DEVELOPING STATE SECTOR COUNSELLING SERVICES IN SRI LANKA

A COMPARATIVE REPORT OF THE REVIEW STUDIES CONDUCTED IN 2013 AND 2017 WITH THE COUNSELLORS OF THE MINISTRIES OF SOCIAL SERVICES AND OF WOMEN AND CHILD AFFAIRS

The Asia Foundation

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Co-authored by
Ermiza Tegal
and
Ananda Galappatti

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Message from the Country Representative of The Asia Foundation

The year 2005 marked a significant milestone for The Asia Foundation with the integration of a psychosocial approach to its development work, particularly in relation to the Reducing the Effects and Incidences of Trauma (RESIST) project and the Victims of Trauma Treatment Program (VTTP). The Asia Foundation has found that psychosocial approaches to healing and improving well-being are effective in strengthening existing coping mechanisms that enable individuals, families, and communities to rebuild their lives. The Foundation's work in mental health and psychosocial support programing is a collaboration between the non-governmental and State mental health and psychosocial support sectors. Through our work, valuable partnerships with the Ministry of Social Welfare and Primary Industries (MSWPI), the Ministry of Women and Child Affairs (MWCA), the Family Rehabilitation Centre (FRC) and Shanthiham have been fostered and developed over the years.

This publication (a comparative report of the review studies conducted in 2013 and 2017 with Counsellors of the Ministries of Social Services, Women and Child Affairs) reflects on the Continuing Professional Development (CPD) programs undertaken under the VTTP II program during the period 2014 to 2016. The review focuses on exploring the impact of CPD programs on service provision and provides recommendations for new training areas as well as for improving ongoing training programs. It also outlines the impact of peer support practice on service provision and examines possible avenues for improvement within the context of post war reconciliation.

The publication comprises of the following sections: introduction, description of the studies conducted in 2013 and 2017, demographics, professional qualification and experience of the counsellors, management and support for counsellors, description of the counselling service, professional development, peer support, problems presented to the state counselling service, a systematic literature review on post-war mental health and psychosocial service problems in Sri Lanka and a summary consisting of the recommendations to the State counselling and psychosocial support services.

The Asia Foundation is a non-profit international development organization committed to improving lives across a dynamic and developing Asia. Informed by six decades of experience and deep local expertise, our work across the region addresses five overarching goals—strengthen governance, empower women, expand economic opportunity, increase environmental resilience, and promote regional cooperation. In Sri Lanka, we remain committed to continue our efforts to integrate psychosocial approaches to healing and improving well-being within our country program portfolio, and, to support the more effective delivery of mental health services through the state sector so that individuals, families, and communities in Sri Lanka can rebuild their lives.

Dinesha deSilva Wikramanayake
Country Representative
The Asia Foundation

Preface

The Asia Foundation has been working in Sri Lanka in the area of mental health and psychosocial support for nearly 15 years. This work initially began in partnership with non-governmental organizations as a response to the changes that were taking place in the country as it transitioned through war, the ending of war and on to post war development and reconciliation. The year 2014 marked a significant shift for The Asia Foundation, from working primarily with non-government partners to working with partners within the government. The state sector collaboration has included work with the Ministries of Social Welfare and Primary Industries (previously known as Social Services), Women and Child Affairs (previously, Child Development and Women's Affairs), Health, Nutrition and Indigenous Medicine, the National Institute of Social Development and the National Institute of Mental Health. In its collaboration with the Ministry of Social Welfare and Primary Industries and Ministry of Women and Child Affairs, The Asia Foundation has focused on the development of state counselling services and has been involved in the training and equipping of counsellors and practitioners, notably through the Continuing Professional Development Program, the introduction of a peer support group model for professional support and the development of clinical tools to assess the progress of clients. This publication, Developing State Sector Counselling Services in Sri Lanka, reviews the impact of these interventions on the delivery of Mental Health PsychoSocial Services in the country over the past 3 years. It also seeks to provide recommendations for further areas of training as well as for improving the peer support practice. The review is based on the two mapping studies published in 2015, the *Mapping Study on the Capacity and Work Experience of Counselling Officers/Assistants attached to the Ministries of Social Services and Child Development and Women's Affairs (2015), the Mapping Study on the Capacity and Work Experience of Counselling Assistants Attached to the Ministry of Child Development and Women's Affairs (2015), as well as the Assessment Study for the "VTTP-II-Modification" Program* that was conducted in 2017. The publication includes a Systematic Literature Review on Post-War MHPSS Problems in the country, and concludes with a summary of recommendations for state counselling and psychosocial support services.

Acknowledgements

This publication was commissioned in 2018 by The Asia Foundation, Sri Lanka, on behalf of the Ministry of Social Welfare and Primary Industries and the Ministry of Women and Child Affairs, with the financial support of USAID. The publication was compiled by The Good Practice Group and reviewed by the Technical Advisor, Program Officer and Senior Program Manager of The Asia Foundation. The co-authors of this publication are Ermiza Tegal and Ananda Galappatti, supported by Suruthi Ragulan and Nilanthi Gunawardena. Maleeka Salih authored the chapter on the systematic literature review of post-war MHPSS problems.

The studies on which this publication is based were commissioned by The Asia Foundation with the financial support of USAID and carried out by the respective institutions and teams below.

Mapping Study on the Capacity and Work Experience of Counselling Officers/Assistants attached to the Ministries of Social Services and Child Development and Women's Affairs (2015)

The Institute for Health Policy (IHP) designed and conducted the study with the close collaboration of The Good Practice Group and under the review of The Asia Foundation. The Secretary, Additional Secretary and key staff of the Ministry of Social Services helped guide the study, along with the Secretary, Additional Secretary and Women's Bureau of the Ministry of Child Development and Women's Affairs. The Director-General, Academic Advisory and key staff of the National Institute of Social Development coordinated and facilitated the Technical Support Committee meetings to guide the mapping study. The IHP-led research team that carried out the study comprised: Reggie Perera, Shanti Dalpatadu, Ananda Galappatti, Nilanga Abeysinghe, Evangeline Ekanayake, Felician Francis, Chamara Anuranga, Prashantha Bhagya Bandara Senarathne, Adikari Pathirannahalage Dilini Madushani Adikari and Tharshana Kugadas.

Mapping Study on the Capacity and Work Experience of Counselling Assistants Attached to the Ministry of Child Development and Women's Affairs (2015)

The Good Practice Group (GPG) designed and conducted the study with support from the Social Scientists' Association. The Secretary, Additional Secretary, Director and Assistant Director of the Women's Bureau and key staff of the Ministry of Child Development and Women's Affairs provided guidance and assistance in the implementing of the study, whilst the Director-General, Academic Advisor and key staff of the National Institute for Social Development coordinated and facilitated the Technical Support Committee meetings that brought the collaborating institutions together to implement the study. The Asia Foundation reviewed each step of the study from the development of the tools for data collection to the final document. The GPG research team comprised: Ananda Galappatti, Roshan Dhammapala, Nilanga Abeysinghe, Evangeline Ekanayake, Felician Francis, Nilanthi Gunawardana and Judy Pietersz. The Social Scientists Association team comprised: Pradeep Peiris, Shashik Dhanushka, Andi Schubert, Buddhima Padmasiri, and Mithun Rahul.

Assessment Study for the "VTTP-II-Modification" Program of The Asia Foundation (2018)

The study was designed and conducted by The Good Practice Group, under the guidance of a Technical Steering Committee that included: Additional Secretary, Director of Counselling and Counselling Coordinator of the Ministry of Social Welfare and Primary Industries; Director of the Women's Bureau, Ministry of Women and Child Affairs; Director of Training and Training Coordinator, National Institute for Social Development; Consultant Psychiatrist, National Institute of Mental Health; and The Asia Foundation, Senior Program Manager, Program Officer and Technical Adviser. The GPG research team comprised: Ermiza Tegal, Ananda Galappatti, Nilanthi Gunawardena, Razia Esufally, Maleeka Salih and Marsha Cassiere-Daniel.

Abbreviations

ADS	Assistant Divisional/District Secretary
CA	Counselling Assistant/s
CO	Counselling Officer/s
CPD	Continuing Professional Development
CRPO	Child Rights Protection Officer
DS	Divisional Secretary
FGD	Focus Group Discussion
GBV	Gender Based Violence
GN	Grama Niladhari
GPG	The Good Practice Group
MCDWA	Ministry of Child Development and Women's Affairs
MHPSS	Mental Health and Psycho Social Services
MOH	Medical Officer of Health
MSWPI	Ministry of Social Welfare and Primary Industries
MSS	Ministry of Social Services
MWCA	Ministry of Women and Child Affairs
NISD	The National Institute of Social Development
PADHI	Psychosocial Assessment for Development and Humanitarian Interventions
RESIST	Reducing the Effects and Incidences of Trauma
TAF	The Asia Foundation

Introduction

The Asia Foundation, Sri Lanka has adopted a psychosocial approach to its development work since 2005, particularly in relation to the Reducing the Effects and Incidences of Trauma (RESIST) project and the Victims of Trauma Treatment Program (VTTP). As a part of the RESIST project, the Psychosocial Assessment for Development and Humanitarian Interventions (PADHI) framework was developed through the University of Colombo. PADHI is a conceptual framework developed through field based research conducted in two districts to understand the determinants of Psychosocial Wellbeing within a Sri Lankan context and established in 2006 to develop culturally relevant and contextually specific assessment methodologies and related tools. The PADHI framework identifies five domains of wellbeing: 1. accessing physical, material and intellectual resources 2. experiencing competence and self-worth, 3. exercising participation, 4. building social connections and 5. enhancing physical and psychological wellness.

The psychosocial approach taken by The Asia Foundation is a response to the contextual changes that took place in the country transitioning through phases of war, ceasefire, resumption of active combat, the end of war, and postwar accelerated development and reconciliation processes. Under the RESIST and VTTP initiatives, the Foundation has found that psychosocial approaches to healing and improving well-being are effective in strengthening existing coping mechanisms that enable individuals, families, and communities to move forward with their lives. Psychosocial approaches recognize that those who have survived war, conflict and natural disasters not only suffer direct psychosocial impacts, but may also be severely affected by social, political, and economic breakdown. It takes a broader view of suffering that it is not limited to individuals, but also recognizes how this extends to families and communities and may continue years after the precipitating events. The Asia Foundation's work in mental health and psychosocial support programming began with the non-governmental sector and currently is a collaboration between the non-governmental and state mental health and psychosocial support sectors, including the Ministries of Social Welfare and Primary Industries, Women and Child Affairs and Health, Nutrition and Indigenous Medicine.[1]

An important area of work that the Foundation has focused on, in collaboration with the Sri Lankan government, has been in relation to the development of the state counselling services. The Diploma in Counselling conducted by the National Institute of Social Development (NISD) commenced in 2001 to equip Counselling Assistants (CAs) / Officers (COs) for their roles. Between 2010 and 2015, the Asia Foundation collaborated with the NISD under an earlier phase of the Victims of Trauma Treatment Program (VTTP) to revise the Diploma in Counselling and develop a Higher Diploma in counselling to further equip practitioners with skills to meet the needs of their clients. The Foundation also commissioned rapid mapping studies through the Ministry of Social Services and the Ministry of Child Development and Women's Affairs in 2013 to better understand

1 This paragraph describing The Asia Foundation's approach and work in the psychosocial sector is an extract from the publication titled "Transitions in Mental Health and Psycho Social Support Services", The Asia Foundation, September 2016.

the roles, work practices and capacity-building need of the government's counsellors. Based on the findings from these studies, in 2014, The Asia Foundation initiated a three year process of delivering a program of training for Continuing Professional Development (CPD) in collaboration with both Ministries and the NISD. In addition, The Asia Foundation helped introduce a peer support-group model for professional support that was adopted institutionally by the two Ministries for use by their counsellors. This provided a platform for service providers to present difficult cases to their peers and receive constructive feedback, share best practices, and learn from the experiences of their fellow counsellors.

The Asia Foundation publication, *Transitions in MHPSS Services in Sri Lanka 2004 – 2015: A Decade in Review* examined the growth and transitions of the mental health and psychosocial support (MHPSS) sector in Sri Lanka over the period of the decade, from response to the Indian Ocean tsunami up to the post-war period to better understand what aspects have acted as enablers and what factors have been challenges to the development and growth of the sector.

The Asia Foundation's most recent MHPSS initiative, the 'Victims of Trauma Treatment Program: Phase II-Modification' (VTTP-II–Modification) seeks to build on the work of the VTTP-I & II programs and is also supported by USAID. The goal of the VTTP-II-Modification Program is to *consolidate best practices in mental health and psychosocial support services (MHPSS) within government and non-government enabling them to lead and sustain the provision of care to victims of trauma, conflict, and other vulnerable communities.* The program seeks to continue to strengthen the partnerships that the Foundation has established with the government and NGO sectors to develop the capacities and skills of government and NGO mental health cadres to provide effective service delivery. The VTTP II-Modification will contribute to this goal through three program components: (1) research, development and service delivery; (2) improvement of service delivery; and (3) monitoring and evaluation (M&E). In achieving this goal, the VTTP II-Modification aims at making substantial contribution to improving mental health and psychosocial support services (MHPSS) delivery.

As a basis for the VTTP-II-Modification activities to further support the development of state counselling services, The Asia Foundation commissioned an assessment in 2017 to review the impact of its previous work on the practice of government counsellors and determined the priorities for future cooperation with the relevant Ministries. This publication seeks to draw on outputs of the two rapid mapping studies conducted in 2013 and the more recent 2017 assessment study to reflect on the status of counselling services in Sri Lanka's state sector with particular reference to two of the key government ministries that the Foundation has collaborated with.

Limitations

The content of this publication is specifically based on the published reports of the previous mapping studies conducted in 2013 and 2017 with the two Ministries. A lack of access to the raw data for both the 2013 studies meant that the data from these

could not be re-analysed in ways that were consistent across all three studies. However, it was possible to use published data tables and the accessible raw data from the 2017 study to yield a comparative analysis. The data on which this publication is based is also limited to the studies and materials shared with The Good Practice Group. The respective Ministries may have access to additional data including client intake forms and monthly reports which could possibly enable valuable triangulation of findings and analysis presented here, but this would probably require a separate study. The original limitations of each of the three studies of course also carry forward into this publication, and these are discussed briefly in the next chapter.

Description of the Studies Conducted in 2013 and 2017

The rapid mapping study conducted for the Ministry of Social Services (MSS) in 2013 was the first of the studies on the state counselling sector commissioned by The Asia Foundation. It was a collaborative effort by the MSS, MCDWA, NISD, the Institute for Health Policy (IHP) and The Asia Foundation. The study was steered by a Technical Support Committee (TSC) consisting of key representatives from each stakeholder institution. The overall sampling frame was the entire number of 103 counselling staff available at the time. The main objective of this study was to map the capacity and work of the 96 Counselling Assistants attached to the MSS and the 7 Counselling Officers attached to the Ministry of Child Development and Women's Affairs (MCDWA), across the nine Provinces of Sri Lanka.

A three-step methodology which triangulated quantitative and qualitative aspects of the study was followed. Step I was preliminary data collection by a pre-tested, self-administered postal survey questionnaire in Sinhala and Tamil. Step II was in-depth interviews conducted via site visits to a purposive sample of 10 CAs in four selected provinces: Northern, Eastern, Central and Southern. Step III consisted of four focus group discussions with a total of 59 participants to clarify and further study data in self-reported questionnaires and in-depth site visits.

Limitations in resources and time constraints did not permit the research team to sample more CAs for in depth study, conduct key informant interviews of clients, supervisors and other categories of staff collaborating with CAs, which would have provided rich insights. The short time-frame for data collection, and limited direct contact with CAs placed constraints on the depth of data collected and verification of reported responses. However, efforts were made to address these limitations through inclusion of in-depth interviews and FGDs and by including all CAs in the study—although the participation rate was fractionally under 80%.

Ethical clearance was obtained from the IHP ethics review committee. Informed consent was obtained from respondents, and all responses to the postal survey, and during interviews or focus group discussions were anonymised before reporting. The study's data collection methodology was designed to prevent compromising the privacy of the counsellors and their clients, including exclusion of collection of any individual client data.

Following the first study with the MSS, a similar study was also conducted for the Ministry of Child Development and Women's Affairs (MCDWA). This study was a collaborative effort of the MCDWA, NISD, the Foundation, The Good Practice Group (GPG) and The Social Scientists' Association (SSA). The study design and implementation was steered by a Technical Support Committee comprising experts and key stakeholders from each of the collaborating institutions. The study design was heavily indebted to the previous similar study implemented by the Institute for Health Policy. Minor adjustments to the methodology were made, based on the experiences from the prior study and the increased scope of the current study. Given that there were time-constraints that

meant the study had to be conducted within a three-month window, minimal changes to the methodology were made in order to reduce the need for pilot testing of new instruments and study protocols. The objective of this study was to support the Ministry of Child Development and Women's Affairs (MCDWA) and the National Institute of Social Development (NISD), Ministry of Social Services to map the capacity, training needs and scope of work of the then recently recruited 212 Counselling Assistants. The study also sought to understand the infrastructure and support mechanisms currently in place to assist the work of the counsellors. The findings of the study were to be used to direct future capacity-building and service-strengthening measures by the MCDWA. The study was also intended to inform the then ongoing development by the NISD in collaboration with The Asia Foundation of a curriculum for a Higher Diploma in Counselling to further equip practitioners with skills to meet the current needs of clients across Sri Lanka.

The 2017 assessment study was conducted by The Good Practice Group, and was guided by a technical steering committee that comprised institutional leadership and technical personnel from the Ministry of Social Welfare and Primary Industries, the Ministry of Women and Child Affairs, National Institute for Social Development, National Institute of Mental Health and The Asia Foundation. This study aimed to assess the Continuing Professional Development (CPD) training activities and Peer Supervision mechanism introduced between 2014 and 2016 under the VTTP-II Program implemented by The Asia Foundation in collaboration with the Ministry of Social Welfare and Primary Industries and the Ministry of Women and Child Affairs. This study also sought to identify the psychosocial needs of individuals and communities in post-war Sri Lanka, including those associated with the reconciliation processes.

Ethical review of the research design was conducted by the multi-disciplinary Technical Steering Committee. Informed consent was obtained from respondents, and all responses to the online survey, and during interviews or focus group discussions were anonymised before reporting. As with the previous studies, the data collection methodology was designed to prevent compromising the privacy of the counsellors and their clients.

Self administered online survey: Given time and resource constraints, an online/mobile survey form was utilised to obtain feedback from Counselling Assistants and Counselling Officers associated with the two relevant Ministries (MSWPI & MWCA). The sample for the online/mobile survey aimed to include all Ministry personnel who had been involved in the CPD and Peer Support activities under the VTTP-II Program.

Prior to the launching of the online/mobile survey, an orientation was conducted on the 25th of August 2017 for the district counselling coordinators or focal points for each of the two Ministries to familiarise them with the online/mobile survey's objectives and how to access and complete the survey using mobile phones or computers. The meeting was also an opportunity to pilot and receive feedback on the survey, and improve the online/mobile form. Short customised hyperlinks to the online/mobile form in Sinhala (http://bit.ly/VTTP_S) and Tamil (http://bit.ly/VTTP_T) were distributed by short message service (SMS) and WhatsApp to all Counselling Assistants and Counselling

Officers both directly and through the district coordinators/focal points. There were some challenges obtaining up-to-date numbers for all counsellors, and considerable effort and follow up by telephone and text messages was required to ensure that the forms were filled. The difficulties encountered were partly due to counsellors' limited access to the internet and also to some lack of familiarity with use of online tools. Despite these challenges, approximately 314 counsellors (72% of the total cadre of both Ministries) completed the survey form successfully.

Focus Group Discussions and key informant interviews: To complement the structured survey tool, it was decided that there would be semi-structured focus group discussions (FGDs) with personnel from 5 purposively selected field settings to elicit more qualitative data. Unstructured key informant interviews were also undertaken with resource persons who delivered training and technical assistance during the VTTP-II Program. Three-hour focus group discussions (FGDs) were conducted in 5 locations: Kurunegala, Vavuniya, Badulla, Galle and Colombo. The FGD in Vavuniya brought together counsellors from the Northern provincial districts of Kilinochchi, Mannar and Vavuniya. The FGD locations were selected by the Technical Advisory Committee and their selection sought to maximise representation from diverse contexts across Sri Lanka, reflecting socio-economic and ethnic diversity, both urban and rural settings and areas considered to have both high and low levels of public access to counselling services. Across the five locations, a total of 57 counsellors participated in the FGDs.

Literature Review: A systematic review protocol was designed to review published articles and grey literature during the period 2007-2017 from academic databases, key online websites, and repositories of Sri Lanka-related materials established by the GPG and TAF. The detailed methodology is set out in the later Chapter titled "Systematic Literature Review on Post War MHPSS Problems in Sri Lanka".

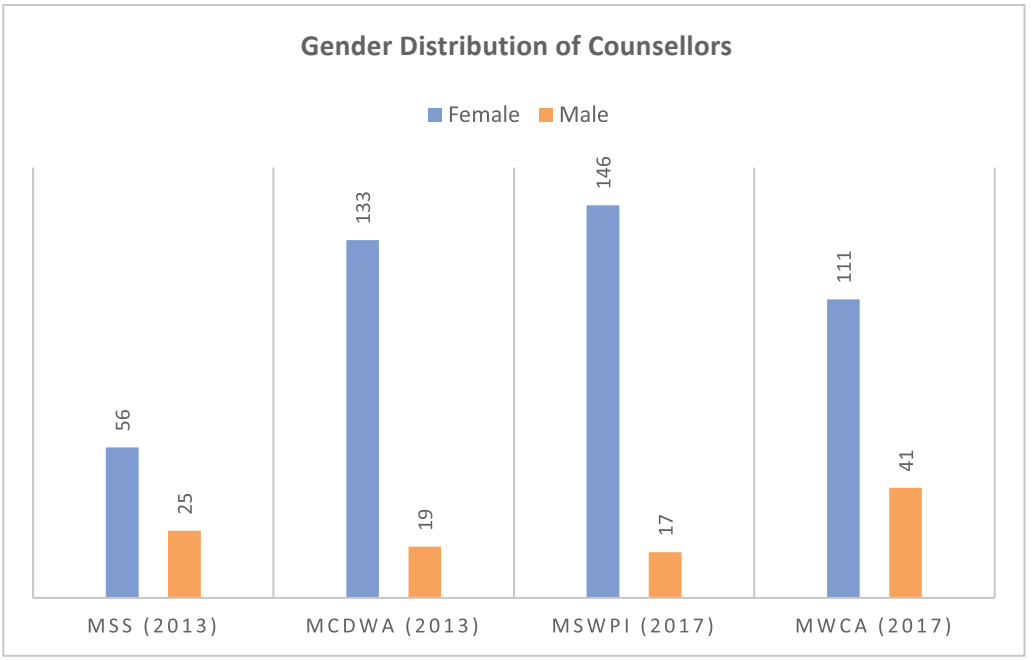
Demographics

Number of Counsellors

At the time of the mapping studies conducted in 2013, there were 103 counsellors attached to the MSS and 212 counsellors attached to the MCWDA and each Ministry had counsellors stationed in each of the nine Provinces in the country. The percentages of counsellors who participated in the 2013 mapping studies were 79.6% for MSS and 71.7% for MCWDA. It was estimated that the mean population served by a single counsellor in the district where they were stationed was 132,642 and the maximum, 1,600,910.

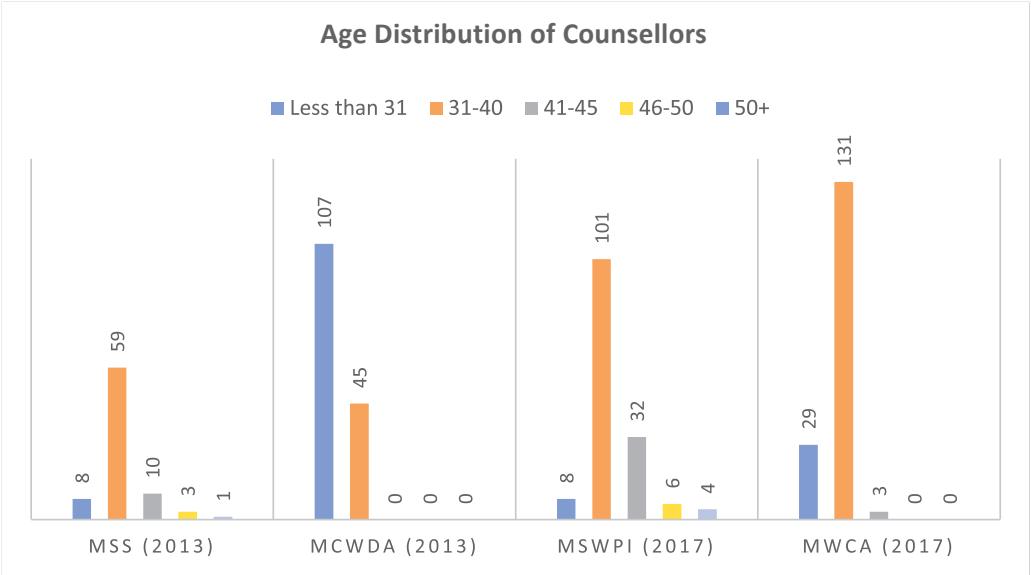
By 2017, there were 202 counsellors attached to the MSWPI and 233 counsellors attached to the MWCA, with each Ministry having representation in each of the Provinces in the country. The response rate for the 2017 review study was 74% for MSWPI and 70% for MWCA. The data presented in this publication represents only responses from those who participated in the three studies.

Gender Distribution



From the study data, it is evident that with the recruitment of counsellors in the period since 2013, the gender gap continued to be skewed in favor of women. MSS/MSWPI has increased its proportion of female counsellors from 69% to 89.6% while the MCDWA/ MWCA had decreased slightly from 87.5% to 73%.

