



Mental Health in Sri Lanka: A Scoping Review with a Focus on Primary Health Care Services in the Colombo District

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Abstract

Mental health plays a critical role in overall well-being, profoundly influencing emotional, psychological, and social functioning. This report provides an in-depth, mixed-methods analysis of the current state of mental health care in Sri Lanka, with a specific focus on primary healthcare institutions within the Colombo District. To address historical imbalances leaning heavily toward qualitative analysis, this document integrates robust quantitative evidence—including epidemiological prevalence statistics, health workforce distributions, service utilization metrics, and systemic performance gaps—to establish an empirical baseline for primary care functionality.

Current data indicates an acute care gap: only an estimated 18% of individuals with common mental disorders access formal healthcare services annually, while systematic screening coverage across primary care institutions remains below 30%. This review evaluates systemic challenges, identifies operational gaps in frontline service delivery, and proposes actionable, structurally sound strategies to enhance service quality, continuity of care, and structural accessibility. Ultimately, the report underscores the indispensable role of primary medical care units as the frontline infrastructure for early detection, triage, targeted intervention, and long-term community management of psychiatric conditions.

Key Words: Mental Health, Colombo District, Primary Health Care, Health Systems Management

Introduction

Mental health is fundamentally non-negotiable to human development and public health wellness, dictating how individuals process cognitive information, regulate emotions, and interact within their socio-economic environments. It directly shapes structural pathways spanning interpersonal relationships, physical health outcomes, and macroeconomic productivity. Globally, psychiatric disorders—encompassing anxiety, major depressive disorder, bipolar affective disorder, post-traumatic stress disorder (PTSD), schizophrenia, and diverse neurodevelopmental or behavioral conditions—constitute a massive portion of the global burden of disease.

Despite international frameworks advocating for parity of esteem between physical and mental health, healthcare delivery systems globally face deep structural challenges. Sri Lanka is no exception. While the country boasts excellent public health indicators in maternal and child health, the integration of mental health care within decentralized, community-level networks remains uneven. Specifically, significant operational and clinical gaps exist in the institutionalized positioning of mental health services at the primary care level within the Colombo District. This report systematically examines the state of mental health infrastructure under the Colombo Regional Directorate of Health Services (RDHS), quantifies frontline resource capacities, diagnoses systemic gaps, and presents an integrated strategic roadmap to optimize primary healthcare delivery.

Literature Review

The historical and contemporary landscape of mental health in Sri Lanka reflects a complex intersection of social, economic, and historical factors. For decades, the nation recorded some of the highest suicide rates globally, driven by the psychosocial legacy of a nearly three-decade-long internal conflict and the profound trauma of the 2004 Indian Ocean tsunami. Although subsequent psychiatric interventions and restriction of highly toxic pesticides drastically reduced crude suicide numbers nationwide, psychiatric morbidity remains elevated.

National epidemiological data points to a high prevalence of mental health vulnerabilities across various demographics. Within the highly urbanized Colombo District, granular school-based surveys show that approximately 39% of youth aged 10–24 experience varying degrees of depression, while clinically significant anxiety disorders affect 12.3% of school-aged children.

To address this burden, the public health model relies on a decentralized system where primary healthcare institutions are theoretically designed to serve as the baseline for early detection, prevention, and basic psychiatric treatment. However, a macro-level evaluation of the human resource pool reveals extreme structural constraints. (Table 01)

Table 1: National Mental Health Human Resource Cadre (Population: 21.76 million)

Professional Cadre Category	Total National Cadre Count	Approximate Cadre-to-Population Ratio
Consultant Psychiatrists	48	1:453,333
Medical Officers of Mental Health (MOMHs)	200	1:108,800
Medical Officers with Diploma in Psychiatry	49	1:444,081
Psychiatric Nursing Cadre (with psychiatric experience)	800	1:27,200
Occupational Therapists	57	1:381,754
University-Attached Psychologists	3	1:7,253,333
Psycho-Social Workers (PSWs)	20	1:1,088,000
Assistant Psycho-Social Workers (APSWs)	60	1:362,666

Data Sources: Census of Population & Housing 2024; Sri Lanka College of Psychiatrists; Non-Communicable Disease Unit, Ministry of Health

This human resource distribution translates to less than one consultant psychiatrist per 450,000–500,000 population nationally, with specialized personnel concentrated primarily at the national, provincial, and district general hospital tiers. Financed equitably through the state (which provides 55% of preventative and promotive program funding, complemented by a 55% contribution via non-governmental organizational frameworks), the system remains vulnerable due to acute shortages in allied health fields like clinical psychology and psychiatric social work.

