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From Trauma to Resilience: Developing a Community-Driven Psychosocial Recovery Framework for Post-War Sri Lankan Communities

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ABSTRACT

In post-conflict Sri Lanka, community-based mental health systems are critical to long-term psychosocial recovery, yet the roles and effectiveness of non-clinical cadres remain underexamined. Drawing on interdisciplinary collaboration between psychiatry and public policy, this study evaluates the contribution of Community Service Assistants (CSAs) to mental health service delivery in Mullaitivu District—a region heavily affected by war and structural deprivation. Employing a convergent parallel mixed-methods design, data were collected from 11 CSAs, 20 service users, and 12 mental health professionals between March and July 2025. Quantitative data were analyzed descriptively, while qualitative data were thematically coded and interpreted through implementation science and community resilience frameworks. Results reveal that 95% of service users rated CSA support as "very helpful," highlighting strong relational effectiveness. However, systemic weaknesses were pronounced: 90.9% of CSAs were diverted to non-mental-health duties and 81.8% experienced transfers disrupting continuity of care. Three interlinked constraints emerged: erosion of role identity through task drift, capability gaps due to inconsistent training and supervision, and operational frictions limiting outreach. The study proposes a reform-oriented Community Psychosocial Systems Model grounded in capability strengthening, institutional recognition, and intersectoral alignment. By integrating clinical insight with governance and systems analysis, the paper advances a scalable framework for post-conflict mental health recovery applicable to similar low-resource contexts globally.

Keywords: Community Mental Health, Post-Conflict Recovery, Mixed-Methods Research, Task-Shifting, Sri Lanka, Psychosocial Workforce

INTRODUCTION

The scars of war extend far beyond visible infrastructure damage, embedding themselves within social institutions, identities, and collective memory. In Sri Lanka's Northern Province—particularly Mullaitivu District—post-conflict recovery remains incomplete, not only at the psychological level but also within institutional systems responsible for community wellbeing. This study emerges from an interdisciplinary collaboration between psychiatry and public policy. From a clinical standpoint, the daily realities of trauma, depression, and social fragmentation underscore the necessity of sustained psychosocial engagement. From a governance perspective, however, the sustainability of such engagement depends on workforce structuring, institutional recognition, and policy coherence. Community Service Assistants (CSAs), introduced in 2009 by psychiatrists working in the Northern Province with NGO support, were envisioned as a bridge between specialist psychiatric services and war-affected communities. While their relational effectiveness is widely acknowledged, their institutional positioning remains ambiguous. This study therefore asks not only whether CSAs are effective—but under what systemic conditions their effectiveness can be sustained, scaled, and institutionalized.

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By integrating clinical field experience with public policy analysis, this paper situates the CSA model within global debates on:

- Task-sharing in mental health systems
- Post-conflict resilience frameworks
- Implementation science in low-resource settings
- Governance reform for community-based care

LITERATURE REVIEW

Community-Based Mental Health in Post-Conflict Contexts

Globally, community-based mental health services have become a cornerstone of post-conflict recovery, emphasizing accessibility, cultural relevance, and social reintegration. The World Health Organization's Mental Health Gap Action Programme (mhGAP) (WHO, 2022) and the United Nations' Building Back Better initiative advocate for decentralizing mental health care and empowering local human resources to deliver psychosocial support. These frameworks recognize that after conflict, conventional clinic-based services alone cannot address the widespread and layered mental health burdens rooted in trauma, displacement, and poverty (Miller & Rasmussen, 2010).

Global reviews emphasize that effective community mental health interventions in humanitarian settings require systematic integration between field practice and evidence-based research (Tol et al., 2011).

In Sri Lanka's Northern Province, where conflict-affected populations remain dispersed and infrastructure fragile, community-based approaches are indispensable. The end of the civil war in 2009 created both an opportunity and a challenge: while the national health system expanded its outreach capacity, it also faced an acute shortage of trained professionals and a need for community-embedded psychosocial work (Somasundaram & Sivayokan, 2013). Within this gap, Community Service Assistants (CSAs) were introduced as local mental health facilitators—tasked with bridging the divide between specialist psychiatric services and marginalized communities.

Task-Shifting and Lay Cadres in Mental Health Systems

Task-shifting—the redistribution of selected mental health responsibilities from specialists to trained non-specialists—has proven effective in addressing workforce shortages in low- and middle-income countries (WHO, 2008; Patel et al., 2010). Evidence from Africa, South Asia, and Latin America shows that community-based lay counselors can successfully deliver psychological interventions when adequately trained and supervised (van Ginneken et al., 2013; Jordans et al., 2016).