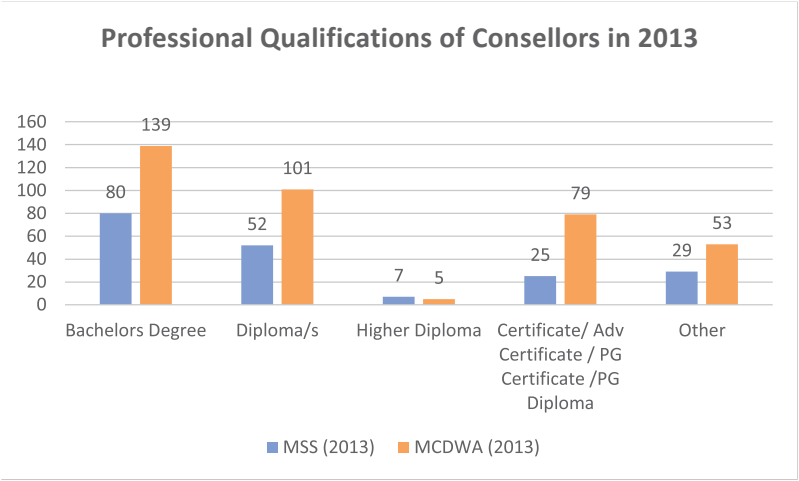
Age of Counsellors



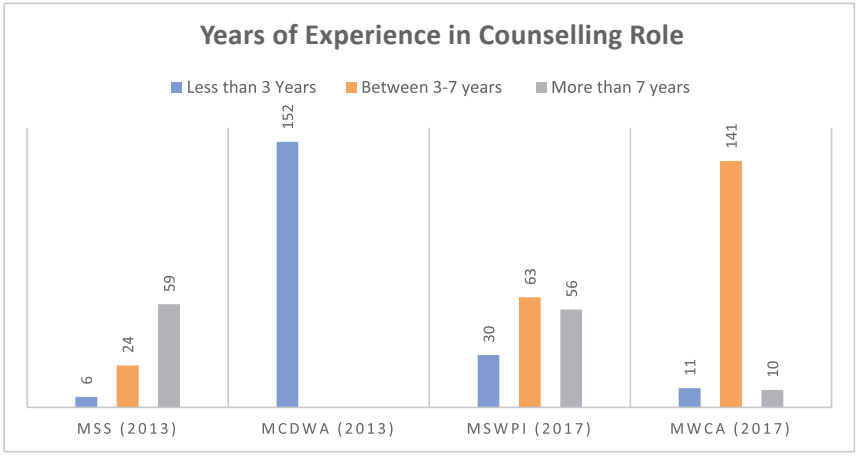
The age range of the counsellors surveyed across Ministries ranged from 25-54. In 2013 counsellors in the MCWDA skewed younger, with most of the respondents being younger than 31 years old. However, by 2017, counsellors from both Ministries were now predominantly between the ages of 31-40. The MSWPI continues to have a small percentage of older counsellors.

Professional Qualifications and Experience

The 2013 surveys indicate that in both the MSS and MCDWA, a majority of the respondents possessed a degree: 93% of the respondents from MCDWA and 97.6% from MSS. This corresponds with the fact that the recruitment of counsellors was largely through the graduate recruitment scheme. It was also noted that counsellors possessed multiple professional qualifications including Diplomas, Certificate course qualifications and Higher Diplomas. A majority of the Diplomas were obtained in the fields of psychology, counselling, social work; while a few were in English, Tamil and Computer skills. Of the respondents from the MSS, it was reported that there was a high motivation for acquiring professional knowledge and skills.

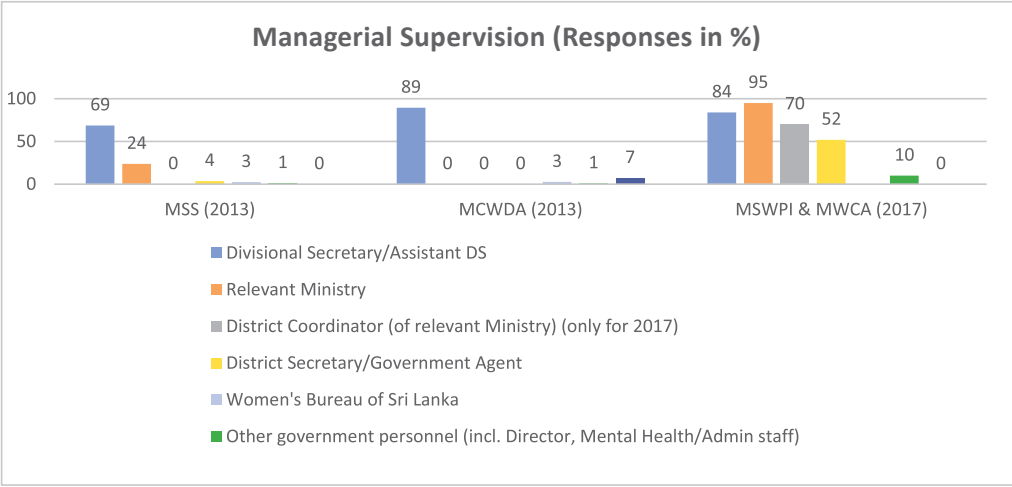


In 2017, a majority of counsellors reported having between 3-7 years of experience in a counselling role. It is critical to note that all the counsellors surveyed in the MCDWA (2013) reported having less than 3 years of experience, reflecting the relatively recent recruitment of these counsellors at the time of the survey. By 2017, a noticeable number (6.8% from the MCDWA and 38% from the MSWPI) of counsellors reported having over 7 years of experience in the role.



Management and Support for Counsellors

In 2013, counsellors reported mainly receiving managerial supervision from the Divisional Secretary, with a few from the Ministry of Social Services identifying the Ministry as providing supervision. In 2017, the counsellors detailed receiving direction and support from a varied number of sources. Across the different Ministries, the Divisional Secretary/ Assistant DS continued to play a key role in managerial supervision. However, this was secondary to the significant supervisory role that counsellors reported the relevant Ministries played. Interestingly, District Coordinators, District Secretaries and other Government Officials were also reported as playing a managerial supervisory role. This prompted the 2017 report to recommend further investigation of the multiple lines of authority that were reported during the survey.



In 2013, in terms of administrative support and technical guidance, counsellors reported their Line Manager/Supervisor as being the primary sources of support. Whilst this is expected for administrative support, a high dependence (55.7% of Social Service counsellors, and 56.6% of Women's Affairs counsellors) on the Line Manager / Supervisor was identified. In 2017, counsellors from MSWPI and MCWA identified their respective Ministries, District Coordinator and Divisional Secretary as being the primary sources of support for these issues.

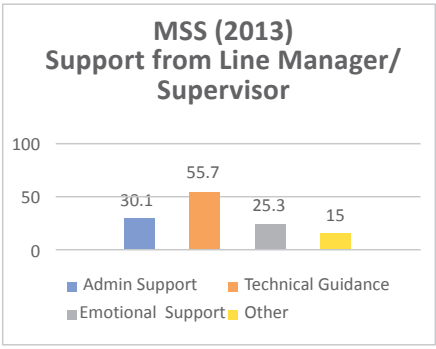
> *"We do not receive technical support or substantive supervision to do with our subject officially. We are expected to find this for ourselves. I talk to the team for this kind of support. The Assistant District Secretary had regular weekly administrative supervision at which we can get support and advice from him about procedures and administration. We do not get formal technical support."*
>
> ***28 year-old female, In-depth interview 10- MSS Report (2013), p. 91***

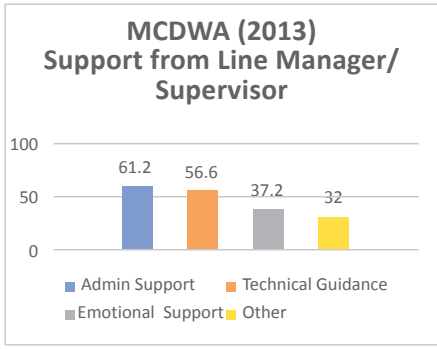
"I meet with the Assistant Executive Director of the center for administrative supervision. We discuss cases and procedures and progress and feedback. Every time I go to the center, each week, I give feedback to my supervisor but we cannot discuss theoretical issues of the case as supervisor is not from this professional field. There is no official supervision system but I approach the MSS counselor, who is more senior, on my own, and I speak with her and she supports me. Though I don't think it is right for me to discuss cases with the MSS counselor because this would be breaching confidentiality. I don't want to do this. It is very hard to find professionals we can speak to and get advice from."

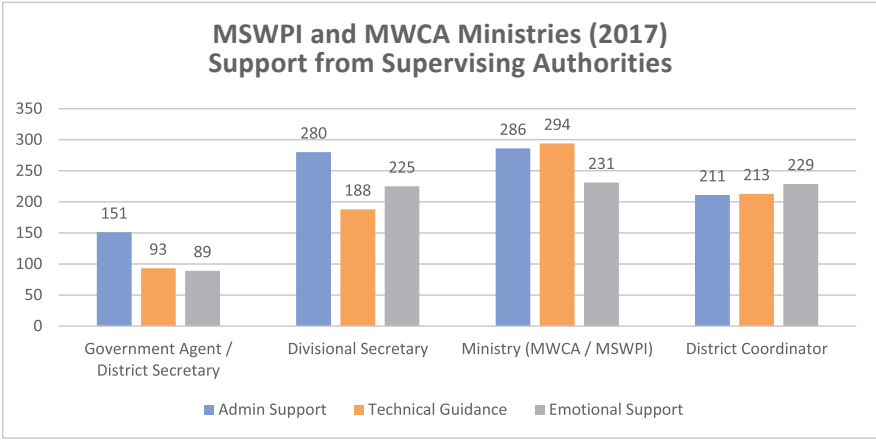
29 year-old female, In-depth interview 01- MCDWA Report (2013), p. 65

"We do not have anyone for technical subject related supervision. It is expected that we provide peer supervision and we do this. But since my colleagues are from different fields I can't always share everything. I am also unable to share things which are confidential sometimes. So, I have made my own team (other CAs) from other areas. I also talk to a senior counsellor. But this is not a formal arrangement. We do it whenever we want or can."

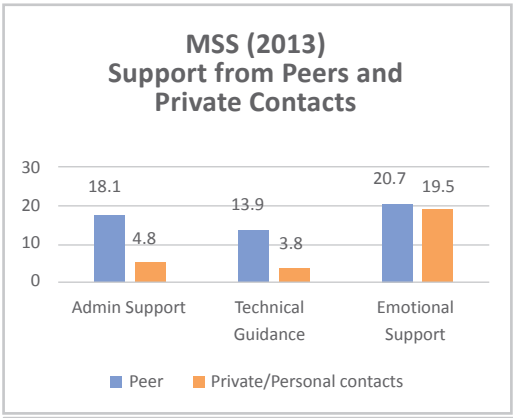
32 year-old female, In-depth interview 08- MSS Report (2013), p. 76

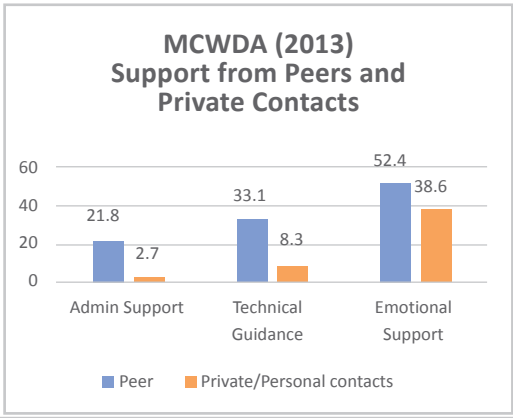


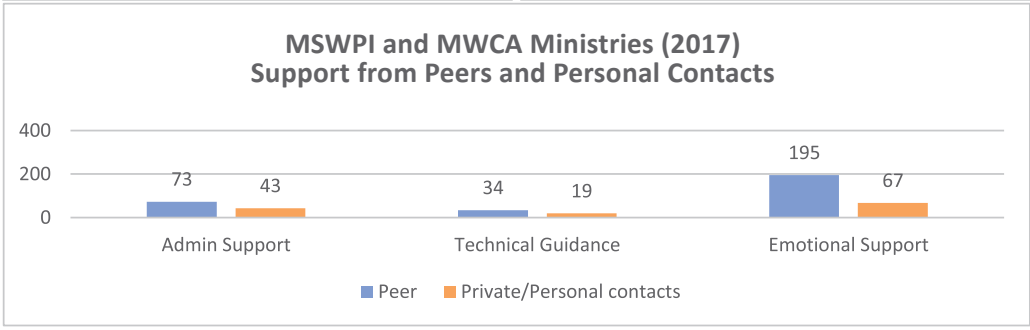




Across all Ministries, peers and private/personal contacts were the primary source of emotional support. Significantly, counsellors surveyed in 2013 also reported turning to peers for technical guidance (MSS 13.9%, MCDWA 33.1%) and administrative support (MSS 18.1%, MCDWA 21.8%). While peers were seen as a source of administrative support for counsellors surveyed in 2017 (23.3%), a significant portion of CAs also reported turning to private/personal contacts for administrative support (13.7%) and technical guidance (6.1%).







Description of the Counselling Service

Broad Strategic Vision

In 2013, it was observed that, considering the overall counselling service in both Ministries, there was a lack of a broad strategic vision on how the counsellors contributed to addressing psychosocial problems in the community. This was reflected in the lack of clarity that the counsellors felt regarding their individual roles.

> *"Also, having a specified job role is important. At the moment, we are expected to do everything and it has a negative impact on our dignity."*
>
> ***Counselling Assistant, In-depth interview 15- MCDWA Report (2013) p. 115***

> *"I have been given an appointment and it's useful, but I am not very clear to which Department or Ministry we are aligned to and it looks like our position is combined with two departments. It will make me more effective if there is clarity over my designation…"*
>
> ***Counselling Assistant, In-depth interview 17- MCDWA Report (2013), p. 119***

The studies conducted in 2013 also saw counsellors expressing a need for a framework for professional advancement, within their current post/role and more broadly within the field of counselling and psychosocial work. Counsellors also identified a need for greater recognition vis-a-vis other officers working at the DS level, and expressed a dissatisfaction with their 'assistant' title.

A work instruction to guide Counselling Assistants / Officers at the Ministry of Social Services & the Ministry of Child Development & Women's Affairs was prepared and published in Sinhala and Tamil in October 2016. The purpose of the document was to provide clarity about what the counselling service can offer. It also hoped to identify available resources and services within their district /region to refer clients who have needs which are not addressed by a counsellor or a counselling service (eg: financial, medical, legal). The document aimed to support a good counsellor to work within their abilities and their limits and thereby avoid causing harm to a client by providing a support or service which does not fall into their job description, training or capabilities. The topics and content of the document were developed by Clinical Psychologist, Roshan Dhammapala, in consultation with District Coordinators (MSS) and Counselling Officers (MCDWA) as well informed by the Mapping Study on Capacity and Work Experience of Counselling Assistants (2015) by The Asia Foundation and The Good Practice Group.

The three broad areas of focus were:

1. **Assessment:** Issues and areas to be explored in order to determine needs which can be addressed by counsellors and those which require referral.
2. **Intervention options by Counsellor:** Broadly outlines scope of counsellor support in relation to each domain and what types of support options can be explored within the counsellor's role.
3. **Referral:** Identifies issues and needs which may need referral for support from other institutions, individuals and services.

It was anticipated that through a discussion process, Counselling Assistants and Counselling Officers will have an opportunity to talk about their approaches to intervene in each of these domain areas while also identifying referral options they had accessed and that were available in each region.

The 2017 study observed that although the training provided to counsellors of both Ministries had provided a basic minimum standard and framework, the overall broad strategic vision for the service continued to be unclear.

In 2017, the fact that counsellors of the two Ministries attended FGDs together, highlighted the similarities and differences in their respective practice, and also the variable nature of the operational relationships between the two groups of counsellors. In some instances, there appeared to be close working relationships, whereas in others, opportunities did not even appear to be available. A key insight is that the working relationships and collaborations were determined mainly by the strength of relationships between personnel. Structural barriers such as distance between working locations, local administrative arrangements and limited Ministry-level cooperation were reported as posing a challenge to close working relationships.

The 2017 study also revealed a problem of communication (in terms of direction and support) between the field and the center. It was perceived as contributing to many of the day to day concerns of counsellors not being addressed and a weak sense of working collectively. Although many of the survey respondents identified their respective Ministries and the District Coordinator as their main source of support, it is also a reflection of the fact that these institutions and individuals are often seen to be the only sources of support for many counsellors who otherwise felt isolated. As a result, failures to address concerns or grievances of the regionally-based counsellors resulted in requests to the researchers to communicate with respective hierarchies their needs and concerns. At one FGD, participants said that a lack of funds allocated to conduct programs resulted in them having to conduct these with their own finances to ensure that the required number of programs were conducted. Another concern was that there was greater focus on numbers from managers and not on quality or results.

Work of the Counsellors

In 2013, the arrangements for counsellors' work varied across locations, with activities and collaborations apparently determined by opportunities and initiative on the part

of the counsellor, his/her supervisor and other relevant institutions and staff (i.e. mental health services, government community services, courts, etc.). For places of work, the 2013 survey respondents reported vastly different experiences from each of the two Ministries. The MSS reported that over 60% of counsellors had more than one working place. The primary place of work being the Divisional Secretary's office and other locations being counselling centers, mental health units, prisons, etc. The MCDWA reported that 88.2% had only one place of work. One possible reason given for this, as suggested in the study, was the fact that the counsellors of the MCDWA were recent recruits, suggesting that recent recruits are likely to have one place of work until they are oriented into the service. A significant proportion of the 11.8% of counsellors who reported having secondary places of work referred to hospitals, probation homes, police stations and women's counselling centers.

"On Mondays and Wednesdays I am based at the office and meet clients (around 3 to 5 persons come and I provide counselling support). I spend one hour with a client...I also work in the field (3 days a week). The GS identifies and refers cases and I make home visits. I meet clients at their home and spend around two hours with each case."

Counselling Assistant, In-depth interview 18- MCDWA Report (2013), p. 119-120

"On Mondays, Wednesdays and when necessary on Fridays I stay at the office and meet clients. Whenever requested I attend the MHU clinic at the hospital. On Wednesday afternoons I go to the courts and meet the clients. On other days, I visit the field if there are default cases or if there is a need to do the family assessment I do it on those days."

33 year old male, In-depth interview 07- MSS Report (2013), p. 69

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33 year old male, In-depth interview 07- MSS Report (2013), p. 69

In 2017, the survey looked at the question of how clients were accessing counsellors as opposed to the places of work. The study revealed that the main means by which counsellors were accessed by clients appeared to be by referrals, walk-ins and by telephone. Referrals often came through state institutions and services such as the Women and Children's Desk of police stations, school teachers, women's groups and Samurdhi officers, the Magistrate and District Courts - although which institutions made

the referrals varied by local context. The counsellors also conducted outreach activities, including home visits and visits to institutions such as hospitals, prisons, detention centers, schools for deaf and blind persons, elders' homes, legal aid commission offices, probation centers, community/village based groups (women's groups, migrant worker groups, war widow groups) and schools. With regard to home visits in some instances it was stated that permission from a supervising officer was to be obtained in order to make a home visit. A few counsellors attached to the MSWPI also indicated that they had responded to several disaster situations.

The 2017 survey also indicated that the practice of home visits varied across geographical locations. In some locations, there had been a reduction in home visits as a result of a directive that counsellors be accompanied by another state officer when making a home visit, presumably to avoid possible allegations of impropriety and to ensure the safety of the counsellor. Another reason was the requirement of a request from either the client or a state officer prior to a home visit. The Colombo FGD reported that home visits were usually not conducted. An observation shared at one of the FGDs was that there was a difference in the way people from rural and urban communities accessed counselling services, with a view expressed that in rural areas there appeared to be a greater sense of stigma attached to seeking the assistance of a counsellor resulting in a reluctance to visit the counsellor's office. The participant who made the observations, related this insight as her own work modality had changed to fewer home visits after she had moved to a more urban location. The Galle FGD reported that counsellors were required to stay at the office all 5 days of the week, and had to report back to work even after a field visit, and stated that this resulted in less time spent with clients in the community. The counsellors attached to the MSWPI reported in 2017 that Mondays and Wednesdays were public clinic days for walk-in clients. A dedicated space for counselling was not always available at the DS office, so some counsellors used the spaces they shared with other officers.

The 2017 study also observed that phone based access to counsellors was approached differently by the two respective Ministries. The MSWPI had a system of publicising (at awareness programs and on social media) the mobile numbers of the counsellors for each specific area. The phone service was said to be a 24 hour service, which sometimes led to inconvenience for counsellors when they were contacted outside of working hours - although they said that over time they had learnt how to identify issues requiring urgent attention and those that could be redirected to a local counsellor at a convenient time. The MWCA publicized a centralized 24-hour hotline service (1938), which would redirect clients calls to the most appropriate counsellor to respond to the client directly or arrange an appointment to meet in person.

In 2017, Vavuniya and Colombo FGDs highlighted the fact that there were a considerable number of requests from Magistrate and District Courts to provide reports for domestic violence and divorce cases. The Colombo FGD also reported direct referral by the police in the case of domestic violence complaints. Some counsellors at the Vavuniya FGD said they undertook these cases as there was no court counsellor, even though they understood they had no authority or mandate to deal with such legal matters. Although

they had to prepare reports on their clients' status for the court, the Divisional Secretary would countersign these. They experienced difficulties in handling these cases as there was an expectation from the court that several sessions should be conducted within a given time period. They said, *"We have about 15 case referrals per month…[but] have to do three sessions... separate at first and later together".* The Colombo FGD also reported difficulties of working with clients who had been compelled by a direction of the police, court or correctional officer. Many such clients were identified as not consenting to the counselling process and as such would not engage with the process with the awareness and interest of seeking to understand the problem and work towards a solution. The complex power dynamics and ethical implications of these referrals for the practice and goals of counselling were troubling to some FGD participants, and they identified the need for a circular to guide and protect them professionally.

Number of Clients

In the studies conducted in 2013, the MSS respondents reported a total of 20 clients counselled per counsellor for the month of May 2013. The numbers of children counselled showed equal distribution by gender and there was hardly any difference in the gender of counselled clients. On average 4.5 clients were counselled by MSS counsellors per week. The MCDWA respondents reported an average of 3.3 clients counselled within the two-week period that the counsellors were assessed. Of this, most clients were adult women (an average of 5.3 in the two week period). In general, most counsellors counselled about 10 clients within the given two weeks. It was noted that compared to male counsellors, women counsellors appeared to meet with a slightly higher number of clients.

It was very clear in 2013 that counsellors could not meet the volume of psychosocial needs of the large populations that they were assigned to serve. Their approach of combining a couple of days with a counselling focus and the remainder of their time on what might be described as promotional or preventative public programs was seen as an on-the-ground response to this challenge. Clear direction around the balance between responding to individual cases and community-level interventions, as well as prioritization of particular areas of work, was recommended to benefit both counsellors and the populations they serve. It was also felt that it would help define the specific competencies and knowledge that counsellors should develop in each area, with implications for pre-service and in-service training content and approaches.

In 2017, the question of the number of clients was covered as part of the FGDs. The monthly reports that the counsellors provided to their respective Ministries was said to contain information relating to numbers of clients counselled. The perception of number of clients including repeat clients that the counsellors met with during the course of a month varied greatly. For example, at the Kurunegala FGD, counsellors in some areas reported seeing a total number of 2 to 3 clients per month on the low end and another area reported meeting 6 to 7 clients per month. At the Galle FGD, counsellors reported receiving 0 to 5 clients per month and another reported seeing 10 to 12. In the Vavuniya FGD, some counsellors suggested they saw 10-15 new cases each

month, in addition to follow-up for existing clients (which typically lasted 3-4 months). In the Colombo FGD, several counsellors stated that 75% of their clients attended only a single session. This information was based on self-reported estimates, and could not be verified against other sources in the context of this study.

Awareness and other Programs

The MSS counsellors in 2013 reported, that over a one week period (end May 2013) they had participated in counselling sessions (131 activity counts), awareness raising and workshops (93 activity counts), networking and collaboration (17 activity counts), other psychosocial activities (26 activity counts) and other activities (20 activity counts). Most MCDWA counsellors reported in 2013 that over a two-week period they participated in counselling sessions (93 counsellors) while a significant number were also involved in other psychosocial activities (57 counsellors) and awareness raising workshops (44 counsellors). These MCDWA counsellors also reported having participated in a number of 'other events' (109 counsellors). This was due to the fact that counsellors participated in the events organized to mark the World Children's Day, International Day of the Girl Child and Elders' Day - all of which fell during this period. These events may also have had an impact on the rather high number of awareness programs that the counsellors reported being involved in.

In 2017, a key role of all of the counsellors was to conduct awareness programs, and some FGD participants stated that they were required to conduct a minimum of 2-4 awareness programs each month. Awareness programs were conducted for a wide variety of target audiences, including schools, hospitals, families of prisoners, places of detention such as Methsevana, mental health facilities like Angoda and Mulleriyawa hospitals, the school for deaf and blind persons, elders homes, probation centers, and community/village based groups (women's groups, migrant worker groups, war widow groups). Respondents described difficulties in accessing information and material for these awareness programs and having to develop materials and aids by themselves.

In 2017, it was also reported that the MWCA had recently initiated an island-wide pilot program to support community interventions designed by counsellors. One such project which commenced last year was 'Sadhaniya Mithuru Gammana', where 11 villages were identified to receive integrated supports towards addressing a specific concern identified by the counsellor. In Hettiyawatta, Homagama, a village selected for children not attending school, a concerted and collaborative project was described as involving various state officers to uplift the selected community. The counselling officer appears to play the role of main point of contact with target individuals or families in the community. In 2018, it was planned that 50 villages would receive similar targeted interventions. It was observed that there was no common guidance or framework for psychosocial interventions guiding the design of these projects, and counsellors highlighted the need for training in planning and implementing these kinds of interventions, which went beyond the counselling methodologies that they had been trained on.