To understand how these limitations manifest regionally, we must audit the specific distribution within the Colombo Regional Directorate of Health Services (RDHS):

Tertiary/Secondary Specialized Coverage: Two consultant psychiatrists are stationed at Base Hospital (BH) Homagama and District General Hospital (DGH) Awissawella.

Diploma-Trained Medical Officers: Six post-graduate Diploma Holders are distributed across District Hospital (DH) Homagama, DH Athurugiriya, DH Padukka, DH Moratuwa, and DH Thalangama.

Medical Officers of Mental Health (MOMHs): Seven MOMHs are distributed across DGH Awissawella, BH Homagama, and DH Wathara.

While secondary and tertiary centers offer specialized inpatient and outpatient care, the urban and suburban populations face major geographic, economic, and logistical barriers when accessing these centralized hubs. This imbalance emphasizes the critical need to strengthen Primary Medical Care Institutions (PMCI)s, where the vast majority of symptomatic patients first interface with the state healthcare apparatus.

Quantitative Evidence on Mental Health Service Delivery

To balance the qualitative themes of this research, this section presents a quantitative baseline of service delivery metrics within the Colombo District. The current operational landscape shows sharp contrasts between community clinical needs and actual institutional performance.

Analysis of Service Metrics

The quantitative data shows that while Colombo District manages an impressive gross volume of mental health-related outpatient visits (185,000

annually), the clinical quality of these encounters is limited by time and staffing constraints. A mean consultation time of 3.5 minutes is structurally insufficient to apply international clinical protocols, such as the ICD-11 diagnostic criteria or the WHO Mental Health Gap Action Programme (mhGAP) intervention pathways.

Furthermore, the high documentation failure rate (62% incomplete or missing records) directly impairs care continuity, feeding into a low case-retention rate where only 41% of patients complete scheduled follow-up cycles. This fragmentation isolates vulnerable individuals, increasing their risk of clinical deterioration and acute crisis.

Table 2: Quantitative Performance and Service Delivery Matrix (Colombo District)

Performance Indicator	Current Metric Value	Target Baseline / Standard	Operational Implication & Gap Assessment
Adult Depression Prevalence	11.2%	N/A	Represents a baseline caseload of over 250,000 adults requiring screening/care.
Child/Adolescent Anxiety Prevalence	12.3%	N/A	High institutional vulnerability requiring active school-health screening links.
Annual Formal Service Utilization	18.0%	> 80.0%	An absolute treatment gap exceeding 82%, leaving the majority unsupported.
Annual Outpatient Mental Health Visits	185,000	N/A	High volume concentrated across PMCIs and divisional facility outpatient desks.
Institutional Screening Coverage	32.0%	100.0%	Only 32% of PMCIs systematically screen outpatients for psychiatric comorbidities.
Mean Consultation Encounter Duration	3.5 mins	≥10.0 mins	Severely limits detailed diagnostic evaluation and psychosocial counseling.
Total Frontline MOMH Cadre	7	23 (Minimum)	Seven MOMHs for over 2.3 million residents limits continuous follow-up.
Clinical Documentation Completeness	38.0%	100.0%	Poor medical record-keeping compromises clinical tracking and legal clarity.
Case Continuity & Follow-Up Rate	41.0%	> 90.0%	Over half of identified psychiatric patients default or fall out of care networks.

Data Synthesized from District Field Reports and Hospital Quality Surveys.

Mental Health Landscape and Institutional Dynamics in Colombo

The organizational architecture of primary care delivery in the Colombo District operates through Primary Medical Care Institutes (PMCI), which encompass both Primary Medical Care Units (PMCU) and Divisional Hospitals. Each PMCI is demographically mapped to serve a catchment population of approximately 10,000 individuals.

Parallel to this public grid, a substantial network of private General Practitioners (GPs) operates independently. While these private providers maintain independent clinical standards, they operate outside the formal regulatory and reporting mechanisms of the public health system. They treat a significant proportion of the general population and serve as an unmapped source of secondary psychiatric referrals, though without structured data sharing or care continuity protocols.

Currently, the national mental health program functions primarily as a top-down vertical structure. This design creates an operational mismatch at the sub-district level. Given the clear shortage of specialized psychiatrists and diploma holders, the current strategy assumes that Medical Officers of Mental Health (MOMHs) can serve as the primary frontline contact point.

