions in Sri Lanka? How do they differ from the UK?

Common conditions in the UK such as depression, schizophrenia and bipolar disorder are also the most common conditions seen in adult psychiatry in Sri Lanka. On the adult psychiatric ward I have met patients with depression, suicidal ideation or attempted suicide, bipolar disorder, schizoaffective disorder and psychosis. The patients on the ward present in very similar ways to such patients in the UK, suffering from similar types of delusions. Triggers such as adverse life events or emotional stressors also matched those experienced by patients in the UK. When taking chronological histories from patients suffering with chronic disorders, the evolution of their illness, particularly in the case of psychosis, mirrored many cases seen in the UK. I was surprised at this finding; I had expected that more material issues such as poverty and unemployment would represent the triggers for depression and suicide; however this was not the case. Problems with family relationships, in-laws, feelings of inadequacy and loneliness seemed to fuel most cases of depression seen on the ward.

Despite overall similarities in disease prevalence, there were two classes of disorders which are common in the UK yet are not seen in Sri Lanka; Personality disorders and eating disorders. It makes sense that eating disorders would not exist in a country with so many people living in great poverty and struggling to find food for their families. A larger figure is still considered more attractive in Sri Lanka than a slim figure, as it can be associated with wealth. This finding clearly reflects the strong cultural and environmental causes of eating disorders in our Westernised society. The fewer diagnoses of personality disorders were more difficult to understand. My consultant explained that although many patients in Sri Lanka may be considered to suffer with personality disorders, few are diagnosed, as the healthcare system is unable to provide the intensive therapy to treat these patients.

I attended some child psychiatric clinics during my placement and discovered that the common psychiatric problems of children in Sri Lanka closely mirrored those of children in the UK. The majority of patients seen in the clinic were suffering from either ADHD or autistic spectrum disorder.

How are mental health services organised and delivered? How does this differ from the UK?

Overall, mental health services in Sri Lanka are organised in a similar way to those in the UK. The principles are the same, however, as resources are far more stretched, the reality of the services provided is very different. Management plans for patients are very similar to that in the UK, however, the lack of follow up and community care provided means that treatment plans are rarely completed. However, all services are entirely free, including prescriptions, therefore if patients are compliant they can receive very good care.

I was based on an acute psychiatric ward, and despite very unwell patients being admitted to the ward, the turnover of patients was high. Many patients stayed less than one week on the ward. Patients presenting in similar ways in the UK would have been in hospital for months. Patients on the ward were heavily medicated; I believe this was used as a way to ensure patients remained on the ward until discharge. Unlike the UK, the Mental Health Act in Sri Lanka does not allow patients to be sectioned, unless they are in hospital in the capital city of Columbo, where there is a specialist hospital. This can make patient care extremely difficult on the wards in the hospital in Galle. Patients suffering with psychosis do not wish to stay in hospital, and family members are expected to encourage their ill relatives to stay on the ward. Failing this, patients are sedated; making any talking therapy or interviews with patients very difficult. Many patients remain on the ward for a week or so, they receive a few sessions of ECT and are given antipsychotic medications, and then discharged home to the care of their families. This treatment does resemble the treatment in the UK, but there are obvious differences, all of which are related to resources.

The major difference in mental health services in Sri Lanka is the lack of community care provision. In the UK the majority of mental health services are based in the community and well trained community psychiatric nurses have much more contact with psychiatric patients than their psychiatrists. In Galle, a fairly large city, there is only one community psychiatric nurse. Therefore patient follow up after discharge was almost non-existent, unless the patient attended their outpatient appointments. Non pharmacological therapy was of limited availability in Sri Lanka, there was a provision for therapies such as CBT, however, waiting lists were long and sessions were infrequent.

How do cultural attitudes towards mental health affect service provision and patients' access to care?

In general, this picture is identical to that of the UK. There is a huge stigma associated with mental health problems and many patients avoid contact with mental health services and wish to avoid receiving a diagnosis. As in the UK, there have been many media campaigns implemented to try to raise awareness of mental health issues and diminish the associated stigma. The doctors in the hospital felt that progress had been made, but there was still a long way to go. In spite of this, there are still many patients in Sri Lanka whom are in contact with mental health services and whom are receiving treatment and have been for years. The wards are overcrowded and the clinics over run, thus mental health services still make up a large part of health service provision in Sri Lanka. The medical school I was attached to have also changed their curriculum to include psychiatry in all three clinical years, and students are examined in psychiatry in both written and practical examinations at the end of every academic year. This demonstrates huge efforts to incorporate psychiatry into the rest of medicine and change the attitude towards the discipline that this subject is somehow separate to the rest of medicine.

To gain clinical experience in working in a psychiatric setting in a different culture.

Although I have mostly been observing during my placement, I feel that I have certainly fulfilled this objective. I have gained great insight into what it would be like to work as a doctor in Sri Lanka and the cultural differences that exist.

The doctors in Sri Lanka work very hard and see many more patients per day than doctors in the UK; however, they all seem very relaxed in their practice and less stressed at work. There is less documentation required and protocols do not have to be followed so religiously. Although less obvious in psychiatry, the main cultural difference appeared to be the doctor-patient relationship. Patients in Sri Lanka have a lot of respect for doctors and are happy to receive care in a more paternalistic way to that in the UK. Patients are very grateful for the doctor's time and are generally happy to do whatever is asked of them.