Case Conferencing

This practice was mentioned during the FGDs conducted in 2017. Counsellors at the Vavuniya FGD stated that they found it easy to work using the approach of case conferencing when assisting clients with problems that required a multi-disciplinary response. The practice of case conferencing was described as a consultation convened by the Probation Officer and invites relevant officers such as the Child Rights Promotion Office (if a child is involved) or Women's Development Officer (if it is a women's problem). The approval for the case conference was given by the Additional District Secretary who would issue a formal letter calling the relevant officers to meet. Local variance like this sometimes arose through introduction of practices from allied disciplines, like child protection services. For instance, at the Vavuniya FGD, some counsellors mentioned that they are required to provide the Divisional Secretary with case studies from their field visits, which they said was a practice associated with personnel from the National Child Protection Authority at the same DS office.

Burn Out and Self-care

In 2013, both Ministry studies recognized issues of 'burn out' or 'compassion fatigue' and it was recommended that the need for options of lateral movement away from direct support work, where counsellors are unable to continue effectively in this role be considered.

> *"I speak with my closest friend and other good friends. I have a very good relationship with my mother and tell her everything. Sometimes when handling all these issues I think it's enough, then I go and do some sport like netball or I do dance exercises and listen to music. I also speak with colleagues about work related problems"*
>
> ***Counselling Assistant, In-depth interview 05- MCDWA Report (2013), p.87***

> *"...I talk to my four colleagues regularly. We all worry a lot about our work and the problems we encounter in people's lives. We have a sense of despair sometimes. "kalakireemak" because we try so much but don't see results. I speak with my husband daily and with family friends. I sleep well and gain a lot of support from Buddhism by listening to pirith."*
>
> ***Counselling Assistant, In-depth interview 09- MSS Report (2013), p. 86***

In 2017, counsellors at two FGDs mentioned the need for a confidential counselling service for themselves, suggesting that this was best provided through service providers external to their line Ministries. In the 2017 Colombo FGD, commenting on the counselling training they had received, a few experienced participants reported that much of the content on counselling practice was familiar to them, but that the

self-care component was entirely new to them - and that this had a profound effect on their acknowledgement of their own emotional and psychological issues arising from their work. Some FGD participants also expressed an interest in learning more about yoga and self-care practices, and even offered to pay for it themselves to get resource persons to train them. Others expressed a desire to learn about ways of protecting themselves and being safe in the context of risks from potential threats from disturbed or violent community members or clients.

Infrastructure

There were several practical challenges counsellors experienced in their daily work, most importantly the lack of access to a private room for counselling sessions and limited transport facilities to enable them to access community-settings. The counsellors attached to the MCDWA additionally identified lack of desks and chairs.

> *"... However we don't have the space right now. When someone comes, I have to take them to the tea room or some free space. There is a room with a big board saying "counselling room" which has been occupied by a senior translator and no one is willing to ask him to leave this room, so the DS has allocated another space for us and we are waiting till that is cleared and partitioned and furnished."*
>
> ***30 year old female Counselling Assistant, In-depth interview 07- MCDWA Report (2013), p. 96***

> *"We don't have a computer or internet connection in the center. There is one computer in the DS office and that's the only one we can use to connect to the internet. We need technology that can help our work. I have to cover 97 divisions in this GS."*
>
> ***49 year-old female, In-depth interview 09- MSS Report (2013), p. 86***

> *"...We even don't have the basic facilities like a table and a chair. Probably this is the place to start and it will be useful to have the counselling room in order to provide a good service. We do not have resources to update ourselves and also we do not have the resources to document our practice and work. We also lack training and on the job skill development which is another important aspect."*
>
> ***31 year-old female, In-depth interview 10- MCDWA Report (2013), p.105***

> *"Most of the training by the Ministry has been conducted by Sinhalese resource persons and we have difficulty in understanding (often our peers are asked to do the translation and it would be good to have professional translators); but recently they conducted two separate programs in Tamil, which was convenient for me."*
>
> ***37 year-old male, In-depth interview 6- MSS Report (2013), p. 68***

In 2017, an FGD group mentioned that it would be very useful if the counselling material and information is hosted on a website. They suggested a website for counselling resources, particularly a database of information from which material for presentations for awareness programs can be accessed. Another FGD participant requested that line ministries also invest in equipment, such as toys and tools (memory tools, activity cards) that are needed to carry out certain assessments and make them available to the counsellors.

Professional Development Training

The Development of a State Training Program for Counsellors and its Assessments

The National Institute for Social Development (NISD) is Sri Lanka's premier institution in the field of social work and social development education that currently functions under the purview of the Ministry of Social Services. Established by an Act of Parliament in 1992, its mission is to "enhance human resources for social development through the preparation of competent manpower in social work at all levels, generate and disseminate new knowledge and technologies for social work practice, provide specialized services for social welfare and social development." In seeking to achieve this objective, the NISD currently conducts a 30 credit Diploma and a 60 credit Higher Diploma in Social Work, a four-year Bachelor's degree program in Social Work and a two-year Master of Social Work degree program. It also offers a regular part time 30 credit Diploma in Counselling and a 60 credit Higher Diploma in counselling, in addition to Diplomas in Child Protection, Gerontology, Community-based Correction, Social Care and Women's Empowerment in response to demand.

The Diploma in Counselling was introduced in 2001 by the Training Division of the NISD. It took the form of an 18 month training program that was mainly conducted over the weekends. The Diploma program consists of eight course units and one field practicum unit. During the first semester of the first year, modules on General Psychology, Development Psychology, Social Psychology and Psychology of Abnormal Behavior are offered while the second semester modules are Counselling Theories, Counselling Techniques, Counselling Treatment Planning, and Counselling Skills Development. The field practicum is offered over a six month period in the second year. According to a 2012 review, the eight course units contained 288 hours of lectures (19 credits) and the field practicum contains 144 hours of field work (three credits) totaling 21 credits, which is less than the 30 credits required for a National Diploma according to the Sri Lanka Qualification Framework (SLQF) of the Ministry of Higher Education. As such the diploma currently meets the standard NVQL5 specified in the Sri Lanka Qualifications Framework. Recently, the NISD collaborated with The Asia Foundation to revise the Diploma in Counselling (DipC). In November 2013, the NISD launched a Higher Diploma in Counselling (HDipC) with a view to further equipping practitioners with the skills they require to meet the needs of their clients.

In 2013, the study conducted on Counselling Assistants attached to the MSS observed that although the diversity and complexity of problems dealt with by the counsellors often exceeded the initial training they have received prior to recruitment, through self-study and access to ad hoc or supplementary training, the counsellors had sought to improve their skills and knowledge in order to serve their clients. It was noted that there was a lack of ongoing formal systematic support for counsellors but they had sought to mitigate this through informal arrangements amongst themselves and contact with other resource persons. Administrative supervisors and peers at a local level were seen

to be largely supportive of the counsellors and appeared to be appreciative of their work, even if they did not always understand it well.

Just under half of the counsellors attached to the MSS interviewed in 2013 had a degree in Psychology and the remainder had a degree in Sociology or another field in the social sciences. Again, roughly half the counsellors interviewed had followed a (part-time) counselling course (described as a diploma) over the period of one year at a private training institute. A couple of counsellors had followed or were following at the time of the study, shorter counselling courses at the NISD, and one had followed a diploma in counselling from the South-Eastern University. Apart from this, they had attended ad hoc one-off training events held by government and non-government institutions. Of those attached to the MCDWA, counsellors said that they had not received any training from the Ministry at the time of the interview. A couple of counsellors reported having no formal counselling training at all.

Several counsellors reported in 2013 that their private counselling courses were very helpful, although there were some comments that there was inadequate practical training in some of the courses. One counsellor admitted that s/he, "didn't remember much," from the counselling diploma, but that some of the skills learned were still being used. One said that that a previous job in the field of counselling had helped them learn new skills (i.e. use of puppets and art-based methods or motivational approaches) that were useful in her work as a counsellor. Another counsellor described being trained on the job by an experienced MSS counsellor, who had assigned cases to handle and mentored him/her for more than a year. S/he said, "I learned everything from her, otherwise I wouldn't have known what to do." Other counsellors with a counselling background said that their knowledge was 'refreshed' when working with the MSS counsellors. Roughly a third of the counsellors reported using self-study – via the internet or books – to advance their knowledge. Some also said that they enroll in training events whenever these are available.

In the 2013 study, counsellors also reported feeling able to deal with some problems (this view varied across counsellors), but said that they found it difficult to deal with others. Several said that they felt their knowledge and training was not satisfactory – considering the work that needed to be done. "My knowledge is limited. For example, I do not know how to help a person with drug abuse [problems]. [I] also do not know how to help in a case of a child abuse, sex- related matter, sex-related disorder or I even do not know to whom I could refer them," shared one counsellor. Another admitted to lacking confidence – "[I] don't know what to say, what not to say". One counsellor also said that she had limited ideas about how she could work with other departments and institutions beyond only increasing awareness of counselling services. This acknowledgement of their need for further training was commendable, and should be seen as a call for help and support.

The studies conducted in 2013 observed overall that the counsellors actively dealt with many serious psychosocial problems at a community level and, they were committed to their own professional development and improvement of the services they provide.

Continuing Professional Development (CPD) training was provided in the period 2014 to 2016 by the Ministry of Women and Child Affairs and the Ministry of Social Welfare and Primary Industries together with the support of The Asia Foundation. Over this two year period, three rounds of training, each preceded by a training of trainers was conducted.

The first phase of CPD training introduced the following modules designed to be delivered over a period of 14 contact hours:

1. Counselling Process, Assessment and Formulation of the Problem
2. Role and Scope of a Counsellor
3. Key Ethical Principles in Practice
4. Understanding the Purpose and Process of Self Care and Supervision for the Practicing Counsellor

The second phase of CPD training utilized the following modules designed to be delivered over a period of 12 contact hours:

1. Steps within the Counselling Process
2. Self Work - Self Worth
3. Egan's Skilled Helper Model
4. Intervention Techniques when Facilitating Family

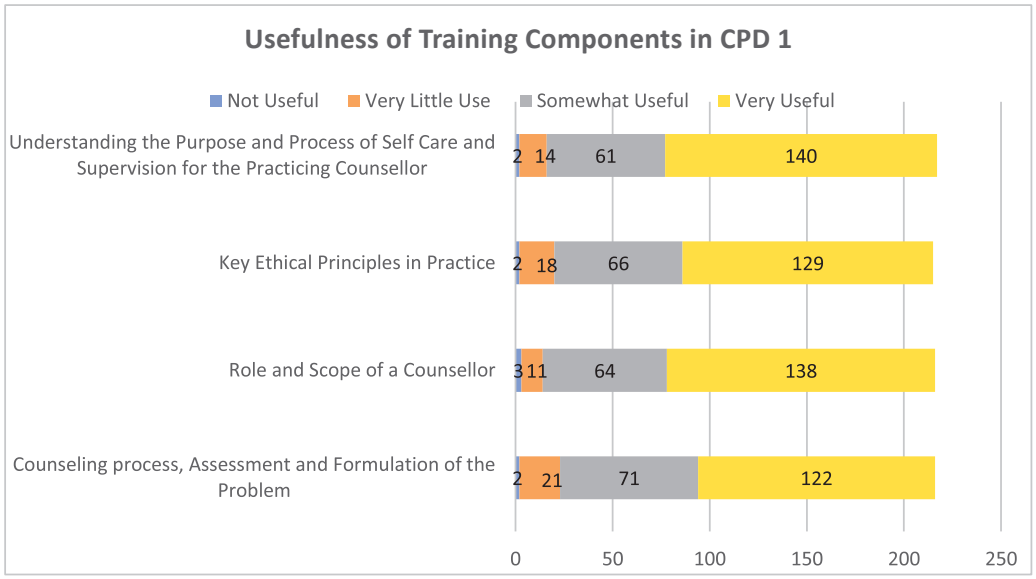
The third phase of CPD training consisted of the following modules designed to be delivered over a period of 12 contact hours:

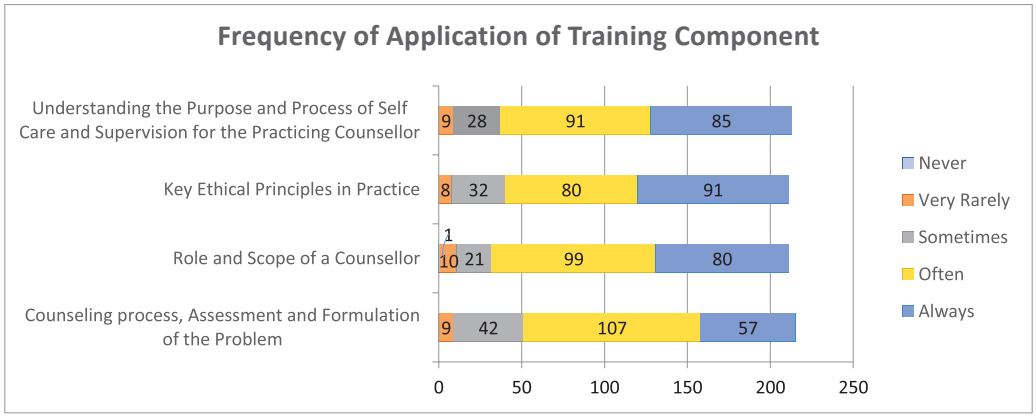
1. Engagement and Intervention Tools to work with Children and Adolescents
2. Couples Therapy

The CPD trainings were carried out through a cascade model of training, with a Training of Trainers (TOT) process preparing a group of counsellors to deliver training to all counsellors attached to both Ministries via 13 separate training sessions for each of the 3 phases of the CPD training over the period of the VTTP-II Program.

The 2017 assessment of the CPD trainings revealed that most counsellors were generally satisfied that it was conducted well, it was relevant to their work and reported positively on usefulness and level usage of the tools and techniques. Assessment results for the specific phases of the training are described below.

On the first phase of training, a total of 217 respondents (69%) indicated that they had participated in the first phase of CPD training whilst 61 respondents (19%) said that they had not. 89-94% of respondents found the training components of the first phase of CPD training either very useful or somewhat useful. Between 95-96% respondents indicated that they used content or learning from the components of first CPD training in their practice either sometimes, often or always.

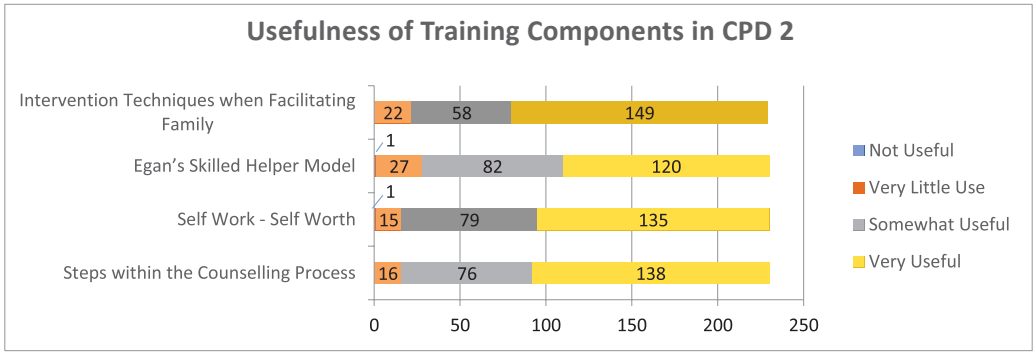


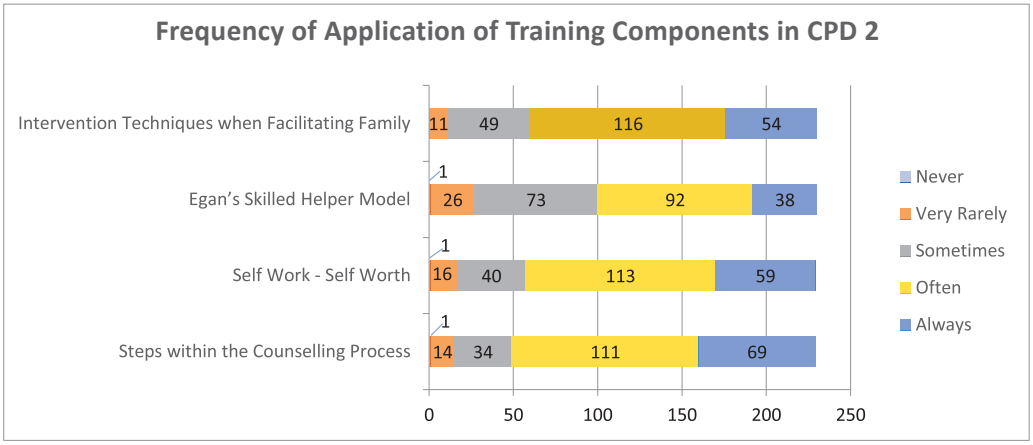


In the more detailed responses at the Galle FGD, participants unanimously agreed that this phase was the most useful of the three rounds of training provided. It was felt to be most easy to understand and adopt. The Kurunegala FGD participants identified that 'having a process' was the most useful learning and that this extended to feeling that they were part of a common system and did not feel 'alone'. They also noted that the assessment tools 'makes it very easy to explain progress to the client' In the Badulla FGD, participants claimed that the training had a major effect on the way in which they worked, especially on how they spoke with clients and sought to identify their existing strengths. In the Colombo FGD, a few more experienced participants reported that much of the content on counselling practice was familiar to them, but that the self-care component was entirely new to them - and this had a profound effect on their acknowledgement of their own emotional and psychological issues arising from their work. There were similar statements from participants at the Vavuniya FGD, who said that this training enabled them to manage their caseload better and work towards termination of counselling processes rather than keep clients on indefinitely. They

reported that the training on the counselling roles was very useful as they hadn't learnt this before and it was useful to understand that other counsellors faced similar issues to theirs. Understanding the limits of their role helped them to feel less guilt and be more satisfied with their work.

On the second phase of training, a total of 231 respondents (74%) indicated that they had participated in the second phase of CPD training whilst 57 respondents (18%) reported that they had not. 88-93% of respondents who participated in the second CPD training phase indicated that they found the training content either somewhat useful or very useful. Between 88-95% of respondents indicated that they used content or learning from the components of the second CPD training in their practice either sometimes, often or always.

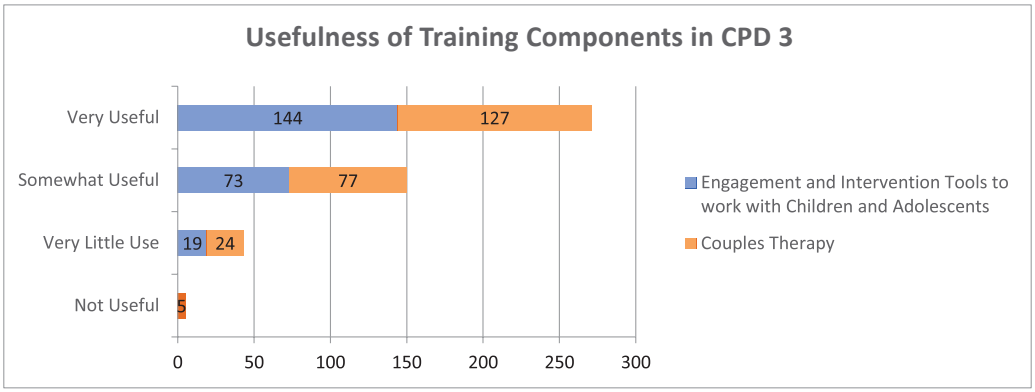


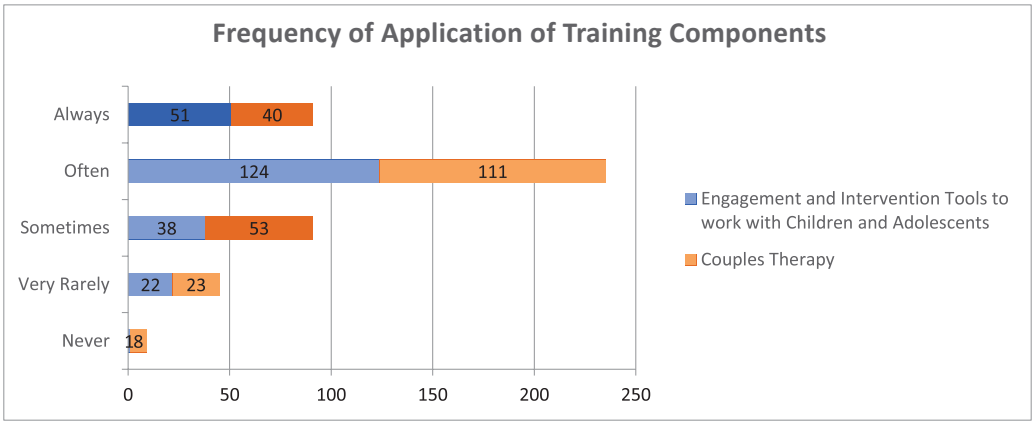


During one of the 2017 FGDs, some respondents had difficulty recalling the content of the second training. In another FGD, they said that they only had 1 day on Egan's Skilled Helper model, which was insufficient to learn how to use it. They said it was a good model but without a chance to use it practically, or without guidance when using it, it was difficult to apply - and that they had not used it as a result. At the Colombo FGD, an experienced counsellor articulated that learning the Skilled Helper model had been one of the most significant training inputs professionally in the person's training, as it helped structure and guide the counselling process in a way that they had not

been trained previously. It was also mentioned that in one location a participant had challenged the model for not being specific enough to the field of counselling.

Regarding the third phase of training, a total of 238 respondents (76%) indicated that they had participated in the third phase of CPD training whilst 54 respondents (17%) reported that they had not. Between 86% and 91% of respondents who participated in the third CPD training phase indicated that they found the training content either somewhat useful or very useful. The majority of respondents (86-89%) indicated that they used content or learning from the components of the third CPD training in their practice either sometimes, often or always.

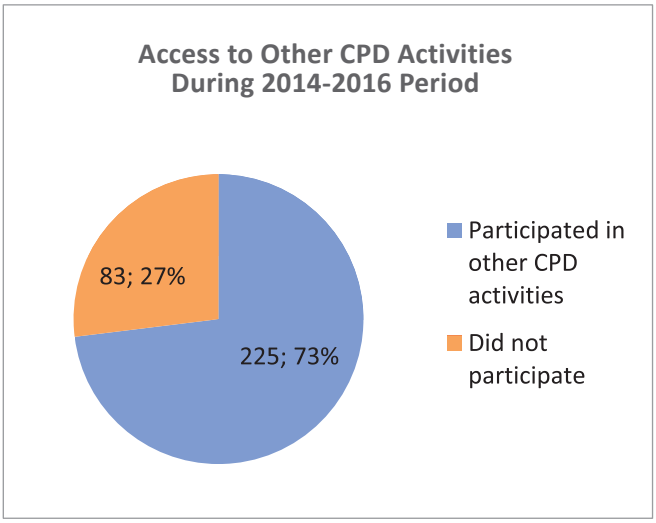




In the Kurunegala, Galle and Colombo FDGs, participants reported challenges in implementing the couples therapy techniques as introduced in the training although for different reasons. Some identified difficulties of bringing both parties together for counselling when only one person is seeking counselling assistance or when the other person has been compelled (by court, police or social pressure) to attend the counselling session. It was also discussed that in some non-urban settings, the techniques (especially the dialogues) were felt to be socially or culturally inappropriate, and participants felt that they would not be successful using them in the form they had been trained on - with one participant remarking that *"they will think we are crazy if we ask them to do this".* Despite this, at the Colombo FGD there was considerable appreciation for couples therapy as a very relevant area for their work - and suggestions were made

that it would be good if the trainers could help the counsellors adapt the approaches to the specific social contexts in which they worked. Kurunegala FGD participants said that they adapted the training to suit the specific cases and contexts that they deal with, and mentioned that it would be useful if future trainings are simple and draw on local cases and particularities of clients. Galle FGD participants mentioned that the 2nd and 3rd rounds of training were difficult to understand and they also did not have confidence in the trainers who delivered the training. One participant for example stated that when she had asked questions about the application of the technique, the trainer did not have a response. In the Vavuniya FGD, participants said that the third training was useful particularly to identify root causes, understand group/relationship dynamics and to explore how to manage conflicts of interest. They also said it was useful to have the opportunity to use their own cases, and also to learn from other participants.

The 2017 survey revealed that 73% of counsellors of both Ministries had accessed programs for their professional development outside of The Asia Foundation sponsored CPD programs.

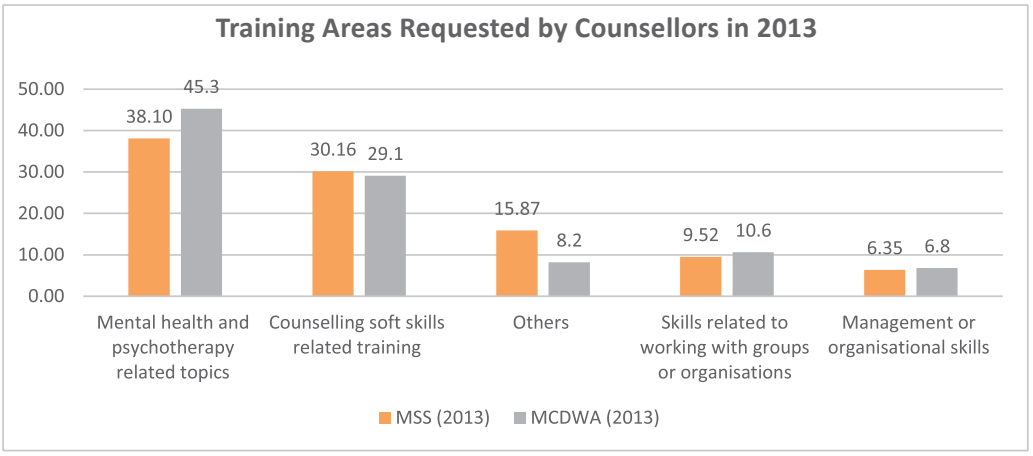


The general critique, if any, was that the extent or duration of the training could be improved and that more time would be useful for practicing the learning and to understand particularities of the cases or contexts of the trainees.

