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Letter to Editor

IMPROVING MENTAL HEALTH ACCESS TO MULTI-RELIGIOUS UNIVERSITY STUDENTS IN DIVERSE CULTURES

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Dear editor,

Gale and Thalitaya's article titled 'supporting students of diverse cultures and faiths - experiences from a university perspective'; showed ways to improve the mental health of university students of diverse cultures and faiths (Gale & Thalitaya 2017). We are attempting to show the relevance of this publication to universities in Sri Lanka.

Sri Lanka which is a former Portuguese, Dutch and British colony has a 21 million multi-religious population and a middle-income economy. More than 70% of the population in Sri Lanka are Theravada Buddhists, another 12.6% Hindus, followed by 9.7% Muslims and 7.6% Christians (Department of Census, 2012). The country had experienced 30 years of war in the North with more than sixty thousand deaths and a boxing day Tsunami taking thirty thousand lives in the South in 2004.

Sri Lanka's literacy rate is close to 93%, which is the highest in South Asia and one of the best in Asia. The country has a free education system up to the tertiary level and the higher education in the country was initiated by Buddhist monks many centuries before the arrival of the Europeans. The modern higher education began in 1870 when the Ceylon Medical School was established by the British (Ministry of Education, 2017). Some of the Buddhist higher education centres were converted into modern universities, such as the University of Kelaniya, which originated from the Vidyalankara Pirivena. In addition, Roman Catholic, Anglican, Methodist, Baptist and other missionaries established many schools throughout the country. Therefore, the birth and development of Sri Lankan higher education are closely associated with religious faith.

Kuruppuarachchi et al. found that almost 40% of the students from five universities in Sri Lanka showed significant psychological distress (Kuruppuarachchi et al. 2002). In contrast to the need, the number of mental health professionals is limited and there are stigmatizing attitudes towards mental illness. However, the number of psychiatrists has risen after the end of the armed conflict in 2009 as many obtaining advanced training in the United Kingdom and Australia returning to the peaceful country (Chandradasa & Kuruppuarachchi 2017). This has lead to psychiatry departments being established in all eight medical faculties and students having access to mental health care inside the university premises. But the mental health access to students is not properly coordinated and limited in faculties situated away from medical faculties.

Gale and Thalitaya have written about employing a full-time mental health advisor to provide culturally sensitive psychological support to students. It is highly appreciative that the mental health advisor is clinically supervised by a consultant psychiatrist. We believe this model that provides initial assessments, supporting structures and referral to appropriate services, could help to consolidate culturally sensitive mental health access to Sri Lankan university students from diverse religious faiths. A mental health advisor could help to improve the mental health literacy among the students and coordinate mental health services in liaison with the psychiatry departments.

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