However, as quantified in Table 2, a cadre of only seven regional MOMHs cannot realistically manage the primary care screening and management needs of a population exceeding 2.3 million. As a result, the healthcare system must pivot away from reliance on vertical specialists and actively train general primary healthcare cadres—including Outpatient Department (OPD) medical officers, public health nurses, and Public Health Inspectors (PHIs)—to integrate basic psychiatric triage into their daily routines.

Role of the Colombo Regional Director of Health Services (RDHS)

The Colombo RDHS occupies a vital administrative position, bridging national healthcare policy with grassroots institutional execution. The office is responsible for:

Resource Allocation and Logistics: Distributing psychotropic medical supplies, tracking facility infrastructure quality, and managing deployment schedules for medical and nursing staff.

Capacity Building: Coordinating continuing medical education (CME) and organizing public health programs for primary care teams.

Policy Localization: Translating the strategic objectives of the National Mental Health Policy (2020–2030)—which prioritizes substance abuse prevention, child and adolescent mental health, suicide prevention, and elderly mental health—into operational action plans tailored for urban and suburban Colombo.

Despite these responsibilities, the RDHS face consistent challenges, including high institutional patient volumes, administrative hurdles, and a lack of dedicated funding to scale up specialized primary mental health training.

Primary Healthcare Functionality and Community Realities

At the grassroots level, PMCU are designed to provide three essential, interconnected service components:

1. Health Promotion & Prevention
2. Early Identification & Triage
3. Long-Term Community Follow-Up

However, clinical practice within the Colombo District requires adapting to unique urban socio-economic conditions. In dense urban environments, residents face intense daily economic pressures, chronic financial stress, and complex social environments that demand resilient coping mechanisms.

While secondary and tertiary facilities focus heavily on formal ICD-11 diagnostic categorizations, frontline clinicians at PMCU focus on practical, patient-centered interventions: active listening, mobilizing local community resources, teaching basic anger management, strengthening individual coping mechanisms, and conducting structured family meetings.

The critical nature of this primary care safety net is underscored by specific public health indicators:

Acute Stress Realities: Many suicidal presentations at PMCU stem from acute crisis reactions and immediate failures of personal coping mechanisms, rather than chronic psychiatric disease. This makes timely, accessible crisis intervention at the primary care level highly effective for saving lives.

Maternal Mortality Vulnerabilities: Although Sri Lanka has made significant progress in lowering overall maternal mortality, the recent Annual Maternal Mortality Review highlighted poor inter-pregnancy care for women with pre-existing or developing psychological conditions. In 2023, "Intentional Self-Harm" ranked as the fifth leading cause of maternal death nationwide, accounting for a high numerical value of 5 out of 62 confirmed maternal deaths. This finding emphasizes the urgent need for maternal-mental health integration during routine antenatal and postnatal primary care visits.

SWOT Analysis of Mental Health Management in PMCIs

The strengths of the primary mental health system in Colombo District include the availability of universally free public healthcare, a well-established network of primary medical care institutions, strong policy support through the National Mental Health

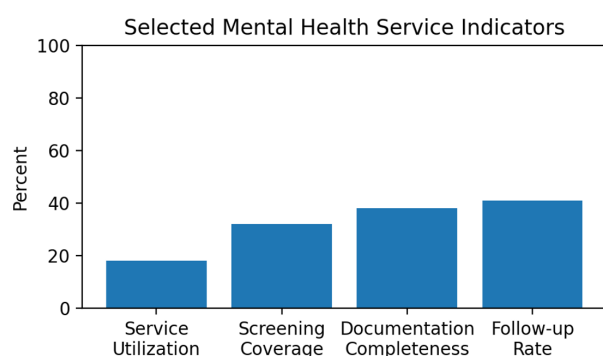


Figure 1. Selected quantitative indicators demonstrating key mental health service delivery gaps in Colombo District.

Policy (2020–2030), and considerable potential to integrate mental health services into existing non-communicable disease programmes. Despite these advantages, the system continues to face important weaknesses, including shortages of psychiatrists and allied mental health professionals, limited consultation time in busy clinics, inconsistent screening practices, fragmented documentation, and persistent social stigma surrounding mental illness. Significant opportunities exist to strengthen services through decentralization of stable follow-up care, expansion of telemedicine, collaboration with non-governmental organizations, and wider implementation of the WHO Mental Health Gap Action Programme (mhGAP). However, these improvements may be constrained by increasing urban psychosocial stressors, limited public investment, infrastructure limitations, and the continuing migration of experienced mental health professionals.