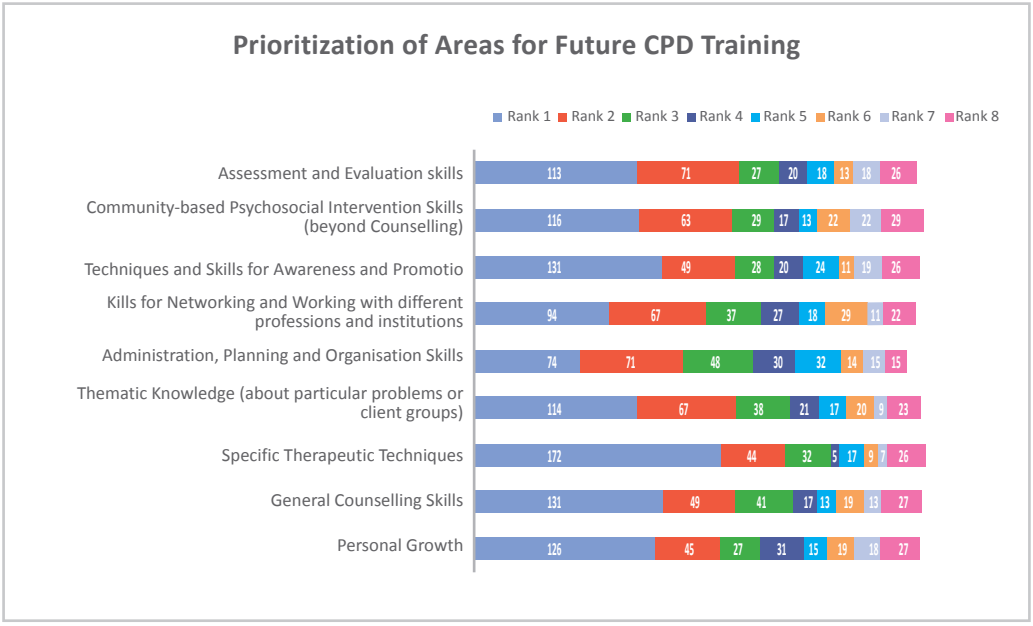
A peer supervision training was also delivered, targeting all counsellors attached to the respective Ministries. The trainings were aimed at contributing to the broader goal of improving service delivery in the counselling.

Counsellor Recommendations for Future Trainings

In 2013, the most common training areas requested were mental health and psychotherapy (38% by MSS and 45.3% by MCDWA) and counselling soft skills (30.16% by MSS and 29.1 by MCDWA).



In the 2017 survey responses, specific therapeutic techniques, techniques and skills for awareness raising and community based psychosocial intervention skills were identified as the most common areas highly prioritized for future training. Thematic knowledge about particular client groups or problems and general counselling skills were also prioritized. It was interesting also to note that personal growth and assessment and evaluation skills were also identified as areas in which respondents wanted to receive training. It appears that the demands of the state counselling role have revealed a need for skills training which are not purely based on counselling and related soft skills.



In FGD's conducted as part of the 2017 assessment, participants provided more details about their priorities for continuing development. The table below sets out the detailed responses from the FGDs against each of the areas for future CPD training ranked through the survey.

Training Area	% Ranking as highest priority	Details of training as requested by FGD respondents
Personal Growth and Development	40.6%	Participants felt they needed inputs in this area, but in a couple of FGDs, they mentioned the need to have this at a district level so that there aren't a large number of people - stressing the need for sensitivity around personal issues. In two FGDs, participants proposed the idea of having access to counselling services that are located outside their own system, so that the counsellors from both Ministries could approach them for support for their own personal problems and growth issues. There was a strong sense that such support could not be provided within their own system due to conflicts of roles/interest and risks to privacy.
General Counselling Skills	42.2%	In one FGD, participants said that many counsellors haven't been able to update their skills since they did their counselling diplomas, and that regular refreshers would be helpful. Some recently recruited personnel who did not have a strong counselling background also indicated the value of obtaining some grounding on counselling fundamentals, including those covered by Part 1 of the CPD Training. In another district, participants said that they didn't have adequate experience or knowledge to run group counselling sessions.
Specific Therapeutic Techniques	55.1%	FGD participants in one district asked for further training in specific psychotherapeutic approaches. They said, "Psychiatrists ask us what psychotherapy techniques have you learned. We struggle to respond to what doctors ask us to do." They said that they currently look up content on psychotherapeutic approaches like cognitive behavioral therapy and rational emotive therapy on YouTube. Participants in another district also asked for training on psychological methods.

Thematic Knowledge (about particular problems or client groups)	36.8%	FGD participants indicated that they meet clients with a wide range of problems that require basic knowledge across a wide range of disciplines (i.e. disability, legal issues, relationship issues and abuse, etc). Some participants suggested it would be helpful to have a framework to know how to navigate their roles when presented with such diverse client problems. One area that FGD participants highlighted was child mental health problems. School-related problems were common and challenging to deal with, whether to do with developmental challenges like dyslexia, autism, behavioral or family issues. They spoke about their needs to be better able to identify what children's problems are, to know where to refer children to for specific support, and to know how to assist families to support children with specific problems. In the Badulla FGD, the need for training on disaster related MHPSS support was mentioned. This emphasis was due to the relevance of regular landslide and flood related hazards. The following areas were also highlighted: ● How to deal with challenges related to new technology, including 'addiction' to computer games, mobile phones and Facebook. ● Methodologies to intervene on suicide, family violence, school issues, intimate partner/ relationships, communication skills. ● Methodologies for behavioral change. ● Early childhood development methods for parents. ● Sound therapy. ● Working with children in institutional care. ● Counselling for elders, HIV Aids patients, cancer patients and their families. ● Common legal issues facing clients. ● Drama and art therapy. ● New insights related to the younger generation and changing social conditions.

Administration, Planning and Organizational Skills	24.7%	Some FGD participants from the MWCA mentioned the need for skills related to proposal development, including both project design and proposal writing, because they have to undertake projects for their Ministry.
Psycho-Education Skills	42.5%	Some FGD participants indicated the need for knowledge, materials and skills to better undertake the 'awareness' activities that they had to conduct in a variety of community settings. Amongst the areas they identified for special attention were the following: ● Family relationships: how to relate, deal with problems, manage anger, communication, dealing with other (extra-marital) relationships and responding to external pressures/temptations. ● Early marriage and relationship management for young persons. ● Prevention of drug use. ● How parents and teachers should respond to children's problems. ● Psycho-education relating to debt management as a result of microfinance schemes. ● Community awareness approaches to suicide prevention.
Community-based Psychosocial Intervention Skills (beyond Counselling)	37.2%	Counsellors at the Badulla FGD mentioned the need for community-level interventions to address complex social problems that they encountered, and the need to work in multi-disciplinary teams to implement these. They spoke about areas where a chronic kidney disease had made families very vulnerable, and asked for training on how to design and implement relevant interventions for the specific problems in their respective areas of responsibility. They articulated the need to be able to address factors that produced psychosocial problems, illustrated by, *"Whatever we do [in terms of] counselling, we can't do much about child abuse or violence in line-rooms and so on, where the conditions in which people live have a direct [contributing] impact on the problems."*

"Whatever we do [in terms of] counselling, we can't do much about child abuse or violence in line-rooms and so on, where the conditions in which people live have a direct [contributing] impact on the problems."

FGD participant, Badulla, 2017

Other Topics

The 2017 FGD participants also highlighted other areas or issues related to training and professional development that went beyond the categories identified in the survey.

Some of these FGD participants expressed an interest in learning more about yoga and self-care practices, and even offered to pay for it themselves to get resource persons to come and train them. Others expressed a desire to learn about ways of protecting themselves and being safe in the context of risks from potential threats from disturbed or violent community members or clients.

In two locations, there was a request for language skills training. Counsellors in Kurunegala asked for Tamil and English courses. In Badulla, counsellors who were predominantly Sinhala speaking mentioned the problems they faced in working with the Tamil-speaking communities. They were not satisfied with communicating through translation, highlighting that they could tell when the translators don't do a good job in communicating with and connecting to their clients or the awareness program audiences. In one location, there was a request to provide opportunities for counsellors who were interested in developing specialized skills such as sign language to access appropriate training.

In one FGD, participants asked for training on how to manage when there is no one to refer clients to. They highlighted both the lack of services for people with specific problems, and also situations where officers who are responsible for a particular issue (i.e. elderly persons for example) did not have the skills to deal with their clients' problems.

Overall, there was a general interest in gaining access to new knowledge and approaches, which seemed to underscore a sense of having limited avenues for professional growth. Some respondents articulated the need to establish ways of gaining access to new knowledge.

Counsellor Recommendations for the Modality of CPD Training

The 2017 FGD participants made the following suggestions to improve future training delivery:

a) When designing CPD manuals in the future, try to use local case studies and engage counsellors from diverse contexts in the design process, so that the manuals cater to their experiences and can ensure that the tools are practical.

b) It would be easier for the counsellors if training could be conducted locally, as travel to attend training is tiring and not optimal for participants from far away. Women especially, have to manage additional family responsibilities at home when they attend residential training, and it is challenging for those who do not have adequate family support to leave dependents to attend a training.

c) Despite a desire to have training delivered at district level, there are concerns about difficulties in sourcing experienced and specialized resource persons to deliver training in rural districts. The option of having a video recording of a lecture or demonstration by the expert resource person and a local training session facilitated by their assistant was discussed as a solution to this problem.

d) Don't try to put too many subjects into one meeting or program when designing trainings. It is instead better to focus on one that can be learned properly.

e) Teaching methodologies need to be practical and applied. Opportunities to practice and get feedback are also needed.

f) It would be interesting to have a session every 3 months with someone who has experience.

g) Conduct the program in Tamil for Tamil speaking participants, but if an interpreter is needed try to ensure that the interpreter is also a practitioner.

h) When selecting participants, attention needs to be given to status and dynamics within training groups, as there are some individuals who will be inhibited from talking/sharing at trainings.

Peer Supervision

The Aim and Scope of Peer Supervision

Peer supervision was introduced to the counselling services of the two Ministries with the aim of achieving the following outcomes: (a) the development of reflective capacities (this would include greater awareness of one's own learning needs, therapeutic barrier and one's emotional wellbeing, which could be exacerbated due to vicarious trauma and distress of client stories (b) advancing one's own knowledge and skills, and most importantly, (c) improving the quality of one's therapeutic work[2].

Peer supervision was designed and introduced to include the following components:

(a) Presenting the key issues to conceptualise a case,

(b) Fostering an empathic perspective for the client,

(c) Fostering an awareness of oneself as the counsellor and fostering empathy for the person in this role,

(d) Perspective sharing, and

(e) Fostering a strengths-focused approach.

The model was introduced in 2014, and government circulars endorsing the professional value of clinical supervision and mandating counsellors to engage in peer supervision every month at their monthly review meetings were issued in 2015 by the Ministry of Social Welfare and Primary Industries and in early 2016 by the Ministry of Women and Child Affairs.

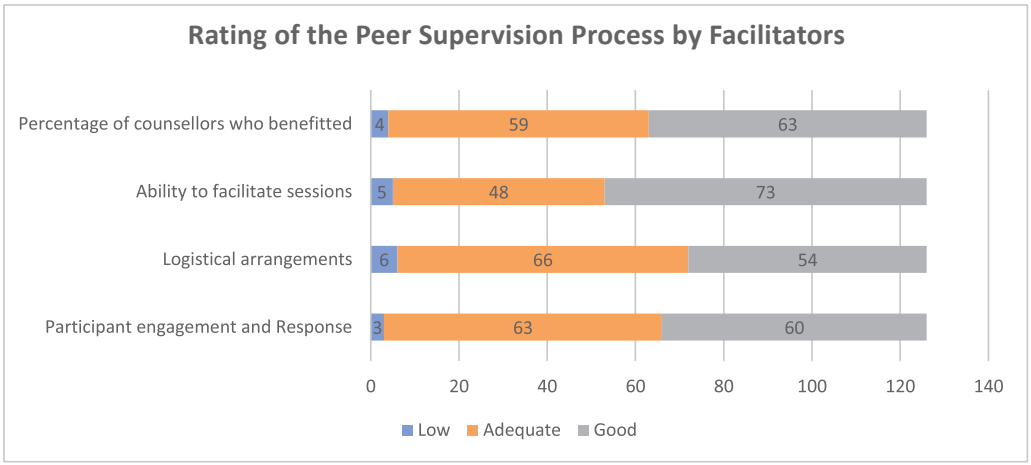
A core group was trained on the peer support model through the means of three TOT programs over the course of three years. The training programs were conducted in 2014, in August for the Ministry of Social Services and in June for the Ministry of Women and Child Affairs. Once the model was introduced to counsellors in all the districts, two follow up training programs were conducted after a 6-month period (2015: MSS - Jan, MWCA - March) and again 12 months later (2016: MSS - Jan. MWCA – Feb).

Assessment of the Peer Supervision Practice

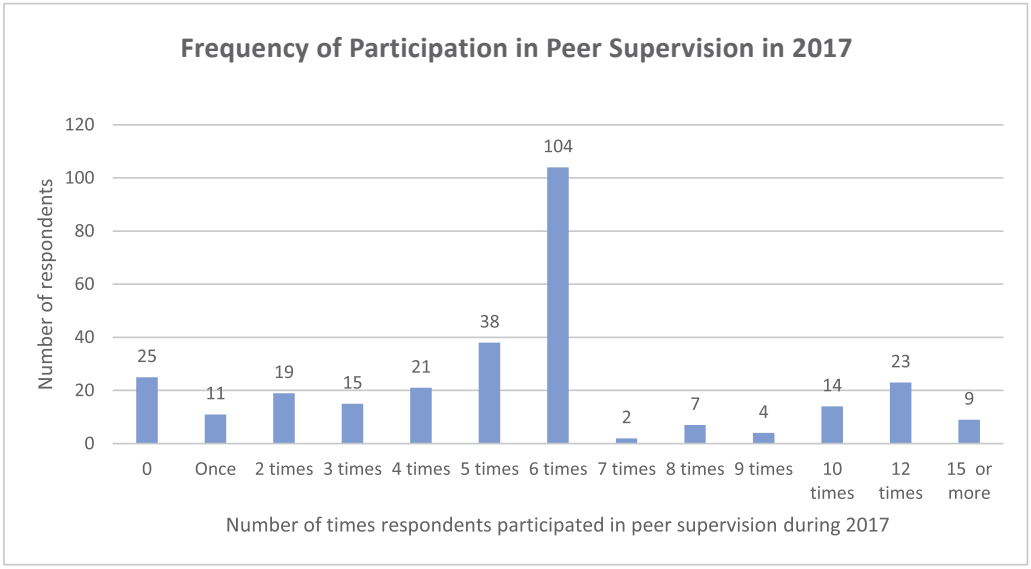
The 2017 assessment study focused on understanding whether the practice had been adopted by the counsellors, whether they found it to be beneficial and what obstacles, if any, they faced in implementing the practice.

The respondents to the 2017 self-administered survey had an overwhelmingly positive view of the practice of peer supervision, based on the previous occasion in which they had facilitated a peer supervision session. They gave a rating of 96-98% for the benefits to counsellors, participant engagement and involvement and their own ability to facilitate a session, while also rating that arrangements for the session were good or

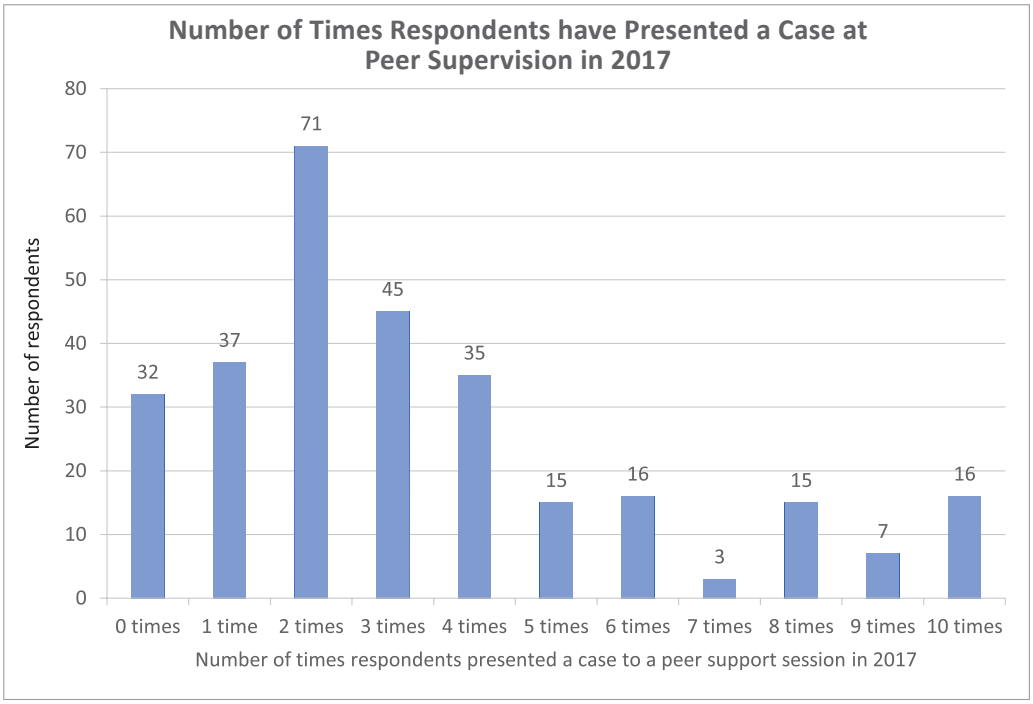
2 Piloting a Peer Support Mechanism for Counsellors in Sri Lanka: Focusing on the State Sectors for Social Services, Women and Child Affairs, The Asia Foundation, Sri Lanka, 2017.



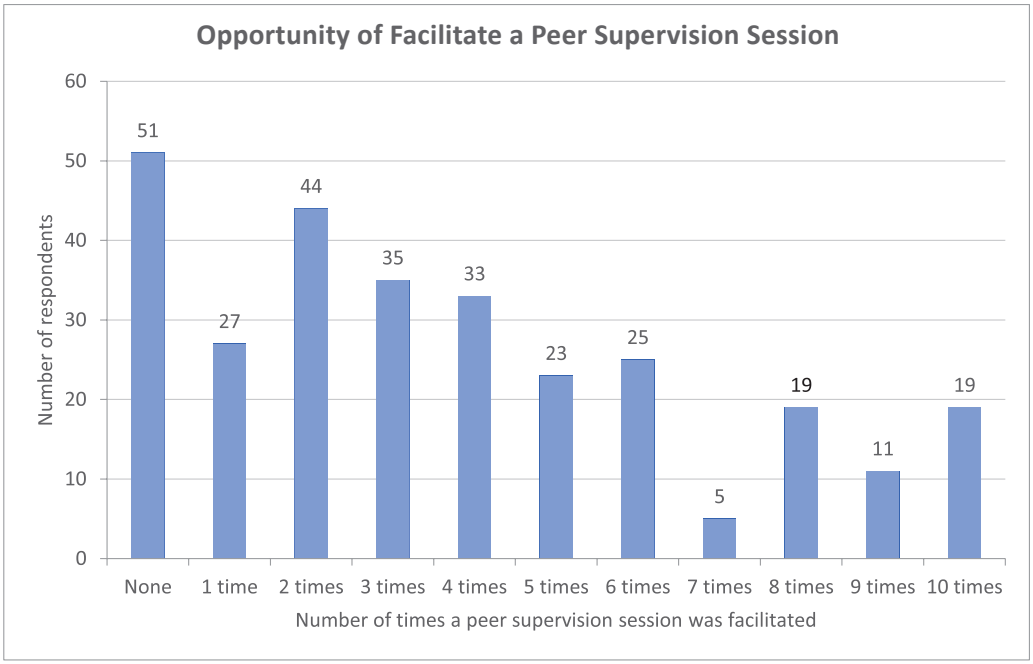
adequate.The survey also revealed that only 11% of counsellors were able to participate in peer supervision sessions at least once a month. 53% participated in at least six sessions in the year, and 8.5% of the respondents were unable to participate in any peer supervision sessions. During the FGDs, some counsellors stated that reasons for non-participation included being on extended leave and not having a District Coordinator to convene sessions. Some respondents also cited inadequate numbers in their district to hold meaningful sessions or other logistical barriers to bringing counsellors together.



In terms of presenting a case at a peer supervision session, 32 respondents (11% of the respondents) had not presented a case in 2017, and 71 respondents (24% of the respondents) had presented a case twice during the course of the year. 16 respondents (5% of the respondents) reported having presented a case 10 times during the year 2017.



34.9% of respondents had an opportunity to facilitate 5 or more times during 2017, whilst 17.4% did not have the opportunity of facilitating a single session.

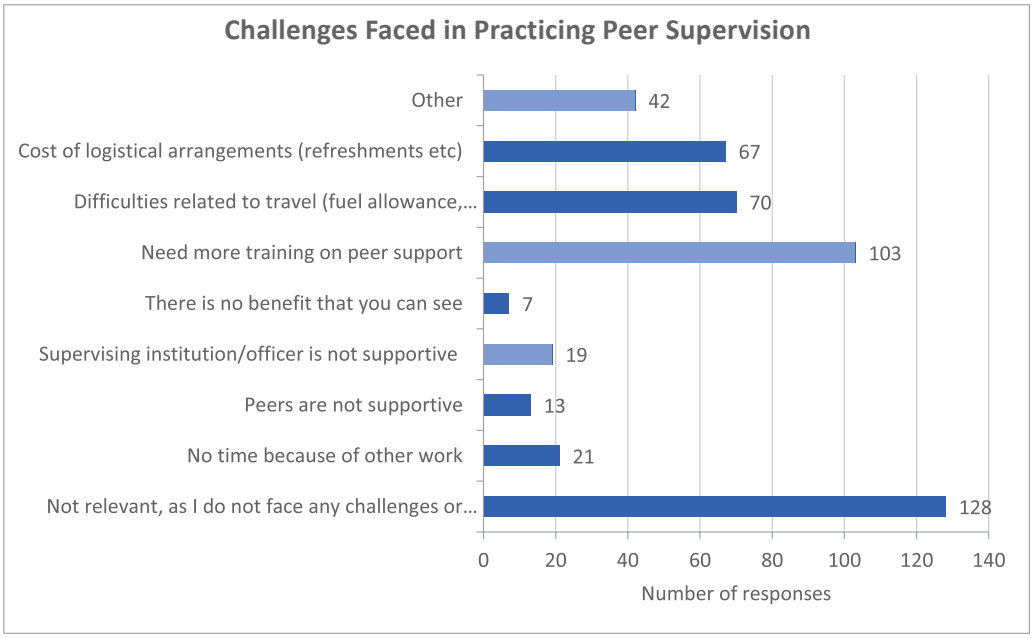


The responses on the practice of peer supervision varied across the geographical locations in which the FGDs were conducted. Peer supervision was widely felt to be a useful practice, and was typically organized with counsellors from a single Ministry.

Kurunegala and Galle reported a strong and regular practice of peer supervision sessions. Respondents from Galle viewed peer supervision as an institutional requirement and described this as a fixed item on the agenda of monthly progress meetings, where two counsellors would routinely present challenging cases to their peers. They also sent a report of sessions to the Ministry as part of their progress meeting minutes. The practice of peer supervision in Kurunegala had been built in to incorporate a process of identification of areas requiring further expertise and subsequent organizing of programs to improve counsellors' understanding of those identified difficult or emerging issues. The participants of the Badulla FGD reported difficulties in conducting peer supervision sessions on a monthly basis due to complications in finding convenient times and securing the attendance of adequate numbers of counsellors to make the sessions viable.

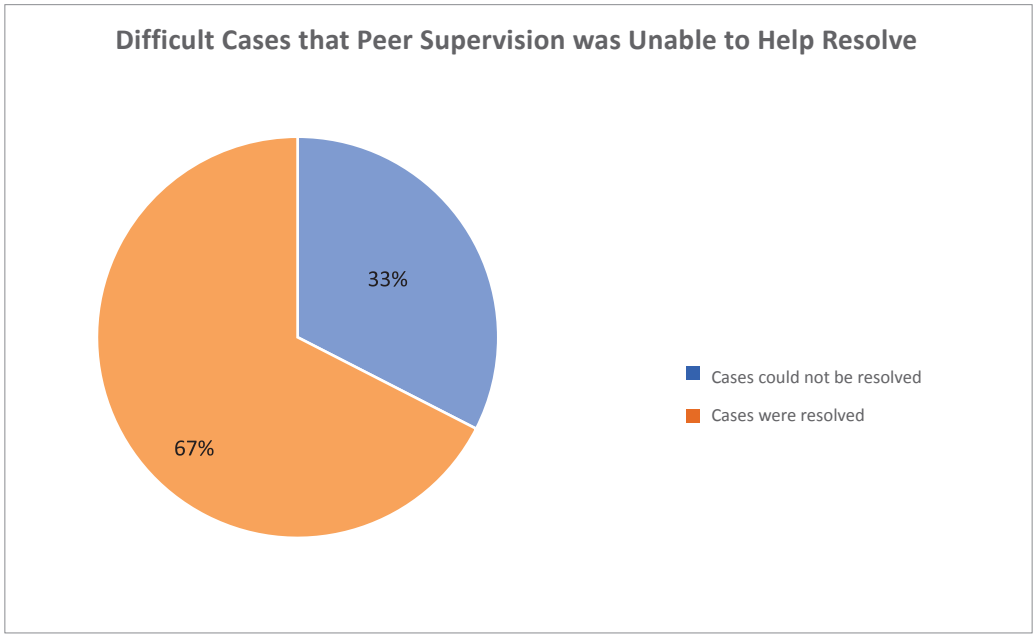
Barriers to adopting the practice as routine were identified as a lack of institutional administrative support such as the provision of an allowance or refreshments to accommodate the session (Kurunegala). Participants from the Kilinochchi FGD stated that in their experience a minimum number (6-7) of counsellors were required to successfully engage in a peer supervision session, further stating that this was fortunately possible in their context. In contrast, the Vavuniya, Puttalam and Mannar FGD participants reported that the low numbers of counsellors (1-6) available in each district for peer supervision sessions was a barrier to holding sessions that yield useful ideas for improving their practice. They also mentioned constraints of cost and effort that inhibited regular sessions for counsellors across the Districts of the Northern Province to come together for peer supervision. Further, some counsellors attached to the MWCA in the Northern Province were not aware of the circular mandating that they conduct monthly peer supervision sessions. Participants at the Vavuniya FGD also reported that at the monthly meetings they spent a lot of time filling forms (client intake forms) and as a consequence there was less time available for peer supervision sessions. The institutional commitment to peer supervision, in terms of provision of facilities to support the practice, appeared to be strong from the MSWPI.