The success of these initiatives depends on three interlinked dimensions: role clarity and institutional legitimacy, capacity building and supervision, and operational and policy support. Where these elements are weak, such initiatives risk fragmentation and demotivation, as seen when lay workers are diverted to unrelated administrative duties or face burnout due to unclear expectations (Rathod et al., 2017).

Community Resilience and Psychosocial Recovery

Contemporary models of post-conflict mental health increasingly adopt a community resilience perspective, recognizing that psychosocial wellbeing is shaped not only by clinical recovery but also by social cohesion, livelihood, and belonging (Norris et al., 2008; Ventevogel, 2018). This emphasis on strengthening psychosocial wellbeing through community participation and intersectoral collaboration aligns with global mental health promotion frameworks advocating integration within health systems (Barry et al., 2019; World

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Health Organization, 2013). These frameworks highlight the importance of psychosocial protection systems bridging health, education, and welfare sectors, with community-based workers—such as Sri Lanka's CSAs—serving as care facilitators and agents of social rebuilding.

Somasundaram and Sivayokan (2013) demonstrated that local psychosocial workers in Northern Sri Lanka fostered "collective healing" by re-establishing trust networks and cultural rituals. Similarly, Miller and Rasmussen (2010) argue that daily stressors—such as poverty and disrupted social roles—often contribute as much to psychological distress as direct trauma. Consequently, effective post-conflict mental health systems must address both psychological and social determinants of distress.

Within this paradigm, CSAs are positioned as essential intermediaries: they are embedded within communities, attuned to cultural idioms of distress, and able to mediate between biomedical frameworks and traditional coping systems. However, without institutional recognition and continuous capacity building, their potential contribution to community resilience remains underutilized.

Silove's (2013) ADAPT model provides a conceptual framework for understanding psychosocial recovery after conflict, highlighting five adaptive systems—safety, interpersonal bonds, justice, roles and identities, and meaning. These domains are often disrupted by war, and community-level mental health initiatives must restore them to achieve long-term healing. The findings of this study later reflect disruptions particularly in the adaptive systems of roles, safety, and meaning—mirroring the ADAPT model's post-conflict recovery pathways.

Implementation Challenges in Low-Resource Settings

In Sri Lanka, the mental health system remains hierarchically structured with limited integration between hospital-based psychiatry and primary care. Community Service Assistants (CSAs), though essential at the grassroots level, function in a policy vacuum. They are not formally recognized as a mental health cadre, receive inconsistent supervision, and are frequently diverted to unrelated duties—conditions that mirror global implementation challenges in other low-resource settings (Peters et al., 2013).

These systemic weaknesses contribute to what implementation scholars call "program drift," where original objectives are diluted by administrative and logistical pressures. Despite policy commitments to community-based care, practical mechanisms for supervision, training, and stability remain fragile.

While international evidence strongly supports task-shifting and community resilience models, little empirical research has examined how such approaches actually function within Sri Lanka's post-conflict mental health system. Existing studies focus primarily on therapeutic outcomes rather than on the organizational and workforce dynamics that determine sustainability. Addressing this gap, the present study integrates quantitative and qualitative data to examine CSAs' role clarity, capacity, motivation, and systemic challenges in Mullaitivu District—offering insights for designing resilient and culturally grounded community mental health systems.

METHODOLOGY

Research Design and Rationale

This study employed a convergent parallel mixed-methods design to comprehensively evaluate the role, contributions, and challenges of Community Service Assistants (CSAs) in post-conflict Mullaitivu. This design was selected to allow the simultaneous collection and analysis of quantitative and qualitative data, with both strands holding equal priority. Integration occurred at the interpretation stage to identify convergences, divergences, and complementary insights.

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The mixed-methods approach was particularly suited to this study's aim—to capture both measurable service patterns and experiential realities within a complex, low-resource health system. Quantitative data provided structured evidence of service reach and operational barriers, while qualitative data illuminated the lived meanings, perceptions, and institutional dynamics that underlie those numerical patterns. This combination strengthens validity through triangulation and yields a more holistic understanding of the CSA program's functioning. This approach aligns with Creswell and Plano Clark's (2018) framework for mixed-methods research, ensuring methodological coherence.