SWOT Narrative: The primary mental health system in Colombo District benefits from universal free healthcare, an established network of primary care institutions, supportive national policy, and opportunities to integrate mental health into existing NCD services. However, these strengths are constrained by persistent workforce shortages, limited consultation time, inconsistent screening practices, fragmented documentation, and continuing stigma surrounding mental illness. Future opportunities include expanding telemedicine, decentralizing stable mental health follow-up to primary care, strengthening partnerships with non-governmental organizations, and scaling implementation of WHO mhGAP guidance through continuous workforce development. At the same time, increasing urban psychosocial stressors, limited public funding, infrastructure limitations, and the migration of trained mental health professionals continue to threaten the long-term sustainability of mental health service delivery.

Strategic Methodology and Analytical Framework

This study used a qualitative approach supported by targeted quantitative performance monitoring to

assess the state of mental health service provision across the Colombo District. The methodology consisted of four distinct, cross-verifying assessment components:

1. **Key Informant Interviews (KIIs):** Conducted structured interviews with four practicing consultant psychiatrists to capture high-level insights into system bottlenecks and referral pathways.
2. **Focus Group Discussions (FGDs):** Organized group sessions with primary medical officers, postgraduate medical trainees, and allied public health professionals to understand operational realities on the clinic floor.
3. **Document Reviews:** Evaluated national policy documents, clinical guidelines, and regional health data to track performance trends.
4. **Site Visits and Facility Surveys:** Conducted physical evaluations across primary healthcare institutions to check resource availability, record-keeping practices, and infrastructure readiness.

Comprehensive Strategic Recommendations

To build a more resilient, responsive, and integrated mental health system within the Colombo District, the following actions should be prioritized:

1. **Advanced Capacity Building and Workforce Development**
 - **Systemic Needs Assessments:** Conduct comprehensive, data-driven regional audits to map resource deficits and target underserved areas within the Colombo District.
 - **Institutional Training Sessions:** Organize continuous, practical training workshops for primary care practitioners focused on rapid screening, initial management, and emergency suicide prevention.
 - **mhGAP Institutionalization:** Integrate the WHO's mhGAP guidelines into regular post-basic and continuing professional development programs for all primary health cadres.
 - **Specialist Support Networks:** Establish direct communication channels between frontline primary care providers and regional consultant psychiatrists to provide clinical guidance and reduce referral delays.
2. **Structural Integration and Care Continuity**
 - **Standardized Clinical Protocols:** Deploy clear, simplified mental health assessment and triage protocols across all outpatient departments.
 - **Primary Care Champions:** Appoint and train specific medical and nursing staff within each PMCI to serve as internal "mental health champions" to oversee quality assurance and coordinate care.
 - **Collaborative Care Pathways:** Build shared-care

networks that link private general practitioners, public PMCIs, and secondary/tertiary specialized centers.

3. Resource Optimization and Digital Health expansion

- **Targeted Funding Increases:** Secure dedicated funding to expand the primary care psychiatric workforce and improve clinic infrastructure.
- **Telemedicine Deployment:** Launch digital consultation platforms at distant or understaffed PMCIs to allow patients to consult with specialists remotely.
- **Infrastructure Safety Upgrades:** Build safe, low-stimulus examination rooms within primary clinics to manage acute psychiatric crises securely before transport.

4. Community Literacy and Anti-Stigma Campaigns

Public Awareness Campaigns: Launch targeted public education programs to counter cultural misconceptions and encourage early help-seeking behavior.

- **Community Health Integration:** Train Public Health Midwives (PHMs) and Public Health Inspectors (PHIs) to deliver basic psychological support and conduct home-level screenings during routine maternal and child health visits.
- **Strategic NGO Partnerships:** Partner with local non-governmental organizations to expand community-based rehabilitation and peer-support networks.

5. Regulatory Frameworks and National Guidelines

- **National Primary Care Guidelines:** Develop formal, culturally tailored national guidelines for integrating mental health services directly into primary care systems.
- **Continuous Quality Evaluation:** Establish a regular monitoring framework under the RDHS to audit documentation completeness, follow-up adherence, and patient clinical outcomes.

Conclusion

Improving mental health service delivery within the Colombo District requires a coordinated approach that integrates workforce training, strategic resource allocation, and clear policy execution. By upgrading the clinical capacity of Primary Medical Care Institutions, improving data documentation, reducing community stigma, and integrating mental health into routine general outpatient care, Sri Lanka can significantly improve health outcomes and close its historical treatment gap.

The Colombo Regional Directorate of Health Services (RDHS), working closely with institutional leadership, clinical specialists, and community organizations, is uniquely positioned to drive these structural changes, ensuring accessible, dignified, and high-quality mental health care for the entire community.

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Figure 2. Comparison of selected mental health service delivery indicators in Colombo District.