The survey results shown in the figure below indicate a wider range of challenges to peer support. A significant number (43%) of the respondents did not face any challenges to the practice. 103 respondents (35%) identified the lack of adequate training on peer support as a challenge to the practice. The other significant challenges included difficulties with travel and the lack of logistical support.

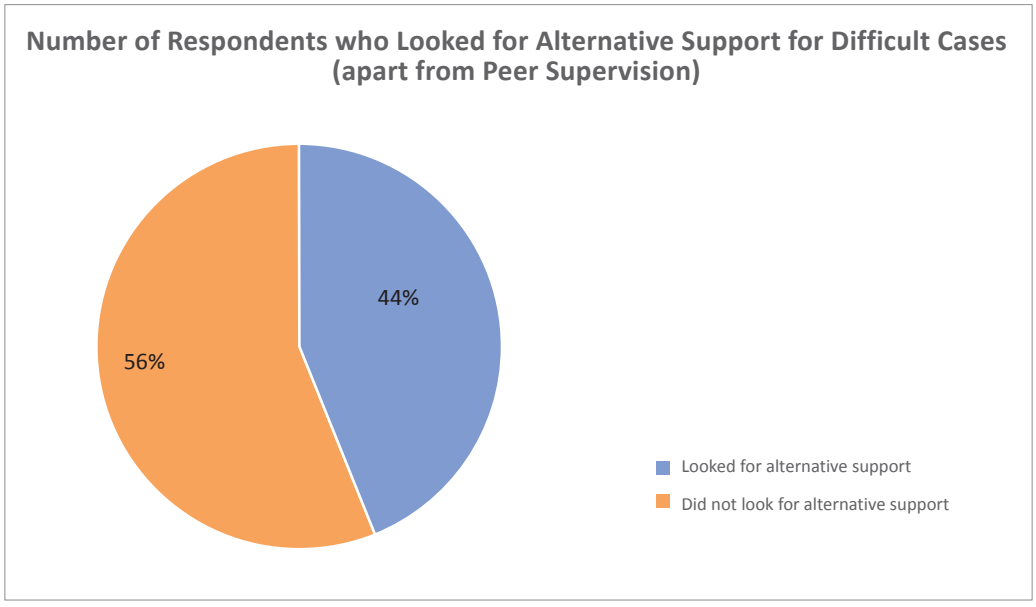


Identifying the problem, improving empathy (as a means of gaining insight into the client's problem), generating new ideas for how to tackle difficult cases and summarizing a case for presentation were four areas that respondents of the FGDs reported as having improved as a result of peer supervision. The identification by one of the FGD groups that they required a counselling mechanism for themselves would also indicate a level of reflection on one's own emotional wellbeing, which was an aim of the peer supervision practice. Participants at the Galle FGD reported that the peer supervision sessions were useful as they helped them to discuss new problems and benefit from a sharing of ideas towards tackling them. Discussion was felt to be useful in connecting counsellors over common problems and sharing and discussing strategies for tackling them. The Badulla FGD reported that the sessions helped improve trust amongst themselves and to have faith in the ability of others to assist them in their practice. Peer supervision sessions were seen as providing opportunities to receive positive reinforcement (i.e. "learning about what I have done that was good") and improving self-confidence.

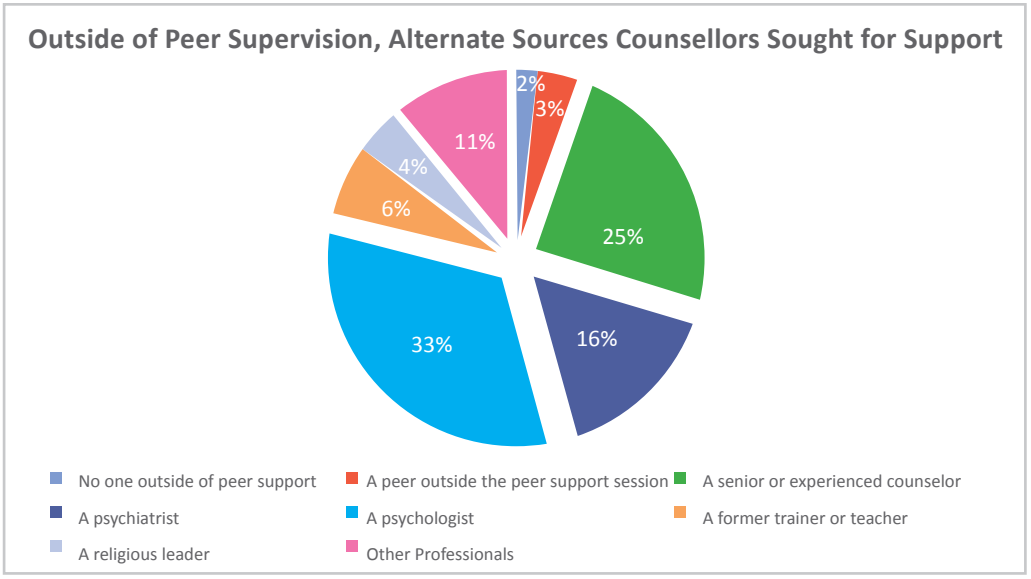
Other observations on the peer supervision practice included respondents stating that it was difficult to involve other state sector personnel involved in counselling work who were not attached to the two Ministries (MSWPI and MWCA) because these other counsellors (i.e. Child Rights Promotion Officers, Women Development Officers, NCPA Psychosocial Officers, etc.) used different approaches to counselling, although many of them had followed the NISD Diploma in Counselling. Participants observed that these other 'counsellors' were more focused on solving problems using a variety of other means as opposed to using a strict counselling approach. The fact that these other personnel had either a legal function or another role distinct from that of providing counselling services was cited as a reason for this lack of involvement, by the respondents at the Vavuniya FGD.



Almost half of the respondents looked for support on difficult cases outside of the peer review process. This self-motivated approach demonstrates that counsellors are looking for sources of support on difficult cases.



The figure below indicates who the counsellors accessed for additional support, this mainly included senior counsellors (25%), psychiatrists (16%) and another professional (11%). The FGDs indicated that the 'other professionals' included lawyers, the National Women's Committee and other state officers such as Child Rights Promotion Officers (CRPOs).



Overall regular peer supervision was reported as a useful part of the practice. Many respondents of the FGDs agreed that peer supervision could be a useful means of identifying issues of importance for future trainings. At one FGD, respondents reported that it would be useful to have relevant expertise on the day the session was conducted.

Regular observation and monitoring of peer supervision sessions would be a strong motivator and source of feedback for the group.

Participant, Colombo FGD, 2017

'My colleagues and I have matured as counsellors over the past 2 years, and as a result the way they used the peer supervision sessions had also evolved'

Participant, Vavuniya FGD, 2017

The recommendations made by the 2017 study regarding peer supervision were as follows:

a. Re-circulate the 2016 circular on peer supervision to MWCA counsellors in both Sinhala and Tamil.

b. Secure administrative support such as approval of transport allowances and refreshments to remove barriers to the regular conducting of peer supervision sessions.

c. Create opportunities for all counsellors to present cases at peer supervision sessions. A low but significant proportion (11%) of the respondents had not presented a case in 2017.

d. Address the situation of low numbers of counsellors available for peer supervision sessions in a given area by (a) identifying areas with low numbers of counsellors and (b) developing strategies to ensure sufficient numbers of counsellors can join each session, including providing for combined sessions for both MSWPI and MWCA counsellors.

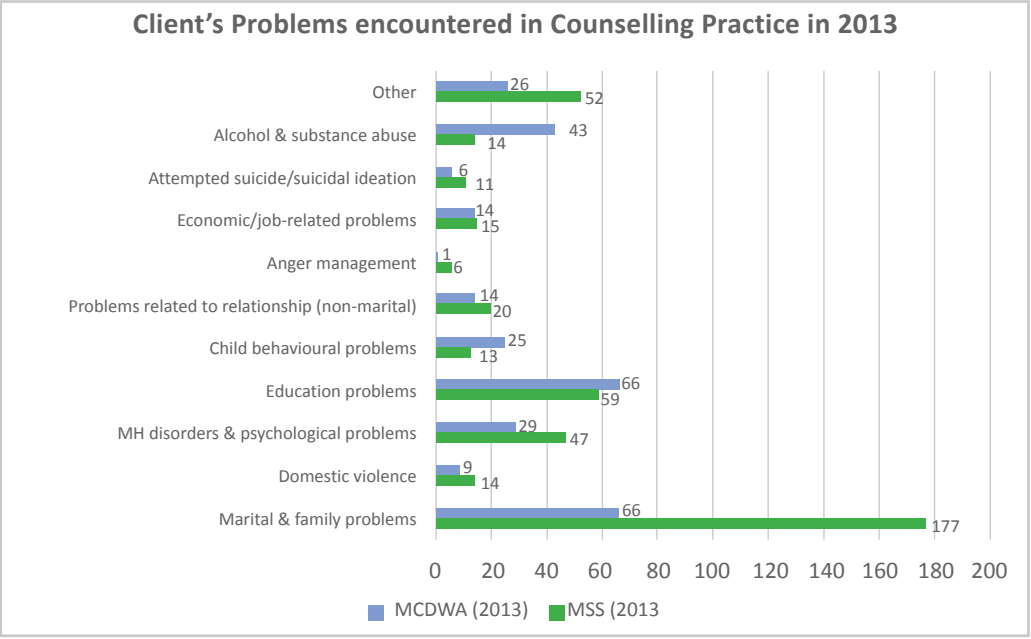
e. Develop a pool of senior counsellors/resource persons that the District Coordinators can access and directly coordinate with and invite to the peer supervision sessions if needed. The pool may also be able to provide assistance to counsellors seeking support for a difficult case outside the peer supervision session.

f. Launch a series of refresher sessions on peer supervision, possibly targeting facilitators - to focus on other skill component techniques such as giving positive feedback, receiving feedback, understanding own emotions and developing a plan for next steps.

g. Document and utilize information from peer supervision sessions to inform future trainings.

Problems Presented to State Counselling Service

Problems Presented in 2013



Marital and family problems dominated client problems and descriptions of the issues relating to this category include, but are not limited to: divorce, separation, conflict between spouses and also amongst other family members, extra marital relationships and experiences of marital neglect.

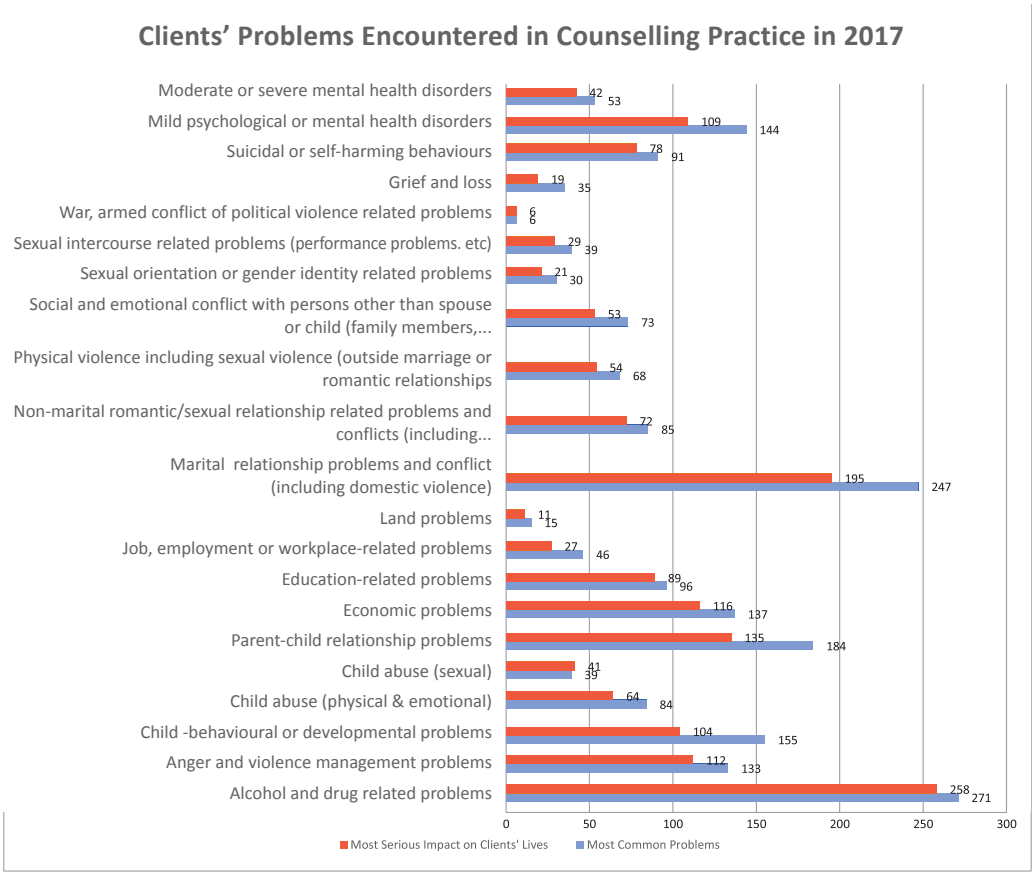
Educational problems were the second most common category. This category covered the following issues: refusal to attend school, disruptive behavior, poor educational performance, learning difficulties, fear of going to school, and loss of interest in, or difficulty pursuing continuing education.

Mental health disorders and psychological problems were categorized together since it is difficult to differentiate between the two categories without a definite diagnosis and problem definition. Under this category, there were reports of depression, anxiety, grief, stress, fear of social situations, insomnia, poor self-care, obsessive compulsive behavior, paranoid thoughts, 'abnormal behavior' and loss of memory.

It is critical to note that these categories are not mutually exclusive and that there is some overlap (i.e. educational problems and child behavioral issues). In addition, differences in the level of detail provided by respondents also limited the ability to differentiate problems beyond these given categories. Coding was done on the basis of problem identification by clients and counsellors. The numbers and diversity of problems presented in counselling suggests that counsellors are a viable source of support for a range of problems, including those of an intimate nature. The preponderance of

marital, family and relationship problems suggest that a focus on these in training and ongoing skills development would be useful. Similarly, a focus on educational and behavioral problems could be helpful – although as with mental disorders and serious psychological distress (including suicidal behavior and substance abuse) there would need to be clarity on how counsellors work in conjunction with other appropriate professionals to support clients. This would also be the case in terms of situations of potential or actual violence and sexual abuse, where cooperative links with other services would be essential.

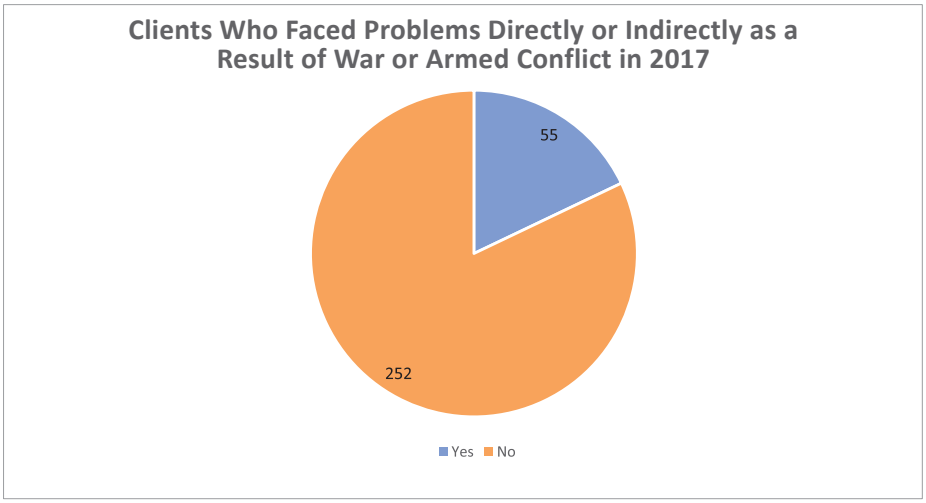
Problems Presented in 2017



89% of respondents indicated alcohol and drug related problems as a common issue encountered by clients they had met. The other frequently identified common problems were marital relationship problems and conflict (including domestic violence) (79%), parent and child relationship problems (59%) and child behavioral and developmental problems (50%). Alcohol and drug related issues was also the problem which was perceived by the highest number of respondents (82%) as having a serious impact on the lives of their clients. Other problems identified as having a serious impact on the client were marital relationship problems (including domestic violence) (62%) and parent and child relationship problems (42%).

Client Problems Related to Armed Conflict (reported in 2017)

In 2017, the majority of counsellor respondents (82%) reported that they did not encounter clients whose problems were either directly or indirectly related to experiences of war or armed conflict, while only 18% of the respondents to the survey responded positively.



Of the respondents who encountered clients with armed conflict related problems, it was reported that the clients' experiences spanned a wide range of types of events, life circumstances and forms of violence. Loss of livelihood and loss and/or destruction of home and other property were the leading types of conflict faced by clients followed closely by experiences of displacement and ill health.

Systematic Literature Review on Post-War MHPSS Problems in Sri Lanka

Methodology for Literature Review

The initial review included articles and publications focusing on mental health and psychosocial (MHPSS) issues in Sri Lanka in the period 2007-2017. Two research assistants curated the articles in the period October and November 2017, using academic databases, online websites and articles accumulated by the Good Practice Group (GPG) and The Asia Foundation (TAF). Included were a variety of articles and publications including systematic literature reviews, research studies utilizing different quantitative and qualitative methodologies such as case studies, process studies, interviews, randomized controlled trials, non-randomized studies, uncontrolled before and after studies, as well as book reviews and research summaries. There were no restrictions on population groups, assessment or measurement tools, analytical tools or methods, or outcomes. The search was conducted only for literature published in the English Language.

The key words utilized in the initial search for relevant literature were as follows: *psychosocial, mental health, counselling, trauma, healing, psychological, distress, emotional health, disorders, suicide, feelings, substance abuse, developmental problems, and social problems.* The broad and inclusive terms were intended to reflect the diversity of the MHPSS field and to increase the capture of all relevant literature.

Free text searching on Google and Google Scholar was employed, as well as using the search filters on the academic databases and online sites to explore and identify literature relevant to the key words and search terms. The only two filters added to these initial searches included location (restricted to Sri Lanka) and time period (2007-2017).

The following academic databases were searched: PubMed, PsycINFO, AnthroSource, JSTOR, and PILOTS. Additionally, the resources repository on the online platform for mental health practitioners (MHPSS.net) and that of the journal, Intervention, were also searched. Finally, the research team perused the archives on GPG and TAF for MHPSS related publications.

All articles and publications identified through the search strategy outlined above were downloaded into a folder. A total of 10,163 articles and publications were collected, of which 9,531 were obtained through academic databases, 457 from the websites, and 175 from other sources. The abstracts and executive summaries were manually screened in two stages for literature relevant to the research's inclusion criteria; at the first stage, 3,018 were selected and 7,415 were excluded and in the second screening, 582 were selected and 2,436 were excluded.

The final screening of the literature focused on identifying those articles and publications that broadly and directly assessed the prevalence and/or incidence of MHPSS issues in

Sri Lanka; all 101 of the 580 that met these criteria were selected for this literature review. 8 were discarded as duplicates, leaving 93 in the final selection.

For the selected literature, data was extracted on the population groups, the type of studies conducted, the assessment tools used and the results/outcomes obtained in relation to prevalence of the MHPSS issues examined. This data is presented here, with the aim of providing an overview of the literature focusing on the prevalence and incidence of MHPSS issues in Sri Lanka, identifying gaps in the current literature, and examining the prevalence and/or incidence of MHPSS issues for the different population groups. The data was analyzed through manual means, focusing on the information provided. No statistical analyses or quality assessments were conducted on the data obtained.

Analysis of the Literature Review

Children and adolescents

The literature on children focused on establishing prevalence rates of mental health problems and psychopathology for the general population of children and adolescents and an understanding of the association of MHPSS impacts of specific situations on children. These specific situations include tsunami and conflict, child abuse and domestic violence, and parental international migration. The majority of papers produced in the last decade focused on post-emergency settings and on violence against children especially that which takes place within families.

Most of the studies assessing MHPSS issues in children have relied on screening measures for psychiatric morbidity and psychopathology, such as the presentation of symptoms associated with PTSD, depression and anxiety or on problematic internalizing and externalizing behaviors (e.g. Agampodi, Agampodi & Fonseka, 2011; Catani, Jacob, Schauer, Kohila & Neuner, 2008; Soysa & Azar, 2016). The meaning of these symptoms and the consequences of their manifestation in the everyday lives of the children, families, teachers and schools have been less well studied. Only a few studies have attempted to present a more locally grounded conceptualization of the problematic and distressing consequences for children in post-emergency settings (Emmanuel, Wettasinghe, Samuels, Thambaiah, Rajendran & Galappatti, 2014; Jordans, Tol, Sivayokan, Reis, de Jong, 2016; Somasundaram & Sivayokan, 2013; Wettasinghe, Emmanuel, Samuels & Galappatti, 2015).

A comparatively smaller number of research studies have investigated the factors that contribute to, sustain and exacerbate children's distress and functional difficulty in these post-emergency settings, with family violence, paternal alcohol abuse, maternal mental health and extreme adversity or deprivation demonstrably having a significant impact on children's coping abilities and their psychosocial wellbeing. Moreover, there appears to be a growing consensus on the importance of recognizing and ameliorating the impact of the daily stressors on children in postwar and post-disaster contexts.

Socio-demographic details of children in the studies

With the exception of one study on preschool-aged children (Samarakoddy, Fernando, McClure, Perera & de Silva, 2012) and another involving those in middle childhood (Ginige Tennekoon, Wijesinghem Liyanage, Herath & Bandara, 2014), most research studies were conducted on children in late childhood and adolescence aged between 12-16 years. In the majority of studies, children were recruited through schools via a process of multi-stage cluster sampling of schools in pre-selected districts. The justifications provided within the literature for the dominant focus on schools are that rates of school attendance are very high in Sri Lanka meaning the number of excluded children will be small and that the well-established schooling system facilitates both easy recruitment and administration of the research tools.

However, these, point to a number of gaps in the available literature on children: firstly, there is a dearth of literature on the prevalence and nature of MHPSS issues for children in the stages of early and middle childhood, and secondly, the rates for a highly vulnerable and at-risk group, i.e. children who are frequently absent or have dropped out, are unlikely to be accounted for in the research studies. Indeed, one study indicated that absenteeism is higher amongst children who experience mental disorders or who have had exposure to the tsunami (Siriwardhana, Pannala, Siribaddana, Sumathipala & Stewart, 2015). A third limitation is that of precluding a better understanding of children in their natural family, community and non-school settings. A few of the studies have incorporated parent and/or teacher reporting and rating of children's behaviors, nonetheless that parents were contacted through schools may result in some reporting biases.

Although all of the studies considered gender as a variable in their analyses for the prevalence rates of MHPSS and psychopathology in post-emergency settings, there appeared to be no notable differences in the rates of emotional distress and problematic behavioral conduct between boys and girls (Hamilton, Foster, Richards & Surenthirakumaran, 2016). One study of children in non-emergency contexts showed that girls were more likely to report higher levels of depression and anxiety (Rodrigo, Welgama, Gurusinghe, Wijeratne, Jayananda, & Rajapakse, 2010). Differences, however, have been noted in a smaller number of studies in how distress manifests itself in emotional, relational and behavioral difficulties for boys and girls. Girls were more likely to engage or report in problematic internalizing behaviors whilst boys were more likely to exhibit or report problematic externalizing behaviors, as conceptualized in the SDQ and other similar assessment tools (e.g. Samarakoddy et al, 2012). The only study that examined an issue gender-specifically within the reviewed literature on childhood was on assessing the prevalence rates of child sexual abuse amongst girls (Shanmugam & Emmanuel, 2010). Girls were also shown to be primarily vulnerable to forms of child abuse such as early child marriage and child sexual abuse (Sathiadas, Mayoorathy, Varuni & Sri Ranganathan, 2017), and one study found that girls and young women were more likely to kill themselves than boys and men in the age range 0-19yrs (Rodrigo, Owada, Wainer, Baker & Williams, 2013).

MHPSS in post-emergency contexts: war and tsunami

Only a small number of studies have directly reported on the prevalence rates for MHPSS issues in post-emergency contexts, with most of them examining and presenting those factors which correspond to moderate post traumatic emotional and behavioral distress. Studies conducted in Galle and Hambantota districts had a focus only on post-disaster situations. Studies in other tsunami-affected areas, such as in Ampara and Jaffna districts, contended with both post-disaster and post-war impacts on MHPSS status of children. The prevalence rate for clinically relevant mental health problems amongst children was 32% (n=539), measured at 8 months post-tsunami as a range of emotional, behavioral and relational difficulties (Agampodi, Agampodi & Fonseka, 2011). It is possible that this study underestimated the prevalence of MHPSS issues amongst directly tsunami-affected children as the majority of children in that study were noted not to have been directly exposed to the tsunami.