Study Setting

The study was conducted in Mullaitivu District, located in Sri Lanka's Northern Province. The district remains one of the areas most affected by the 26-year civil conflict, characterized by displaced populations, disrupted livelihoods, and limited access to specialized mental health care. At the time of study, The researcher was the Specialist Medical Officer in Psychiatry in Mullaitivu. There were only three Medical Officers of Mental Health (MOMHs) attached to District General Hospital of Mullaitivu were available to cover 18 peripheral clinics within the district. In this context, CSAs serve as the primary psychosocial support providers at the grassroots level, operating under the supervision of district health authorities.

Participants and Sampling

Quantitative Strand

A census sampling approach was adopted for the CSA component to ensure comprehensive coverage of the existing workforce. All 11 active CSAs in Mullaitivu were invited and participated (100% response rate).

For service users, a simple random sampling method was used to recruit 20 adult clients receiving CSA support across various clinic catchment areas. Sampling was stratified geographically to reflect both urban and rural contexts. The sample size was considered sufficient for descriptive statistical analysis and for ensuring representativeness within the small district population.

Qualitative Strand

Qualitative data were collected from multiple participant categories to ensure methodological triangulation:

- CSAs (n = 11): Semi-structured, in-depth interviews captured work experiences, perceived roles, training, challenges, and coping mechanisms.
- Service users (n = 20): Two focus group discussions (FGDs) (10 participants each) explored perceptions of care quality, accessibility, and unmet needs.
- Key informants (n = 12): Mental health professionals, including two Psychiatrists pioneered in the CSA programme, Psychiatrists currently working in the Northern province, medical officers involved in initiating CSA programme, MOMHs currently working in Northern province, Administrators were purposively selected to provide experience based and institutional perspectives.

Sampling continued until data adequacy was achieved, evidenced by recurring thematic saturation across participant categories.

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Data Collection Procedures

Questionnaires and interview guides were pilot-tested with two CSAs and three service users to ensure clarity and cultural relevance before full implementation.

Data were collected between March and July 2025 through complementary tools and procedures:

1. Structured Questionnaires (Quantitative)
   - Quantitative data were collected through structured questionnaires, complemented by interviews and focus groups.

2. Semi-Structured Interviews (Qualitative)

   - Conducted face-to-face in participants' preferred language (Tamil or Sinhala) and audio-recorded with informed consent.
   - Interview guides were developed collaboratively by the research team, reflecting five core domains: role clarity, supervision and training, workload, mobility, and institutional support.
   - Each interview lasted between 45–60 minutes.

3. Focus Group Discussions (FGDs)

   - Used participatory questioning to elicit collective perspectives on the accessibility and relevance of CSA services.
   - Facilitated by a bilingual researcher and an observer who documented nonverbal interactions.

4. Document Review

   - CSA duty lists, transfer records, and mental health policy documents were reviewed to contextualize administrative and structural patterns.

To ensure accuracy, all qualitative data were transcribed verbatim and translated into English by trained bilingual assistants. Back-translation was used on a random subset (20%) to confirm semantic fidelity.

Data Analysis

Integration through joint displays (Fetters et al., 2013), ensured methodological transparency and reinforced the validity of cross-strand conclusions.

Quantitative Analysis

Descriptive statistics were generated using SPSS version 28. Frequencies, percentages, and 95% confidence intervals (where applicable) were calculated. Planned cross-tabulations explored:

- Training (yes/no) × Service delivery activities (counseling, home visits)
- Transfer frequency (high/low) × Service continuity indicators
- Non-mental-health duties (yes/no) × Time allocated to psychosocial support

Given the small sample size, inferential tests were not conducted; findings are presented descriptively and interpreted alongside qualitative evidence.

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Qualitative Analysis

Qualitative data were analyzed thematically using NVivo 14. Two researchers independently coded the transcripts, compared interpretations, and refined themes through discussion to ensure consistency and credibility. This hybrid inductive–deductive process was guided by sensitizing concepts from the Capability–Opportunity–Motivation–System (COMS) model. Three major themes emerged: role identity erosion, capability gaps, and operational frictions.

Integration and Triangulation

Findings from both strands were integrated using joint display matrices (Fetters et al., 2013), aligning quantitative indicators with qualitative explanations to identify convergent and divergent patterns. For example, high rates of non-mental-health assignments (90.9%) were interpreted alongside narratives of "task drift" and "identity loss," providing explanatory depth beyond numerical trends.