Another study conducted four years after the December 2004 tsunami on schoolchildren in the Galle district noted that the prevalence rate was at 25% (n=414) for a full or partial diagnosis of PTSD (Ponnamperuma & Nicholson, 2016), where a partial diagnosis is attributed if the diagnostic criteria for functional impairment is not met despite presence of other symptoms. This study only presented the prevalence for PTSD, so it is likely that the number of children with significant distress or other mental health or psychosocial problems was higher. In the postwar and post-disaster context, a study of school-aged children (n=296) estimated that 33% of children fit the full diagnostic criteria for PTSD and 20% for major depression amongst school-going children in Jaffna (Catani et al, 2008). The study also revealed that 17.2% had current suicidal ideation. Children with PTSD were also shown to experience greater numbers of somatic complaints, suicidal symptoms and were more likely to be diagnosed with depression than children without. A study of children living in border villages revealed 40% of children met the diagnostic criteria for PTSD (Soysa & Azar, 2016). Researchers in another study of children in the severely conflict affected district of Kilinochchi and the tsunami and conflict-affected district of Ampara noted that the profile and range of mental and emotional distress of the two samples of children did not differ significantly (Hamilton et al. 2016). Taken altogether, findings from these different studies demonstrate that a relatively large proportion of children (20-40%) living in post-emergency settings in Sri Lanka were in severe emotional distress and difficulty.

Daily stressors within post-emergency contexts: family violence and adversity

A number of studies have moved beyond a focus on traumatic exposure, noting that it is not just the experience of war or disaster related events that precipitate and perpetuate children's distress in post-emergency settings. Rather, they highlighted a number of stressors that were part of the daily lives of children in non-emergency settings continue within the post-disaster and postwar contexts and profoundly distress children living in these circumstances. The two most prominent stressors identified in the literature on children are, family violence and ongoing adversity (e.g. Catani et al 2008; Fernando, Miller & Berger, 2010; Wickrama & Kaspar, 2007). These researchers

convincingly demonstrate that, whilst experience of conflict and disaster-related events have a significant impact on the mental, emotional and social wellbeing of children – and that greater exposure is likely to cause greater distress - this relationship is mediated and exacerbated by the stress resulting from abuse and deprivation. Children in such situations are also likely to continue negatively appraising their situation and futures, thereby prolonging their distress (Ponnamperuma & Nicholson, 2016).

The study conducted by Catani et al. (2008) provides several interesting insights into the interplay of war, disaster and violence on children's mental health and wellbeing. While the number of war-related experiences and exposure to the tsunami were strongly predictive of PTSD in children, it was family violence that was the strongest predictor. Similarly, findings from Fernando et al. (2010) reveal that unlike deprivation, abuse significantly predicted every measure of psychological morbidity and functioning used in the study, beyond the contribution of stresses related to war and disaster.

Research has indicated children, both in post-emergency contexts and non-emergency contexts continue to be subject to considerable amounts of violence not directly related to the conflict (de Zoysa, Newcombe & Rajapakse, 2010; Sathiadas et al., 2017). However, it appears that family violence is compounded and perpetuated by the experience of conflict and war. Catani et al. (2008) show that previous family experience of war violence and paternal alcohol abuse were the strongest predictors of family violence whilst exposure to the tsunami was associated with decreased levels of family violence. They assert that chronic and divisive stresses of war cumulatively come into play within the home, further distressing children and exacerbating their vulnerability in these circumstances. Sriskandarajah, Neuner & Catani (2015) have also confirmed this point, using a two-generational approach studying family dyad combinations. They found that child-reported child abuse was most strongly predicted by their experience of traumatic events and increased emotional and behavioral difficulties. This suggests that being more distressed may result in punishment and abuse, compounding children's initial distress. Mothers' perpetration of child abuse was best predicted by their own exposure to traumatic events, history of family violence, and experience of current intimate partner violence. Father's perpetration of child abuse was primarily predicted by their abuse of alcohol and exposure to traumatic events. These studies make a case for the transmission of trauma into family dynamics, perpetuating violence and dysfunction within the family and increasing children's vulnerability and distress.

As discussed, parental exposure to trauma has been shown to be associated with higher levels of child abuse and family violence. Authors have interpreted these findings to mean that men who have experienced traumatic events are more likely to commit domestic violence against their spouses and children and that this behavior is driven both by their post traumatic distress and their use of alcohol to deal with distress (Catani et al, 2008). Use of alcohol by fathers has been shown to be a strong predictor of children's psychological morbidity (Agampodi et al., 2011; Catani et al., 2008; Sriskandarajah et al., 2015). In the study on mother-child dyads living in border villages, higher levels of maternal PTSD symptoms limited mothers' capacity to accurately assess their own children's wellbeing and coping ability. Maternal mental health impairment

has been shown to positively predict children's distress in post-conflict settings (Soysa & Azar, 2016; Wickrama & Kaspar, 2007).

Analyses from the multi-stage qualitative research conducted with adolescents and their families in the Batticaloa and Polonnaruwa districts (n=60 grandparent-parent-adolescent triads) showed that adolescents were active agents in managing their mental and psychosocial wellbeing and attempting to negotiate their ways in politically and socially charged terrains (Emmanuel et al. 2014). Across the different wellbeing domains used to analyze the findings of that study, it was evident that adolescent girls and boys faced a number of challenges in accessing resources, experiencing security, attaining competence and capabilities, and building social connections. Moreover, both adolescent boys and girls were subject to the social and moral control of their families and societies, with girls experiencing considerable restrictions over their movements and ambitions as they enter into the adolescence phase.

Wettasinghe et al. (2015) list these challenges as being in disruptive family relationships, poor and negative social relationships, having engaged or being at risk for socially unacceptable or inappropriate conduct, having unhealthy personal habits or poor self-esteem, being isolated, withdrawn, angry, apathetic or unhappy, and experiencing economic difficulties. The study also identified protective factors as having supportive families and school environments, being able to interact in socially positive ways and having behaviors that are socio-culturally acceptable, having economic stability, being self-confident and taking initiative for one's self-development, and having religious or spiritual experiences.

Child abuse and domestic violence

The issue of child abuse and domestic violence appear to be the second most highlighted issue of the literature. Looking at the prevalence of child abuse rates in the non-emergency setting of Colombo district, de Zoysa et al. (2010) report that 75% of children (n= 1226, aged 12yrs) experienced an average of 15.5 acts of parental psychological aggression in the last 12 months, such as name calling, nasty hurtful remarks, stony silence, smashing things, making unfavorable belittling comparison or humiliating the child in front of others. The same study noted 70% of children reporting multiple acts of physical aggression or violence that they had experienced or witnessed; 56.4% within their homes, 52.4% in school, and 56.7% within their neighborhood. With regards to the MHPSS impacts of child abuse, 49.4% of the children in the study reported experiencing significant emotional, relational and behavioral difficulties. Children who experienced higher levels of violence also reported higher scores of MHPSS difficulties. The authors argue that the use of physical and psychological violence against children is widespread in Sri Lanka, and are likely to be causing considerable levels of psychological distress and psychopathology in a large proportion of children.

An analysis of the records held by the Child Probation Office in the Northern Province, of children (aged 0-18 yrs) admitted to a tertiary care center through the years 2009-2014 (Sathiadas et al., 2017) aimed to better understand the prevalence and distribution of severe child abuse incidence and explore the socio-demographic details of the

cases. Examining a total of 4270 records of incidence, the authors determined that the majority of severely abused children requiring medical and state intervention were aged 14-16yrs and girls were roughly one and a half times more likely to be abused. The types of abuse included neglect leading to severe malnutrition (6.2% of cases, all below the age of 5yrs), physical abuse (5.5%, over three-quarters of which were children of 5-10yrs, many of whom had experienced bruising on the face and back, ruptured ear-drums or fractured bones) and child marriage (34%, 97% of whom were girls and the mean age of the child=16.2yrs, SD=1.8yrs, and in almost half of these cases the girl was pregnant). The authors noted that children in families where parents engaged in substance abuse (i.e. mainly fathers abusing alcohol) were three times more likely to experience violence severe enough to warrant intervention and treatment and four times more likely to experience neglect than children from families where there was no substance abuse. Of the 4270 incidents documented, a third involved substance abuse.

In addition to experiencing violence themselves, studies have also shown that children are impacted through living in households where domestic and intimate partner violence is perpetrated against their parents, most often the mother. Jayasinghe, Jayawardena & Perera (2009) report that children whose mothers report intimate partner violence (n=828 mother-child dyads) have more behavioural problems, are more emotionally distressed and perform comparatively poorly in school compared to children whose mothers do not, in a matched sample. The prevalence of domestic violence against women has been shown to range from 18% to 30% in various studies (Sivayogan, 2001; Moonesinghe, 2002).

Parental migration: the case of 'left-behind children'

Studies on the parental international migration on the psychological and physical wellbeing of children have shown two-fifths of children from migrant families experience behavioral and emotional difficulties and a third are underweight for their age (Wickramage, Siriwardhana, Vidanapathirana, Weerawarna, Jayasekera, Pannala, Adikari, Jayaweera, Peiris, Siribaddana & Sumathipala, 2015). Boys were shown to be significantly more likely to experience emotional and behavioural difficulties in these circumstances. The findings suggest that poorer psychopathological scores, nutritional outcomes and cognitive functioning were twice more prevalent in children from migrant families compared to those who were not migrants (Wickramage et al 2015; Hewage, Bohlin, Wijewardena & Lindmark, 2011).

MHPSS in non-emergency contexts

Studies have indicated that general prevalence rates for clinically relevant childhood emotional and behavioral problems in children to be in the range of 13.8% to 36% (Ginige et al, 2014; Jayasinghe, 2010). Gender differences were noted in that boys experienced significantly higher prevalence of problems, especially those commonly identified as externalizing, whilst girls demonstrated higher levels of internalizing problems. As in the post-emergency contexts, higher rates of emotional and behavioral difficulties were associated with paternal alcohol use, having parents in low-skilled socio-economic occupations or who were self-employed in micro-enterprises, being in

single parent families, or additionally, being in the class that faced barrier examinations at school that year.

Young adults

All the studies relating to youth were conducted on undergraduate students. Given that this was a very selective and small proportion of the young adult population of Sri Lanka, it may be instructive to conduct more research outside of this limited population.

Amarasuriya, Jorm and Reavley (2015) noted the prevalence for depression to be 20% in a study focusing on undergraduates in Sri Lanka (n=4304), with over 9% meeting the criteria for clinically relevant major depressive disorder. This suggests high levels of distress and depression amongst university undergraduates, a finding that has also been noted in other studies on this subsample of youth. The main stressors identified by the students related to educational difficulties, financial problems and romantic relationship difficulties. These were found to be significantly correlated to depression. Both men and women were equally likely to have depression, as were students from the different faculties and departments, according to the findings of the study.

As with other populations, there were some studies relating to the issue of violence, both within childhood as well as harassment at undergraduate level, and the psychological impacts of these on undergraduate students. In the first of these studies, Haj-Yahia & De Zoysa (2008) carried out a study of the psychological effects of exposure to family violence amongst undergraduates at a major university in Sri Lanka (n=476, mean age=22.2yrs). A number of socio-demographic details (age, self-perceived socio-economic status, and parents' ages) were correlated with psychological distress, including rates of family violence. The study shows that 48% of the students had witnessed parents swearing, yelling or insulting each other, 16% had witnessed parents pushing, grabbing or shoving each other, and 9% had observed parents kicking, biting or hitting each other, before they were aged 18yrs. The students themselves had also experienced high levels of parental violence, with 73% noting psychological aggression and 19% experiencing emotional cruelty. 22% of the students revealed that parents had been physically abusive and 12% had kicked, bitten or hit them before the age of 18yrs. The results revealed that family violence correlates significantly with the following demographics: parents' age, paternal educational level, size of family, family functioning and environment. The more the participants were exposed to different patterns of family violence, the greater their psychological symptoms of dissociation, anxiety, depression, and sleep disturbances. Further analyses of the same population sample revealed that as much as 27% of the variance in PTSD could be attributed to socio-economic characteristics, family functioning and environment, with those who had witnessed or experienced family violence experiencing greater higher rates of PTSD (Haj-Yahia, Tishby & de Zoysa, 2009).

The third study focused on the experience of harassment at university amongst newly admitted undergraduates (n=65) (Premadasa, Wanigasooriya, Thalib & Ellepola, 2011). The study showed that 50% had been mistreated, with verbal and emotional abuse more frequent than sexual or physical abuse. Nonetheless, 18% of students reported

sexual harassment though the number of female students reporting sexual harassment was fewer than male students. Of the students who had been mistreated, 20% reported being distressed by the event or its memories.

Women

Apart from studies that focus on establishing prevalence rates of MHPSS issues for men and women in the general population, the literature on women-specific MHPSS issues in this review relate specifically to violence against women (VAW), sexual and reproductive health issues and issues related to women in the context of war and disaster. Using established tools for measuring aspects of depression, anxiety, general mental health and PTSD, researchers have focused on the psychiatric and psychopathological symptomatology to assess rates of mental health and psychological distress in women. Most of the published literature concerns the impact of violence against women, framed either as domestic violence, gender-based violence or intimate partner violence.

Violence against women: GBV, IPV and domestic violence

Vathsala Jayasuriya, Kumudu Wijewardena and Pia Axemo (2011) carried out a study to establish prevalence for intimate partner violence (IPV) against women. This study reported lifetime prevalence of 34% for physical violence, 30% for controlling behaviors, 19% for emotional abuse, and the low (likely under-reported) rate of 5% for sexual violence. Similarly, researchers in the Eastern Province interviewed a group of key informants on the issue of IPV and reported that informants described the issue of IPV as a widespread but hidden problem, well within the upper ranges of estimated prevalence rates of 20-60%. (Guruge, Ford-Gilboe, Varcoe, Jayasuriya-Illesinghe, Ganesan & Sivayogan, 2017).

Studies show that the most common reported forms of domestic violence were physical violence, with 57% of the acts described by women comprising of being hit with a fist or other object, being kicked, dragged, choked, burnt or threatened with a weapon (Guruge et al., 2017; Jayasuriya et al. 2011). Most women experienced multiple and repeated acts of violence. Medical and mental health practitioners have noted that women whose spouses are violent, show a range of physical injuries including broken bones, black eyes, bruises and burns (Guruge et al., 2017). For the majority of women, physical and sexual violence were the most common combination, along with extreme control and emotional and psychological abuse, such as belittling, humiliation and neglect. The authors noted that 58% had not revealed the violence to another person, prior to the interview. The main reasons for women not revealing the violence were embarrassment, concern for their family's reputation, fear of more violence, and in some cases acceptance of violence as normative behavior.

Some of the factors exacerbating violence against women are early marriage, low educational attainment, exacerbation of vulnerability in the context of war-related and post-disaster situations, and the risks associated with cultural and legal restrictions (Guruge et al., 2017; Fisher, 2010; Jayasuriya et al., 2011). One of the strongest predictors

of violence against women was alcohol abuse by partners, and several studies in this review implicate male alcohol abuse with both violence against women and violence against children (Ariyasinghe, Abeysinghe, Siriwardhana & Dassanayake, 2015; Guruge et al., 2017; Sriskandarajah et al., 2015).

Although prevalence rates for violence against women have been established, none of the studies in this review reported on the prevalence of psychological distress amongst women experiencing violence or the relationship between psychological distress and violence against women. From qualitative interviews with medical and mental health practitioners, it is clear that women who experience violence show symptoms of depression and suicidality as well as a preponderance of somatic complaints such as headaches, fatigue, fainting and vomiting (Guruge et al., 2017).

One study that investigated the overall prevalence of major depressive disorder amongst women whose spouses regularly use alcohol, noted that women whose spouses were violent reported a 41% rate of fulfilling the clinical criteria for major depressive disorder compared to 18.5% of women whose spouses were not (Ariyasinghe et al., 2015). The overall prevalence for major depressive disorder amongst women whose spouses regularly use alcohol was 33%, higher than that for tsunami survivors (19.1%) or war-affected civilians (27%) and much higher than that for the general population (8.1%) (Ball et al., 2010; Hollifield et al., 2008; Somasundaram & Sivayokan, 1994). Older women were more likely to be depressed as a result of long-term cohabitation with an alcohol dependent (and in many cases violent) spouse. The authors pointed out that women in these situations were likely to have experienced physical, emotional and sexual violence, social isolation, financial hardships and marital arguments perpetuating their psychological distress and increasing the risk of becoming depressed.

MHPSS impacts resulting from war and disaster

Most of the studies that examined prevalence rates for postwar or post-emergency psychosocial distress and mental health problems were not confined to women, although gender differences are reported on in almost all of these studies. Two studies in this literature review focused on women-only sample populations and investigated prevalence. Firstly, studying a group of mothers living in temporary housing in 2 villages in the Hambantota district 5 months after the tsunami (n=325), it was reported that 19.9% of the women met the criteria for PTSD and a 37.8% for depression (Wickrama & Wickrama 2008). The most strongly associated factor with both conditions was loss of life to loved ones and family members. All other effects were mediated through intensity of subsequent family problems brought about by the losses resulting from the tsunami. However, depressive symptoms were positively moderated by religious participation, family support, number of children, and informal community support, with these serving as resilient factors. In the second study, war and disaster-affected widows in the Eastern Province reported higher levels of depressive symptoms and these symptoms were mediated by the lack of community support especially in accessing basic resources, lack of security in their daily lives, and limited access to opportunities for employment and education (Lambert et al., 2017). Moreover, war-

related emotional and mental health problems were more likely to be associated with lower levels of community support and higher intensity of post-traumatic symptoms than tsunami-induced losses and problems. The authors suggest that these factors point to the insidious breakdown of social cohesion and trust within communities as a result of long-term war and resultant political divisions.

The other two studies examined the challenges for young women transiting from former combatant to integrated civilian (Krishnan 2011) and explored the increase in the prevalence of violence against women in the post-tsunami context (Fisher 2010).

MHPSS issues in relation to sexual and reproductive health: pregnancy related depression, infertility and single motherhood

A small number of studies examined the prevalence and impacts of antenatal and post-partum depression, infertility and unwanted pregnancies for women in Sri Lanka. Post-partum depression is considered to be high in Sri Lanka, with almost 30% of new mothers at risk of developing it (Agampodi & Agampodi, 2013). The study included in this literature review examined the prevalence of antenatal depression and found it to be relatively low at 16.2%, which was well within the international range for antenatal depression for a number of countries (Agampodi & Agampodi, 2013). The prevalence rate for psychological distress was found to be extremely high at 66% for infertile women in Sri Lanka compared to 18% in a matched group of fertile women (Lansakara, Wickremasinghe & Seneviratne, 2011). Women were more likely to be distressed if they had fewer years of education, experienced poor marital communication, and/or had been investigated or treated for infertility at the time of assessment. Although prevalence rates were not investigated, one study of unmarried pregnant women showed that a high proportion of them reported feelings of self-blame, a sense of subservience and victimhood, and suicidal ideation. Most had been scolded and threatened by family members and were at risk of rejection, even where the pregnancy was a result of rape.

Men

The largest proportion of studies that specifically involved men in the literature were those that examined the MHPSS issues related to current and former military personnel. The other two main themes involved intimate partner violence and substance abuse.

Military personnel: Special Forces and regular forces in the navy

A series of analyses of a single major study dominates the available literature on military personnel in the period under review. Carried out by a team of researchers, the study involves a representative group of Special Forces navy personnel and regular navy personnel (mean age=27.6yrs). The series of analyses examine the prevalence rates of hazardous substance use (alcohol and cannabis), medically unexplained multiple physical symptoms, PTSD and fatigue as well as functional impairment arising from physical and emotional problems. The overall combat exposure was high in the population, comprising discharging weapons in direct combat, thinking one might be killed, seeing dead or wounded, handling dead bodies, aiding wounded, coming under fire, experiencing landmine strikes, experiencing civilian hostility and combat with

enemy vessels. Special Forces personnel had significantly greater combat exposure than those in the regular forces. For example, more Special Forces had discharged weapons in combat (80% vs. 26.7%) and engaged in direct combat with enemy vessels (81.5% vs. 29.4%). However, a number of protective factors were also identified and noted to be significantly higher amongst the Special Forces than regular forces. These included comradeship and unit cohesion (92.8% vs. 78.2%), sharing personal problems with others in the unit (65.5% vs. 50.9%), having seniors interested in what they did (80.6% vs. 66.6%) and training compatible with duties (93.6% vs. 85.4%).

Hanwella & De Silva (2012) examined the mental health of the military personnel using a battery of tools that would help determine prevalence of common mental health disorders, PTSD, fatigue, alcohol use disorder, and medically unexplained physical symptoms (MUS). Fatigue (18.4%) and hazardous drinking (16.5%) were the most common problems in the regular forces, and hazardous drinking (17%) the most common amongst the Special Forces. Prevalence of MUS was 5.8% in Special Forces and 13.3% in regular personnel. Apart from drinking which may have been enabled by better privileges in the deployment situation, all other common mental health problems were more prevalent amongst regular navy personnel than in Special Forces. The prevalence of PTSD was low with only 1.9% of Special Forces and 2.7% of regular forces fitting the diagnostic criteria. The authors suggest that low PTSD rates could result from low rates of reporting, being in active deployment or because of high protective factors. De Silva, Jayasekera & Hanwella (2013) also examined the prevalence of medically unexplained multiple physical symptoms in the representative population and found it to be 10.4%, and strongly associated with PTSD, psychological morbidity and functional impairment.

The prevalence of hazardous alcohol use was 16.69%, lower than other international military forces but these results were likely to be influenced by the fact that the study population was accommodated within facilities where access to alcohol was restricted and controlled (Hanwella, de Silva & Jayasekera, 2012). The prevalence rate is also comparable to the 14.8% of harmful alcohol use in men within a general population. The overall prevalence of cannabis use is 5.22% (De Silva, Jayasekera & Hanwella, 2016). The study reported that cannabis use was significantly associated with PTSD and multiple somatic complaints.

Following up with a cross-sectional representative sample population three years after the end of combat operations, Hanwella, Jayasekera & de Silva (2014) found that mental health problems declined among the regular forces, with the exception of an increase in hazardous drinking, whilst no change was observed in the rates of those in Special Forces. Overall, it appears that mental health outcomes improved to a greater extent and more rapidly in the regular forces than in Special Forces, although the rise in hazardous drinking is more difficult to interpret because the population was no longer in a controlled environment with regards to access.

MHPSS issues of soldiers with disabilities

Two studies examined the prevalence of PTSD and mental health problems amongst soldiers who had limb amputations or spinal injuries and were therefore permanently

with disability (Abeyasinghe, de Zoysa, Bandara, Bartholameuz & Bandara, 2012; Gunawardena, Senevirathne & Athauda, 2007).

Investigating the prevalence of PTSD amongst a number of disabled soldiers in rehabilitation, Abeyasinghe et al. (2012) found PTSD rates to be high at 41.7%, with those who had experienced lower limb amputations and mobility impairments due to spinal injuries demonstrating higher prevalence of PTSD compared to those with upper limb amputations. The majority of participants experienced impairment in social, occupational and other important areas of functioning and this was a cause of considerable distress.

In a study by Gunawardena et al. (2007), the mental health outcomes for soldiers with lower limb amputations were compared with a matched sample of civilians with regular income occupations. The groups were assessed for psychological distress, including depression, anxiety, social impairment and hypochondriasis, and for alcohol and drug use dependency. Soldiers with disabilities had significantly higher prevalence of psychological distress than those in the matched group (36% vs. 8.9%) as well as higher rates for somatic complaints (13.4% vs. 2.8%). Soldiers also noted higher dependency rates, with half of the population increasing their rates of alcohol consumption, and all those using drugs commencing drug use, following the amputation.

Substance abuse among men in the general population

Several previous studies have shown rates of substance abuse, and in particular alcohol abuse, to be high amongst Sri Lankan men. The only two studies on alcohol abuse amongst men in the general population did not assess mental health impacts of substance abuse on men, however one of these, which has been discussed, examined rates of depressive disorder amongst spouses of men who drank regularly. Studies reviewed within this and other literature have also pointed to the increased levels of violence against women and children perpetrated by men who drink regularly or in heavy quantities.

De Silva, Samarasinghe & Gunawardena (2009) investigated the prevalence of alcohol and tobacco use amongst Sri Lankan men in urban and rural settings; their findings state that the overall prevalence of current alcohol use was 27.8% (i.e. at least one drink in the past month), with significantly higher rates of drinking in urban areas (32.9%) than in rural areas (20.8%). The prevalence of alcohol use increased with age in both settings, peaking in the 45-54yr category and showing subsequent decrease, however, income was associated with alcohol use only in the urban setting. The prevalence was highest amongst those with the lowest income (i.e. less than SLR 5000.00 per month) in the urban setting. Arrack was the most popular drink, with 26% in urban and 16.1% in rural settings consuming it, 3.4% of urban men and 5.1% of rural men drank kasippu.

The study showed a mean alcohol consumption of 32.9 units per week in urban areas, indicating that heavy drinking is substantially common. The 2006 Global Status report on alcohol notes that 4.9% of Sri Lankan men could be described as heavy episodic drinkers. Gelderat et al. (2005) points to the rates of fatal liver cirrhosis as a reliable

indicator for problem drinking. With a rate of 33.4 per 100,000 males (Department of Census and Statistics, 2010), Sri Lanka's is one of the highest in the world. In their study of impacts on spouses of men who drink alcohol, Ariyasinghe et al. (2015) noted that 5.16% of the urban sample and 1.46% of the rural sample reported daily consumption of alcohol.

Perpetration of intimate partner violence

There has been growing recognition of and interest in the problem of male perpetration of violence against intimate partners and attempts to better understand and address the issue (Fonseka, Minnis, & Gomez, 2015; Fulu, Warner, Miedema, Jewkes, Roselli & Lang, 2013).

Building on the positive associations between IPV and childhood experiences such as abuse, witnessing of violence against one's mother identified in other research. One such study focused both on establishing prevalence during lifetime and the prevalence of IPV and on understanding the impact of cumulative adverse childhood experiences on the perpetration of IPV in Sri Lanka (Fonseka et al., 2015), with a view to identifying young people most at risk of future IPV perpetration. Findings from the study, conducted in the four districts of Batticaloa, Colombo, Hambantota and Nuwara Eliya, revealed that child physical abuse was the most common form of adverse childhood experience, with 59% of men reporting having been beaten as a child at home and 48% having been beaten as a child at school. 17% of men reported being bullied or harassed by peers. 31% of men reported having multiple adverse experiences in childhood.

Almost half of the men (49%) reported having perpetrated at least one form of IPV at some point in their lifetime, with emotional IPV being the most common (37%), and intimidation the second (28%). Sexual IPV was also a relatively commonly reported form of IPV at 14%. Acts of physical violence, that was the most common experience of IPV reported by women, such as kicking, dragging, choking or burning a partner (Guruge et al., 2017), were the least reported by men (2%). This may suggest some under-reporting of forms of IPV by men in the study, or it could be a result that those women who had sought external help or admitted to experiencing IPV were more likely to have been physically abused.

Findings show that all forms of childhood (emotional, physical and sexual) abuse, child neglect and hunger, as well as witnessing one's mother being abused, were significantly associated with the perpetration of all forms of IPV. Greater frequency of adverse childhood experiences increased the likelihood of perpetrating IPV, showing a cumulative effect. However, the lack of a male parental figure meant men were less likely to commit physical violence and abuse, although they were equally likely to commit emotional abuse. Men who had experienced childhood sexual abuse perpetrated the greatest proportions of emotional (58%), sexual (26%) and any form of IPV (75%), and were twice as likely to commit sexual IPV than any other group. Those who committed the highest perpetration of physical IPV were those who had been bullied by peers as children (40%). However, the strongest predictors for the perpetration of physical IPV were the witnessing of abuse of one's own mother and childhood physical abuse.

Increasing age was associated with the prevalence of most forms of IPV perpetration except for financial IPV, but education did not have any association with the perpetration of IPV. Men in the Colombo district had the highest rates of prevalence for any form of IPV at 65%, but rates differed regionally. In addition to the psychological distress engendered by adverse childhood experiences and inability to manage this, there is strong evidence in the findings that men learn to commit violence through observation and normalization.

General Population

Suicide and self-harm

Studies related to suicide and self-harm behaviors, unsurprisingly, constituted a considerable proportion of the literature on mental health issues in Sri Lanka over the past decade, given the comparatively high rates of suicide in the country. In a cross-sectional study of over 165,000 individuals, Knipe, Gunnell, Pieris, Priyadharshana, Weerasinghe, Pearson, Jayamanne, Dawson, Mohamed, Gawarammana, Hawton, Konradsen, Eddleston & Metcalfe (2017) found a rate of 239 per 100,000 attempted suicides per year. Their study also examined the association of socio-economic position with attempted suicide and reported that having fewer assets and/or having a daily wage laborer as the highest occupation increased the risk of attempted suicide within households. This risk was maintained at individual level, especially for daily wage laborers. The strongest risk for attempted suicide was with lower levels of education, more so for men than women.

An ecological analysis of the incidence of intentional self-poisoning of patients admitted to hospital (n=844), carried out by Manuel, Gunnel, Van der Hoek, Dawson, Wijeratne, & Konradsen (2008) revealed a rate of 315 per 100,000, again strongly associated with socio-economic disadvantages including poor housing quality and lower levels of education, though not with employment status. Whilst intentional use of pesticide for self-poisoning, an area of concentrated interest in Sri Lankan suicide studies, was found to be proportionately higher in agricultural areas, the incidence of self-poisoning was found to be lower in many of these areas. Assessing previous self-harm amongst self-poisoning patients (n=698), one study noted the prevalence rates to be low (Mohamed, Perera, Wijayaweera, Kularatne, Jayamanne, Eddleston, Dawson, Konradsen & Gunnell (2011). 8.7% of the sample reported previous self-harm, with men more likely to have self-harmed (10.7%) than women (6.8%). This study notes that aftercare of those who have attempted suicide may have a smaller impact on incidence than in countries where the incidence of previous self-harm is higher.

There is some indication that self-harm and attempted suicides may be driven by interpersonal conflicts and the difficulties around managing the emotional distress that arise from such conflict. One study investigated the associations across different age groups between self-poisoning and a number of different factors such as psychiatric morbidity, triggers, and type of poison ingested (Rajapakse, Christensen, Cotton, & Griffiths, 2016). Based on the study of 935 patients, it was found that 83% were aged

below 35 yrs. Those below 25yrs were more likely to overdose on medicinal products whilst those above were more likely to use pesticides. The most common trigger for self-poisoning across the different age groups was recent interpersonal conflict, although other factors such as depression and alcohol use increased suicidal intent amongst those older. Follow-up interviews with a smaller group of persons (n=24) indicated a mix of motivations to the act of self-poisoning, primarily difficulty tolerating the distress associated with interpersonal conflict along with intentions to escape the situation, including by dying. The authors suggest that helping people develop adaptive emotional coping strategies when dealing with interpersonal conflict may contribute to preventing distress become a trigger for self-poisoning and other acts of self-harm.

This point was also made by another group of researchers in their study examining the prevalence of suicidal ideation in Sri Lanka (Samaraweera, Sumathipala, Siribaddana, Sivayogan & Bhugra, 2010). The researchers found a 4% prevalence rate of active suicidal ideation and 3% passive suicidal ideation (n=808). Those who were young, feeling hopeless and were physically unwell had higher rates of suicidal ideation. Most strikingly, 60% of those with suicidal ideation were experiencing familial conflict. The authors suggest that the strong emotional reaction to conflict is a result of the society-based collectivist identity within Sri Lankan, and especially Sinhala, culture (the study was on a group of Sinhala individuals.) Other risk factors included being widowed or separated, and/or being unemployed. The authors note that there was a higher level of lifetime exposure to suicidal behaviors, reflecting a modeling effect.

Tom Widger (2012, 2015) explores this latter idea in further detail, asserting that suicide and suicidal behavior, and in particular the act of self-poisoning, is seen as a socially appropriate means to regulate moral transgressions within interpersonal relations and is particularly effective in challenging the behaviors of others. He describes how suicidal actions may be used to affirm or contest actions that challenge class or gender concerns and to express the extent of suffering, anger or frustration brought about by the transgressive actions. He also noted that young unmarried men and women aged below 24 years mostly committed non-fatal self-harm acts whilst middle-aged men were most likely to complete suicide. He also distinguishes between public self-harm acts and private self-harm acts - the former, which he argues, has a communicative function and is meant to be interrupted and interpreted, whilst the latter is less likely to be so.

A number of studies also examined cases of completed suicides with a view to understanding the various contributory factors including the post-war and post-tsunami impacts on suicide (Rodrigo, Owada, Wainer, Baker & Williams, 2013; Samaraweera, Sumathipala, Siribaddana, Sivayogan & Bhugra, 2008). The studies showed that the end of the war resulted in a significant 8% reduction in suicides (n=7854; i.e. a rate of 19.1 per 100,000 population) compared to the period during the war (n=8336, rate=20.7). The study indicated that the reduction was mainly driven by lower rates of suicides by men, whilst that for women did not show a significant change. However, the risk of male suicide increased with age by 3% for each additional year of age both during and after the war, so that men in the age group 30-39yrs were four times, and those in the

50-59yrs age group eight times, more likely to commit suicide as compared to girls and women aged 0-19yrs who were only slightly more likely to commit suicide than boys and men of this age. The tsunami did not have an impact on the rate of completed suicides (Rodrigo, McQuillin & Pimme, 2009). In their study utilizing a psychological autopsy approach, Samaraweera et al. (2008) noted alcohol abuse and domestic violence to be significant contributory factors to the act of completed suicides at an individual level.

Depression

The only epidemiological study of depression that examined its prevalence in a cross-sectional representative sample was conducted by Ball, Siribaddana, Kovaso, Glozierc, McGuffin, Sumathipala and Hotop in 2010. The sample consisted of 2019 individuals aged 15 and above in the district of Colombo. The study notes that lifetime prevalence of depression for men is 4.8% and for women 8.1%. These rates were for symptomatology that met the full diagnostic criteria of the DSM-IV. The authors however argued that the functional impairment criteria did not seem relevant to the Sri Lankan context and therefore also investigated prevalence after removing the functional impairment criteria. This raised prevalence rates to 8% and 13.9% of men and women respectively.

The study found that 18.9% of the sample had experienced more than one episode of depression. The study also indicated that the current point prevalence for depression to be 1.6% and for the past 12 months to be 2.7%.

The prevalence of depression was correlated to a composite index that determined standards of living, work status and gender. Using this index, the findings show that standard of living (SoL) is positively associated with depression for men in the lower two quintiles of the standards of living index. Examining gender and low SoL scores, men were at higher risk for depression if they had worked for only some but not all of the months in the previous 12 months, if they lived in housing of poor quality (without adequate access to water and sanitation facilities) and if they had recently experienced hunger. In the same group, women who had not worked at all in the previous 12 months were less likely to be depressed. However, there was no association between work status and depression for men and women in the top two quintiles of the index. For both men and women, financial wellbeing was negatively associated with depression.

The authors assert that men whose primary responsibility is provision for the family, including housing, are more likely to be depressed when their inability to do so is evident in the quality of their homes or being unable to find enough work and that women whose financial situation makes full-time work a necessity are more likely to be depressed as they struggle to combine childcare and work.

Again emphasizing the importance of daily stressors on mental health and wellbeing, a study conducted by Perera, Østbye & Jayawardhana (2009) revealed key neighborhood social and environmental stressors had negative impacts on self-rated mental health scores in a sample of 2077 Sinhala-speaking individuals aged 18-85 in southern Sri Lanka. Such stressors included neighborhood disputes, drug user harassment, water shortages and poor water/sewage drainage.

Tsunami

In an attempt to identify socio-demographic and personal historical factors that may predict the development of post-traumatic symptoms in adult tsunami survivors living in temporary shelter and camps in the Galle district (n=305), Gunaratne, Kremer, Clarke, & Lewis (2014) present an analysis of data from anonymized counselling records obtained by the National Institute of Professional Counsellors. The counselling records were obtained from the provision of support to survivors in the immediate aftermath of the tsunami in January 2005. In this sample, reported distress was high, with 55% reporting severe stress, 42% suffering from heightened anxiety, 34% stating that they felt unable to cope, 32% reported feeling hopeless, and 20% reporting post-traumatic symptoms. Somatic complaints were presented by 26% of the sample. A quarter of the sample presented with more than 3 of these items. It was noted that women, people above the age of 45 years, those who had been employed at the time of the tsunami, those with substance abuse issues and those with pre-existing health conditions were more likely to report higher numbers of trauma and distress-related symptoms.

One study found a prevalence rate of 56% for PTSD during the 6 months post-tsunami, amongst an internally displaced population (n=264, median=38yrs) living in temporary shelters located in the Colombo, Kalutara, Galle, Matara and Hambantota districts. 64% of women reported post-traumatic symptoms compared to 42% of men (Ranasinghe & Levy, 2007). The study indicated that women were more likely to develop PTSD and depression, even after controlling for age, marital status, being a parent, loss of family members, amount of social support and educational level.

In another analysis of research conducted on the same population, the authors examined the potential contribution of karmic beliefs and a pessimistic explanatory style to the mental and physical health of tsunami survivors (Levy, Slade, & Ranasinghe, 2009). Karmic beliefs and a pessimistic explanatory style were both found to be strongly associated with poorer health and a pessimistic explanatory style with PTSD. Karmic beliefs were, however, not associated with post-traumatic stress symptoms.

The prevalence for PTSD at 15 months after the tsunami for adult tsunami survivors (n=113, mean age=35.9yrs) along the Southern Province was found to be 52.2% (Lommen, Angelique, Sanders, Buck & Arnt, 2009), which had reduced from 63.7% a month after the tsunami. The study also looked at a number of psychosocial predictors for chronic PTSD. It reports that gender and non-replaced lost work equipment was related to PTSD. This study too found a strong association between negative interpretations of tsunami-memories. The authors recommend early intervention programs that help individuals modify their interpretations of tsunami-memories and that support economic recovery.

In another study conducted almost two years after the tsunami to assess the prevalence of psychiatric and somatic symptoms and to determine how people coped with difficulties in the post-tsunami context, Sinhala-speaking adults (n=89, median age=44.5yrs) were selected from a severely affected area in the Galle district through a process of cluster mapping and random selection (Hollifield, Hewage, Gunawardena,

Kodituwakku, Bopagoda & Weerarathnege, 2008). The study indicated that the prevalence of clinically significant anxiety, PTSD, and depression and anxiety was 30%, 21%, and 16% respectively. Those who met the criteria for a full diagnosis were also more likely to report persistent somatic complaints and to suffer from functional impairments. The strongest predictor of a clinically relevant diagnosis was exposure to a life-threatening event and thinking one's life to be in danger. With regards to coping, most people reported their greatest strengths and comforts to have been through relying on themselves, their friends and family, Western medical help, and their religious beliefs and practices.

Based on a retrospective analysis of police records on completed suicide, the authors reported no significant difference was found in the number of completed suicides in those districts affected by the tsunami before and following the disaster, despite high levels of PTSD and depression (Rodrigo, McQuillin & Pimme, 2009).

MHPSS impacts of war and conflict

Husain, Anderson, Cardozo, Becknell, Blanton, Araki, & Vithana (2011) examined the prevalence of war-related mental health conditions in the context of displacement. Using a cluster-based representative sample of the population aged 15 and above in the district of Jaffna (n=1409), they found the rates of prevalence to be highest amongst those currently displaced. Overall prevalence rates for anxiety, depression and PTSD was 32.6%, 22.2% and 7% respectively, however, the rates were highest amongst those currently displaced at 48.5%, 41.8% and 13%. Those who had greater exposure to traumatic events as measured by number of events experienced, had higher levels of these mental health conditions and these were further compounded by displacement status. This suggests a dose-response relationship between traumatic events and mental health problems, mediated by current adverse conditions as well as recent exposure to traumatic events such as experienced by those currently living in camps and temporary shelters. The authors suggest that the comparatively lower rates for post-traumatic symptoms in the sample population may be a result of the normalization of traumatic events and development of coping skills over the protracted nature of armed conflict in the district. Moreover, they note that the currently displaced, experience multiple daily stressors in the forms of insecurity and uncertainty of their future, deterioration of living conditions, coping with various losses including loss of livelihoods, resources and support of their communities, and lack of services, thereby exacerbating their psychological and psychiatric morbidity.

Another study on the post-traumatic impacts of war and displacement was conducted on targeted Tamil and Sinhala populations (n=2449) living in severely affected areas of the Kilinochchi, Mullaitivu, Trincomalee and Vavuniya districts (Jayasuriya, 2014). This study indicated that long-term displacement, i.e. living in camps for over one year, was strongly associated with increasing rates of mental health problems and a decline in the sense of wellbeing comparative to those who had never lived in a camp or those who had been displaced for a shorter period of time. Interestingly, those who had been displaced for less than a year showed higher rates of wellbeing than those who

had never been displaced, as measured by satisfaction in a number of life domains such as health, income and family life. However, this sense of wellbeing is rapidly lost over the course of the first year of displacement and is consistently worse over the following years. The authors suggest that the initial sense of support and relief from having their basic needs met may gradually become eroded through the control exerted over their lives by camp officials and aid agencies, and this recognition of loss of independence and freedom is further exacerbated by evident constraints in rebuilding their lives.

Driven by the emerging links between traumatic symptoms, psychological distress, daily stressors and war, a recent study by Jayawickreme, Mootoo, Fountain, Rasmussen, Jayawickreme, & Bertuccio (2017) utilised network analysis to examine the associations between particular psychopathological symptoms and various stressors. Based on the data collected between 2009-2011 from 337 Tamil adult survivors in the districts of Jaffna, Batticaloa, Trincomalee and Vavuniya who had sought psychosocial assistance from a national psychosocial organization, the study revealed that social problems, family problems and lack of basic needs were as much as, if not more, central to the network than the experience of traumatic events and other issues. The most significant of these were social problems.

In one attempt to understand the trajectories of symptoms in depression and anxiety and their associations with ongoing adversities and exposure to traumatic events, Tay, Jayasuriya, Jayasuriya and Silove (2017) carried out a follow-up survey of 1275 individuals in the districts of Jaffna, Kilinochchi, Mullaitivu and Mannar after a 12-month period. This sub-sample was drawn from a larger survey conducted across 25 districts in Sri Lanka. Four composite trajectories were derived from a three-class model obtained through latent transitional analyses; a persistent symptom trajectory (n=555, 43.5%), a recovery trajectory (n=299, 23.5%), a persistently low-symptom trajectory (n=251, 19.7%) and a new onset trajectory (n=170, 13.3%). Being a woman, exposure to trauma events and lack of health services were associated with both persistent symptoms and new onset trajectories. Loss of a job was uniquely associated with the persistent trajectory at follow-up. Those who showed a recovery trajectory were more likely to be male, older and those without the noted risk factors. This study further underlines the importance of ensuring targeted interventions to support women, provide stable employment and access to healthcare as key factors for reducing the prevalence of anxiety and depressive symptoms in the post-conflict phase.

In order to understand community and family-level mental health and psychosocial problems of war-trauma, multiple displacements, loss of family, relatives, friends, homes, employment and other values and resources resulting from the protracted armed conflict in the Northern Province of Sri Lanka, Somasundaram & Sivayokan (2013) carried out a qualitative ecological study comprising participant observation, case studies, key informant interviews and focus group discussions with a range of stakeholders. The study was intended to identify practical and community-based interventions that can help rebuild strengths, adaptation, coping strategies and resilience. The results of the study showed that complex mental health and psychosocial problems at the individual, family and community contexts impaired recovery. These problems

included unresolved grief, individual and collective trauma, insecurity, self-harm and suicides, poverty and unemployment, teenage and unwanted pregnancies, alcoholism, child abuse and neglect, gender-based violence and vulnerability including domestic violence, widows and female-headed households, family conflict and separation, physical injuries and disabilities, problems of vulnerability associated with children and the elderly, abuse and neglect of the elderly and the disabled, anti-social and socially irresponsible behaviors, distrust, hopelessness and powerlessness.

The study also revealed a number of protective factors that helped recovery at individual, community and societal levels and these included families, female leadership and engagement, cultural and traditional beliefs, practices and rituals, and the creative potential in narratives, drama and other arts. The factors that impeded community rehabilitation and recovery for this population included continuing military governance, depletion of social resources particularly the lack of trust, hope and socio-economic opportunity structures for development that would enable families and communities to regain a sense of collective efficacy. The study recommended the provision of awareness, knowledge and skills to deal with common mental health and psychosocial issues, training of community-level workers and others in basic mental health and psychosocial problem-solving, the use of helping cultural practices, and school-based programs.

Using a psychosocial-ecological approach to the question of war-related collective trauma in the northern districts of Sri Lanka, Daya Somasundaram (2007) explored the impacts of war on families, communities and societies, recognizing that adverse psychosocial impacts manifest themselves beyond individuals. The study comprised of participatory observation, key informant interviews and focus group discussions with relief and rehabilitation workers, state officials and non-governmental personnel. The study reported essential changes within the context of war and disaster, but noted that main prominent changes both in family functioning and social transformations were in response to the chronic war situations. Somasundaram notes a lack of trust, changes in significant relationships and in child rearing practices at a family level, whilst communities demonstrated greater dependence, were more passive, silent and mistrustful, and were also shown to be without leadership. Similar adverse consequences were seen in the breakdown in the traditional institutions and a deterioration of social norms including familiar ways of life.

In an attempt to better understand mental health issues of the long-term displaced, a group of researchers looked at the prevalence of common mental health disorders and resilience amongst 450 displaced individuals from Puttalam district, of whom 338 were followed up and re-interviewed 12-months later and compared with a group of 228 return migrants with similar displacement histories. A series of analyses from the study showed prevalence for any type of common mental health disorder, as measured by the Patient Health Questionnaire, to be 18.8% for the displaced population at baseline (Siriwardhana, Adikari, Pannala, Siribaddani & Abas, 2013). Of the particular disorders, the prevalence for somatoform disorder was 14%, major depression and other depressive disorders 12.4%, PTSD, 2,4%, and anxiety disorder 1.3%. The status of being

unemployed, widowed or divorced, and food insecure were significantly associated with psychopathologies. The prevalence of common mental health disorders had reduced sharply over the course of the year, with follow-up figures at 8.6% for those who had remained in the camp and 10.3% for returnees (Siriwardhana, Adikari, Pannala, Roberts, Siribaddana, Abas, Sumathipala & Stewart, 2015). PTSD, as measured by the CIDI-subscale, was at a prevalence of 2.4% at baseline, 0.3% at follow-up, and 1.6% for returnees. These figures indicate a significant decrease in psychopathology in a short period of time – this decline was attributed to the prospect of return migration and optimism following conflict resolution. These effects appear to be maintained for those who had returned following their long-term displacement.

Within the same research study outlined above, Siriwardhana, Abas, Siribaddana (2015) further analyzed dynamics of resilience and its associations with a number of socio-demographic details and exposure to traumatic events. The findings suggested that resilience was significantly higher for returnees. Moreover, the scores for resilience were independent of existing symptoms of psychopathology at baseline, but associated at follow-up and for returnees, especially for those who had higher levels of food security, greater social support and social integration. The study concluded that resilience was greatly impacted by economic and social factors rather than the presence of existing psychopathology.

In one of the few studies on adults that examined mental health impacts of both conflict war and disaster, Keraite, Sumathipala, Siriwardhana, Morgan and Reininghaus (2016) focused on the prevalence of psychotic experiences amongst individuals who had experienced war-related and tsunami-related traumatic events. The study was carried out on a population of 5927 individuals aged 18-65yrs from 17 districts, using a cluster sampling approach and the findings indicated a prevalence rate of 9.7% for psychotic experiences. Prevalence of psychotic experiences was slightly higher amongst respondents 40-50yrs, those who were Sinhalese, and those who had been exposed to a traumatic event in the tsunami or the conflict, most especially those who lost a close friend or family member, been injured or had a close friend or family member injured. However, there was no increased prevalence amongst those who had experienced both tsunami and conflict-related traumatic events. The authors note that the overall prevalence is well within the ranges noted for other comparable populations.

Rodrigo et al. (2013) note a significant 8% postwar reduction in completed suicides (n=7854; i.e. a rate of 19.1 per 100,000 population) compared to the period during the war (n=8336, rate=20.7). The study was based on an examination of over 16190 completed suicide records collected over 4 years from 39 police divisions. The analysis suggests that the noted reduction is mainly driven by lower rates of suicides amongst men in the postwar period, whilst that for women did not show a significant change.

This review suggests that the association between psychosocial and mental health distress and displacement has been studied to a greater extent over the past decade than any other conflict-related experience and event. The prevalence of psychological distress and psychopathological symptomatology has not been looked at with regards

to other issues such as having had family members been disappeared or having survived torture. Although Daya Somasundaram (2008) notes that those who survive torture are likely to develop a range of psychiatric and psychopathological symptoms such as somatization, PTSD, depression and anxiety, their prevalence was not examined.

Elderly

The review included two articles on the mental health status of the elderly in Sri Lanka, both drawn from the 2006 Sri Lanka Aging Survey carried out on 2413 individuals aged 60yrs and above from 13 of the 25 districts, excluding those from the conflict-affected Northern and Eastern Provinces of Sri Lanka. The overall prevalence of clinical depression amongst elderly Sri Lankans was found to be higher than that reported for most other Asian countries at 27.8%, with 30.8% of women reporting depressive symptoms than men (24%) (Malhotra, Chan & Østbye, 2010). This study also indicated that those with disabilities, functioning impairments, financial difficulties, and from ethnic minority backgrounds were significantly more likely to be depressed. Examining the thirteen dimensions of health in elderly Sri Lankans, including those on cognitive, social and emotional aspects of mental health, in greater depth, one of the studies conclude that elderly women are more likely to be stressed and worried, and for both men and women, social participation declined dramatically with age (Østbye, Malhotra, & Chan, 2009). There was also a decline in normal cognition associated with advancing age.

Summary of Recommendations on the Development of State Counselling and Psychosocial Support Services

The following list of recommendations is compiled from those recorded in the mapping studies conducted in 2013 and the assessment study carried out in 2017 for the development of counselling and psychosocial support services in the state sector. In a few instances, recommendations have been edited and updated for clarity, but no new recommendations have been included for this publication.

1. National Policy and National Level Support

1.1 The need to prioritize a national and provincial policy on counselling and psychosocial support was a key recommendation, including developing a service minute and a career structure for the cadre.

1.2 Developing a common framework for supporting coordination and cooperation between parallel services related to counselling and psychosocial support particularly at the District and Divisional level was recognized. Interestingly, it was recommended that such policies ought to avoid prescribing what local coordination should look like, as the local structure must be allowed to vary to accommodate local dynamics and realities. In this sense, a framework of general principles and guidelines would be the most appropriate form aiming at empowering and encouraging service providers to work closely and systematically together. To foster collaboration between the counsellors of both the MWCA and the MSEW, it was also recommended that services and contacts for common service providers, such as safe housing be made accessible to all.

1.3 A common guidance be developed for integrated community psychosocial interventions by Ministerial projects such as “Sadhaniya Mithuru Gammana” of the MWCA.

1.4 High level officers within the relevant Ministries and administrative institutions within which counsellors function, require awareness on the specific role of counsellors to ensure that they are assigned duties appropriately and that expectations of their role are clear.

1.5 At District and Divisional levels there is a need for clear, complementary roles and effective coordinating mechanisms for the different parallel services related to counselling and psychosocial support. This can be configured at a local level depending on available resources and local structures.

2. Strategic Role, Duties and Scope of Work of Counsellors

1.6 Clarify the duties and roles of counsellors in responding to psychosocial problems, especially in relation to specific types of problems and also in relation to cooperation with other existing service providers.

1.7 The service deals with patients with medical conditions which may necessitate regulation by the Sri Lanka Medical Council. A suitable amendment may be necessary to the Medical Ordinance for this purpose. It is necessary to clearly define the role of counsellors in relation to the treatment and support of persons with mental illness, other disabilities or relevant medical conditions.

1.8 Conceptualization of the role of the counsellors should take into account their skills and developmental trajectory – so that their role may develop as they do.

1.9 There must be a clear vision of their roles and division of labor with regards to prevention/promotion work vs. more supportive and therapeutic work for common psychosocial problems.

1.10 Review the nature and time consumption of the activities assigned by Divisional Secretaries and review the reporting required of counsellors in order to identify if intervention is required with field administrators to reduce extraneous work for counsellors, or perhaps if the reporting functions require guidance via a circular to ensure consistency and to protect potential breaches of client confidentiality.

1.11 Develop material and engage in raising the awareness of other agencies whose officers typically work with the counsellors to ensure that the scope, role and limits of the intervention of the counsellor is clarified.

3. Technical Supervision and Support Mechanism

1.12 Technical supervision is needed to maintain the quality of service and ensure support to manage complex and challenging cases and further develop skills of CAs.

1.13 Where possible, supervisory resources should be identified within the CA's own area of work to reduce costs and facilitate access and continuity of support. Towards this end it is probably most pragmatic to establish a district-level system with occasional inputs and oversight from regional or national technical resources.

4. In-service Training

1.14 Create a scheme of in-service training and technical support to CAs in implementing evidence-supported interventions for common psychosocial problems encountered at a community level (i.e. family and marital problems, educational problems, mental illness and psychological distress, etc.).

1.15 The recommended format for such training was on a rolling-basis, with different common problems (i.e. alcohol harm reduction, domestic violence prevention, etc.) being addressed in a series of capacity-building initiatives. These processes may also benefit from being a part of wider engagement

with other service providers and stakeholders who may be required to undertake activities in order for these interventions to be successful.

1.16 Associated with such training may be the development, adaptation or dissemination of guidelines and resource materials related to addressing common problems or working with particular vulnerable or challenging groups.

5. Guidelines, Templates, and Systems for Record Keeping, Intervention Planning, Reporting and other Forms of Documentation

1.17 The different elements of a documentation system should be designed to minimize difficulty for the intended users (i.e. the counsellor, their administrative supervisors, their technical supervisors, and policy-makers), and should also protect the privacy of clients and prevent misuse of data. It may be possible to build on systems developed for the education sector in Sri Lanka.

1.18 Produce District-level Directories of Services to support referral. The production of the directory can be led by CAs, and could be combined with District and Divisional-level networking activities. Apart from supporting referrals, this could support the clarification of roles and coordination mechanisms between services/service providers.

6. Personal Support to Address the Risks of 'burn-out'

1.19 Establish a workable and systematic mechanism for personal support to address the risks of 'burn-out' inherent to counselling. Incorporating better training on self-care within existing and future courses is also a priority.

1.20 Personal support will often be best provided by close family, friends and other associates of the counsellors, but there should be provision for regular check-ins and professional support for counsellors from outside of their peer and supervisory structure if they require/ want this.

1.21 Establish an independent counselling service for counsellors.

7. Develop and Strengthen Infrastructure

1.22 Ensure all counsellors have basic infrastructure to carry out their work, such as desks, chairs, mobile telephone connections.

1.23 Ensure that counsellors have counselling rooms, improved transport facilities, computer facilities with internet access and are facilitated access to technical resources.

1.24 Solutions for the problems of work space will have to be solved in collaboration with the DS or other relevant administrator of the facility in which the counsellors are to work.

1.25 Provide counsellors with the means to access knowledge and learning independently via provision of access to internet to access journals, communities of practice, etc., publications and training opportunities. Consider providing low cost computers, tablets or cheap smart phones as a means for counsellors to access resources online.

1.26 Facilitating group subscriptions to online journals or posting of scans of print journals may be another means by which counsellors' access to thinking and practice in the field could be enhanced.

1.27 Offering annual leave for counsellors to undertake independent study may also be another low-cost means of enabling them to develop professional skills without having to directly finance such studies.

8. Systematic Distribution of CA Cadres Across the Country

1.28 The provision of a user-friendly GIS map to prioritize placement of the future recruits to ensure equitable distribution of counsellors by geographical region. It is also possible to add "layers" to the system to help human resource development and to reflect psychosocial needs of geographical areas, as well as for prioritization of the deployment of future batches of counsellors, if data is generated by suitable research.

1.29 Maximise equity of access to services for the population and adequate peer support for counsellors. This could be addressed during future recruitment or transfers of counsellors, and should involve a review of current deployment, population density, level of needs, and availability of other complementary services responding to the same population and needs (i.e. counsellors, mental health services, etc.)

9. Review the Practices Relating to Court Referrals and Legal Processes

1.30 Review the practice of court referrals to counsellors for apparently mandatory sessions for couples in the context of intimate partner violence and divorce proceedings, drug users and other persons in conflict with the law; to explore the possibility of standardized guidance for counsellors and their managers on responding appropriately to court referrals, as well as for potential interventions to communicate best practice to the judiciary.

10. Effective Standard Materials and Methodologies for Psycho-education / Awareness Raising

10.1 Provide counsellors with effective standard materials and methodologies for psycho-education / awareness raising on significant and common themes for community engagement.

References

Abeyasinghe, N. L., de Zoysa, P., Bandara, K. M. K. C., Bartholameuz, N. A. & Bandara, J. M. U. J. (2012). 'The prevalence of symptoms of Post-Traumatic Stress Disorder among soldiers with amputation of a limb or spinal injury: A report from a rehabilitation center in Sri Lanka'. *Psychology, Health & Medicine* 17(3) 376–381.

Agampodi, S. B. & Agampodi, T. C. (2013). 'Antenatal Depression in Anuradhapura, Sri Lanka and the Factor Structure of the Sinhalese Version of Edinburgh Post Partum Depression Scale among Pregnant Women'. *PLoS ONE* 8(7) e69708.

Agampodi, T. C., Agampodi, S. B. & Fonseka, P. (2011). 'Prevalence of Mental Health Problems in Adolescent Schoolchildren in Galle District, Sri Lanka: Eight Months After Tsunami'. *Asia-Pacific Journal of Public Health* 23(4) 588–600.

Amarasuriya, S. D., Jorm, A. F. & Reavley, N. J. (2015). 'Prevalence of depression and its correlates among undergraduates in Sri Lanka'. *Asian Journal of Psychiatry* 15 32-37.

Ariyasinghe, D., Abeysinghe, R., Siriwardhana, P. & Dassanayake, T. (2015). 'Prevalence of Major Depressive Disorder Among Spouses of Men Who Use Alcohol in a Rural Community in Central Sri Lanka'. *Alcohol and Alcoholism,* 50(3) 328–332.

Ball, H. A., Siribaddana, S. H., Kovasa, Y., Glozierc, N., McGuffin, P., Sumathipala, A. & Hotop, M. (2010). 'Epidemiology and symptomatology of depression in Sri Lanka: A cross-sectional population-based survey in Colombo District'. *Journal of Affective Disorders* 123 188-196.

Catani, C., Jacob, N., Schauer, E., Kohila, M. & Neuner, F. (2008). 'Family violence, war, and natural disasters: A study of the effect of extreme stress on children's mental health in Sri Lanka'. *BMC Psychiatry* 8:33.

de Silva, V. A., Jayasekera, N. & Hanwella, R. (2016). 'Cannabis use among Navy personnel in Sri Lanka: a cross sectional study'. *BMC Research Notes* 9:174.

de Silva, V. A., Jayasekera, N. E. L. W., & Hanwella, R. (2013). 'Multiple physical symptoms in a military population: a cross-sectional study'. *Annals of General Psychiatry* 12:24.

de Silva, V., Samarasinghe, D. & Gunawardena, N. (2009) 'Alcohol and tobacco use among males in two districts in Sri Lanka'. *Ceylon Medical Journal* 54:4.

de Zoysa, P., Newcombe, P. & Rajapakse, L. (2010) Outcomes of Parental Use of Psychological Aggression on Children: A Structural Model From Sri Lanka. *Journal of Interpersonal Violence* 25(8) 1542–1560.

Emmanuel, S., Wettasinghe, K., Samuels, F., Thambaiah, S., Rajendran, I. & Galappatti, A. (2014) *Adolescent psychosocial wellbeing in the post conflict context of Sri Lanka.* United Kingdom: Overseas Development Institute.

Fernando, G., Miller, K. E. & Berger, D. (2010) Growing Pains: The Impact of Disaster-Related and Daily Stressors on the Psychological and Psychosocial Functioning of Youth in Sri Lanka. *Child Development* 81(4) 1192–1210.

Fisher, S., (2010) Violence Against Women and Natural Disasters: Findings From Post-Tsunami Sri Lanka. *Violence Against Women* 16(8) 902–918.

Fonseka, R. W., Minnis, A. M. & Gomez, A. M. (2015) Impact of Adverse Childhood Experiences on Intimate Partner Violence Perpetration among Sri Lankan Men. *PLoS ONE* 10(8): e0136321.

Fulu, E., Warner, X., Miedema, S., Jewkes, R., Roselli, T. & Lang, J. (2013). *Why Do Some Men Use Violence Against Women and How Can We Prevent It? Quantitative Findings from the United Nations Multi-Country Study on Men and Violence in Asia and the Pacific.* Bangkok: UNDP, UNFPA, UN Women and UNV.

Ginige, P., Tennakoon, S. U. B., Wijesinghe, W. H. M. K. J., Liyanage, L., Herath, P. S. D. & Bandara, K., (2014) Prevalence of behavioral and emotional problems among seven to eleven year old children in selected schools in Kandy District, Sri Lanka. *Journal of Affective Disorders* 167 167–170.

Gunaratne, C. D., Kremer, P. J., Clarke, V., & Lewis, A. J. (2014) Trauma-Related Symptoms in Sri Lankan Adult Survivors After the Tsunami: Pre-traumatic and Peri-traumatic Factors. *Asia-Pacific Journal of Public Health* 26(4) 425–434.

Gunawardena, N., Senevirathne, R. D. A. & Athauda, T. (2007) Mental Health Outcome of Unilateral Lowe Limb Amputee Soldiers in Two Districts of Sri Lanka. *International Journal of Social Psychiatry* 53(2) 135-147.

Guruge, S., Ford-Gilboe, M., Varcoe, C., Jayasuriya–Illesinghe, V., Ganesan, M. & Sivayogan, S. (2017) Intimate partner violence in the postwar context: Women's experiences and community leaders' perceptions in the Eastern Province of Sri Lanka. *PLoS ONE* 12(3) e0174801.

Haj-Yahia, M. M. & de Zoysa, P. (2008) Rates and psychological effects of exposure to family violence among Sri Lankan university students. *Child Abuse & Neglect* 32 994–1002.

Haj-Yahia, M. M., Tishby, O. & de Zoysa, P. (2009) Posttraumatic Stress Disorder Among Sri Lankan University Students as a Consequence of Their Exposure to Family Violence. *Journal of Interpersonal Violence* 24(12) 2018-2038.

Hamilton, A., Foster, C., Richards, J. & Surenthirakumaran, R. (2016) Psychosocial wellbeing and physical health among Tamil schoolchildren in northern Sri Lanka. *Conflict and Health* 10:13.

Hanwella, R. & de Silva, V. (2012) Mental health of Special Forces personnel deployed in battle. *Social Psychiatry & Psychiatric Epidemiology* 47 1343–1351.

Hanwella, R., de Silva, V. A. & Jayasekera, N. E. L. W. (2012) Alcohol use in a military population deployed in combat areas: a cross sectional study. *Substance Abuse Treatment, Prevention, and Policy* 7:24.

Hanwella, R., Jayasekera, N. E. L. W. & de Silva, V. A. (2014) Mental Health Status of Sri Lanka Navy Personnel Three Years after End of Combat Operations: A Follow Up Study. *PLoS ONE* 9(9): e108113.

Hewage, C., Bohlin, G., Wijewardena, K. & Lindmark, G. (2011) Executive functions and child problem behaviors are sensitive to family disruption: a study of children of mothers working overseas. *Developmental Science* 14(1) 18-25.

Hollifield, M., Hewage, C., Gunawardena, C. N., Kodituwakku, P., Bopagoda, K. & Weerarathnege, K. (2008) Symptoms and coping in Sri Lanka 20–21 months after the 2004 tsunami. *The British Journal of Psychiatry* 192 39–44.

Husain, F., Anderson, M., Cardozo, B. L., Becknell, K., Blanton, C., Araki, D. & Vithana, E. K. (2011) Prevalence of War-Related Mental Health Conditions and Association with Displacement Status in Postwar Jaffna District, Sri Lanka. *Journal of American Medical Association* 306(5) 522-531.

Jayasinghe, A. (2010) *Report on Child Mental Health Problems in Hambantota District.* Sri Lanka: WHO

Jayasinghe, S., Jayawardena, P., & Perera, H. (2009) Influence of intimate partner violence on behavior, psychological status and school performance of children in Sri Lanka. *Journal of Family Studies* 15 274-283.

Jayasuriya, D. (2014) Influence of Posttraumatic Growth on Mental Health and Well-being Across Respondents Severely Affected by War in Post-conflict Sri Lanka. *Social Indicators Research* 119 265–280.

Jayasuriya, V., Wijewardena, K. & Axemo, P. (2011) Intimate Partner Violence Against Women in the Capital Province of Sri Lanka: Prevalence, Risk Factors, and Help Seeking. *Violence Against Women* 17(8) 1086–1102.

Jayawickreme, N., Mootoo, C., Fountain, C., Rasmussen, A., Jayawickreme, E. & Bertuccio, R. F. (2017) Post-conflict struggles as networks of problems: A network analysis of trauma, daily stressors and psychological distress among Sri Lankan war survivors. *Social Science & Medicine* 190 (2017) 119-132.

Jordal, M., Wijewardena, K. & Olsson, P. (2013) Unmarried women's ways of facing single motherhood in Sri Lanka–a qualitative interview study. *BMC Women's Health* 13:5.

Keraite, A., Sumathipala, A., Siriwardhana, C., Morgan, C. & Reininghaus, U. (2016) Exposure to conflict and disaster: A national survey on the prevalence of psychotic experiences in Sri Lanka. *Schizophrenia Research* 171 79–85.

Knipe, D. W., Gunnell, D., Pieris, R., Priyadarshana, C., Weerasinghe, M., Pearson, M., Jayamanne, S., Dawson, A. H., Mohamed, F., Gawarammana, I., Hawton, K., Konradsen, F., Eddleston, M., & Metcalfe, C. (2017) Is socioeconomic position associated with risk of attempted suicide in rural Sri Lanka? A cross-sectional study of 165000 individuals. *BMJ Open* 7:e014006.

Krishnan, S. I. (2011) The transition of teenage girls and young women from ex-combatants to civilian life: a case study in Sri Lanka. *Intervention* 9(2) 137-144.

Lambert, J. E., Witting, A. B., Anderson, S., Ponnamperuma, L. & Wickrama, T. (2017) Posttraumatic Cognitions and Depressive Symptoms in War and Disaster Affected Widows in Sri Lanka: The Role of Community Support. *Contemporary Family Therapy*.

Lansakara, N., Wickramasinghe, A. R. & Seneviratne, H. R. (2011) Feeling the Blues of Infertility in a South Asian Context: Psychological Well-Being and Associated Factors Among Sri Lankan Women with Primary Infertility. *Women & Health,* 51 383–399.

Levy, B. R., Slade, M. D. & Ranasinghe, P. (2009) Causal Thinking After a Tsunami Wave: Karma Beliefs, Pessimistic Explanatory Style and Health Among Sri Lankan Survivors. *Journal of Religious Health* 48 38–45.

Lommen, M. J. J., Sanders, A. J. M. L., Buck, N. & Arnt, A. (2009) Psychosocial predictors of chronic Post-Traumatic Stress Disorder in Sri Lankan tsunami survivors. *Behaviour Research and Therapy* 47 60–65.

Malhotra, R. Chan, A. & Østbye, T. (2010) Prevalence and correlates of clinically significant depressive symptoms among elderly people in Sri Lanka: findings from a national survey. *International Psychogeriatrics* 22(2) 227–236.

Manuel, C., Gunnell, D. J., van der Hoek, W., Dawson, A., Wijeratne, I. K. & Konradsen, F. (2008) Self-poisoning in rural Sri Lanka: small-area variations in incidence. *BMC Public Health* 8:26.

Mohamed, F., Perera, A., Wijayaweera, K., Kularatne, K., Jayamanne, S., Eddleston, M., Dawson, A., Konradsen, F. & Gunnell, D. (2011) The prevalence of previous self-harm amongst self-poisoning patients in Sri Lanka. *Social Psychiatry & Psychiatric Epidemiology* 46 517–520.

Østbye, T., Malhotra, R., & Chan, A. (2009) Thirteen Dimensions of Health in Elderly Sri Lankans: Results from a National Sri Lanka Aging Survey. *Journal of the American Geriatrics Society* 57(8) 1376–1387.

Perera, B., Østbye, T. & Jayawardana, C. (2009) Neighborhood Environment and Self-Rated Health among Adults in Southern Sri Lanka. *International Journal Environmental Research and Public Health* 6 2102-2112.

Ponnamperum, T. & Nicolson, N. A. (2016) Negative Trauma Appraisals and PTSD Symptoms in Sri Lankan Adolescents. *Journal of Abnormal Child Psychology* 44 245–255.

Premadasa, I. G., Wanigasooriya, N. C., Thalib, L. & Ellepola, A. N. B. (2011) Harassment of newly admitted undergraduates by senior students in a Faculty of Dentistry in Sri Lanka. *Medical Teacher* 33:10.

Prior, M., Virasinghe, S., & Smart, D. (2005) Behavioral problems in Sri Lankan schoolchildren Associations with socio-economic status, age, gender, academic progress, ethnicity and religion. *Social Psychiatry & Psychiatric Epidemiology* 40 654–656.

Rajapakse, T., Christensen, H., Cotton, S. & Griffiths, K. M. (2016) Non-fatal self-poisoning across age groups in Sri Lanka. *Asian Journal of Psychiatry* 19 79–84.

Ranasinghe, P. D., & Levy, B. R. (2007) Prevalence of and Sex Disparities in Posttraumatic Stress Disorder in an Internally Displaced Sri Lankan Population 6 Months After the 2004 Tsunami. *Disaster Medicine and Public Health Preparedness* 1(1) 34-41.

Rodrigo, A., McQuillin, A. & Pimm, J. (2009) Effect of the 2004 tsunami on suicide rates in Sri Lanka. *Psychiatric Bulletin* 3(3) 179-180.

Rodrigo, A., Owada, K., Wainer, J., Baker, R. & Williams, S. (2013) Comparison of suicide rates in Sri Lanka during and after the civil war. *Australasian Psychiatry* 21(4) 410.

Rodrigo, C., Welgama, S., Gunawardana, A., Maithripala, C., Jayananda, G. & Rajapakse, S. (2010) A retrospective analysis of cannabis use in a cohort of mentally ill patients in Sri Lanka and its implications on policy development. *Substance Abuse Treatment, Prevention, and Policy* 5:16.

Rodrigo, C., Welgama, S., Gurusinghe, J., Wijeratne, T., Jayananda, G., & Rajapakse, S. (2010) Symptoms of anxiety and depression in adolescent students; a perspective from Sri Lanka. *Child and Adolescent Psychiatry and Mental Health*, 4:10.

Samarakkody, D., Fernando, D., McClure, R., Perera, H., & de Silva, H. (2012) Prevalence of externalizing behavior problems in Sri Lankan preschool children: birth, childhood, and socio-demographic risk factors. *Social Psychiatry & Psychiatric Epidemiology* 47 757–762.

Samaraweera, S., Sumathipala, A., Siribaddana, S., Sivayogan, S. & Bhugra, D. (2008) Completed Suicide among Sinhalese in Sri Lanka: A Psychological Autopsy Study. *Suicide and Life-Threatening Behavio*r 38(2) 221-228.

Samaraweera, S., Sumathipala, A., Siribaddana, S., Sivayogan, S., & Bhugra, D. (2010) Prevalence of Suicidal Ideation in Sri Lanka. *Crisis* 31(1) 30–35.

Sathiadas, M. G., Mayoorathy, S., Varuni, K. & Sri Ranganathan, S. (2017) Child Abuse in Northern Sri Lanka. *Indian Journal of Pediatrics* 84(2) 128–133.

Shanmugam, G. & Emmanuel, S. (2010) A study of sexual abuse of adolescent girl children in Batticaloa: At least one out of every thirty girls. Report, Save the Children Sri Lanka. Colombo: The Good Practice Group.

Siriwardhana, C., Abas, M. & Siribaddana, S. (2015) Dynamics of resilience in forced migration: a 1-year follow-up study of longitudinal associations with mental health in a conflict-affected, ethnic Muslim population. *BMJ* Open 5 e006000.

Siriwardhana, C., Adikari, A., Pannala, G., Siribaddana, S., & Abas, M. (2013) Prolonged Internal Displacement and Common Mental Disorders in Sri Lanka: The COMRAID Study. *PLoS ONE* 8(5) e64742.

Siriwardhana, C., Adikari, A., Pannala, G., Roberts, B., Siribaddana, S., Abas, M., Sumathipala, A. & Stewart, R. (2015) Changes in mental disorder prevalence among conflict-affected populations: a prospective study in Sri Lanka (COMRAID-R). *BMC Psychiatry* 15:41.

Siriwardhana, C., Pannala, G., Siribaddana, S., Sumathipala, A. & Stewart, R. (2013) Impact of exposure to tsunami, conflict and mental disorders on school absenteeism: findings from a national sample of schoolchildren aged 12-17 years. *BMC Public Health* 13:560.

Siriwardhana, C., Wickramage, K., Siribaddana, S., Vidanapathirana, P., Jayasekara, B., Weerawarna, S., Pannala, G., Adikari, A., Jayaweera, K., Pieris, S. & Sumathipala, A. (2015) Common mental disorders among adult members of 'left-behind' international migrant worker families in Sri Lanka. *BMC Public Health* 15:299.

Somasundaram, D. (2007) Collective trauma in northern Sri Lanka: a qualitative psychosocial-ecological study. *International Journal of Mental Health Systems* 1:5.

Somasundaram, D. (2008) Psycho-social aspects of torture in Sri Lanka. *International Journal of Culture and Mental Health* 1(1) 10-23.

Somasundaram, D. & Sivayokan, S. (2013) Rebuilding community resilience in a post-war context: developing insight and recommendations: a qualitative study in Northern Sri Lanka. *International Journal of Mental Health Systems* 7:3.

Soysa, C. & Azar, S. (2016) Active War in Sri Lanka: Children's War Exposure, Coping, and Post traumatic Stress Disorder Symptom Severity. *American Journal of Orthopsychiatry* 86(6) 671-685.

Sriskandarajah, V., Neuner, F. & Catani, C. (2015) Predictors of violence against children in Tamil families in northern Sri Lanka. *Social Science & Medicine* 146 257-265.

Tay, A. K., Jayasuriya, R., Jayasuriya, D. & Silove, D. (2017) Twelve-month trajectories of depressive and anxiety symptoms and associations with traumatic exposure and ongoing adversities: a latent trajectory analysis of a community cohort exposed to severe conflict in Sri Lanka. *Translational Psychiatry* 7 e1200.

The Asia Foundation (2016) Transitions in Mental Health and Psychosocial Support Services in Sri Lanka 2004-2015: A Decade in Review, Colombo: The Asia Foundation.

The Asia Foundation (2015) *Mapping Study on the Capacity and Work Experience of Counselling Assistants attached to the Ministry of Child Development and Women's Affairs*, Colombo: The Asia Foundation.

The Asia Foundation (2015) *Mapping Study on the Capacity and Work Experience of Counselling Officers /Assistants attached to the Ministries of Social Services and Child Development and Women's Affairs*, Colombo: The Asia Foundation.

Thomas, F. C., Vallipuram, A., Jordans, M. J. D., Tol, W. A., Sivayokan, S., Reis, R. & de Jong, J. T. V. M. (2016) Emic Perspectives on the Impact of Armed Conflict on Children's Mental Health and Psychosocial Well-Being: Applying a Social Ecological Framework of Resilience in Northern Sri Lanka. *Peace and Conflict: Journal of Peace Psychology,* 22(3) 246–253.

Wettasinghe, K., Emmanuel, S., Samuels, F. & Galappatti, A. (2015) *Mental health and psychosocial support provision for adolescent girls in post-conflict settings: a culturally sensitive response,* United Kingdom: Overseas Development Institute.

Wickrama, K. A. S. & Kaspar, V. (2007) Family context of mental health risk in Tsunami-exposed adolescents: Findings from a pilot study in Sri Lanka. Social Science & Medicine 64 713–723.

Wickrama, K. A. S. & Wickrama, K. A. T. (2008) Family context of mental health risk in tsunami affected mothers: Findings from a pilot study in Sri Lanka. *Social Science & Medicine* 66 994-1007.

Wickramage, K., de Silva, M. & Peiris, S. (2017) Patterns of abuse amongst Sri Lankan women returning home after working as domestic maids in the Middle East: An exploratory study of medico-legal referrals. *Journal of Forensic and Legal Medicine* 45 1-6.

Wickramage, K., Siriwardhana, C., Vidanapathirana, P., Weerawarna, S., Jayasekara, B., Pannala, G., Adikari, A., Jayaweera, K., Peiris, S., Siribaddana, S. & Sumathipala, A, (2015) Risk of mental health and nutritional problems for left-behind children of international labor migrants. *BMC Psychiatry* 15:39.

Widger, T. (2012) Suffering, Frustration, and Anger: Class, Gender and History in Sri Lankan Suicide Stories. *Culture, Medicine and Psychiatry* 36 225-244.

Widger, T. (2015) Suicide and the 'Poison Complex': Toxic Relationalities, Child Development, and the Sri Lankan Self-Harm Epidemic. *Medical Anthropology,* 34(6) 501-516.