Ethical Considerations

Conducted under Sri Lanka's national ethics framework (Ministry of Health, 2015). The formal ethical clearance was taken from the University of Vavuniya Ethical Review committee. The research was an independent service evaluation and also no interventions were introduced and all data were anonymized.

Given the sensitivity of working with mental health staff and conflict-affected populations, interviews were conducted in safe, neutral settings. Participants were reminded that withdrawal was voluntary at any stage without penalty.

Researcher Reflexivity and Trustworthiness

The study was carried out by a researcher with professional experience in mental health service delivery in Northern Sri Lanka. This positionality was acknowledged and reflected upon throughout the research process to reduce potential interpretive bias. A reflexive journal was maintained during data collection and analysis to examine assumptions, emotional responses, and the influence of prior experience on interpretation.

To ensure trustworthiness (Lincoln & Guba, 1985):

- Credibility was strengthened through triangulation across data sources and participant groups, and through member checking with two CSA representatives.
- Dependability was supported by a detailed audit trail documenting methodological decisions, coding procedures, and reflexive notes.
- Transferability was facilitated by providing rich, contextual descriptions of the research setting and participant characteristics.
- Confirmability was upheld through transparent data management and systematic documentation of analytic steps, allowing interpretations to be traced to the data.

Findings from both quantitative and qualitative strands are presented below in an integrated narrative.

RESULTS

1. Participant Characteristics

Community Service Assistants (n = 11)

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CSAs were predominantly aged 30–50 years (72.7%), and 100% were female. The majority of CSAs (90.9%) had more than six years of service, demonstrating a well-established and experienced workforce.. Educational qualifications ranged from secondary education to basic diploma level.

Ten of the eleven participants (90.9%) reported having received formal mental health training, suggesting that while the majority had foundational instruction, the adequacy and consistency of this training may still vary considerably.

Service Users (*n* = 20)

Service users ranged in age from 21 to 65 years, with a near equal gender distribution. All were residents of war-affected areas and received services for conditions such as depression, anxiety, substance misuse, and psychosocial distress related to displacement and loss. Most participants had ongoing relationships with their CSA for at least six months.

This cohort reflected the district's post-conflict demographic composition, providing insights into both gendered and age-related variations in care needs.

Mental Health Professionals (n = 12)

Participants included two Psychiatrists pioneered in starting the CSA programme, three psychiatrists currently working in the Northern province, two Medical Officers pioneered in starting the programme and three Medical Officers of Mental Health (MOMHs), one Psychiatric Social Worker (PSW) and one senior nursing officer. All had supervisory responsibilities for CSAs. They provided contextual perspectives on training, workload, and systemic functioning.

2. Quantitative Findings: Service Delivery and Role Allocation

2.1 Service Provision Profile

All CSAs (100%) reported providing psychosocial support and referral services, with 90.9% additionally delivering counselling and the full cohort (100%) conducting home visits. Furthermore, 72.7% were engaged in mental health awareness activities within local communities and schools.

Despite these core responsibilities, 90.9% indicated that they were routinely assigned non–mental-health duties, including administrative and public health tasks such as office maintenance, dengue surveillance activities, school health programmes, and dental campaigns. An analysis of time allocation revealed that 38.4% of their work hours were spent on MOH-related duties unrelated to mental health, while only 48.5% were dedicated to psychosocial service delivery. This pattern of task drift significantly diverted their time away from their primary mandate of providing community-based psychosocial support.

Participants described feeling constrained in their ability to deliver timely services and expressed a sense of diminished professional autonomy and recognition. As one CSA noted:

"There are five Health Service Assistants assigned to my MOH office, although the actual cadre is only three. Yet I am still required to remain in the MOH office, and my scheduled home visits are questioned as if they are unnecessary." (CSA participant)

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2.2 Training and Supervision

A majority of CSAs (90.9%) reported having received some form of structured training in basic counselling or psychosocial skills. However, following the initial training, there has been no continuity of training-oriented programmes to support ongoing skill development. Technical support is provided intermittently by the district mental health team, while routine day-to-day supervision is primarily overseen by the MOH. Monthly meetings are conducted with the mental health team, although these sessions tend to focus largely on administrative issues and challenges encountered in the field. Nonetheless, efforts are currently being made by the mental health team to strengthen the quality and structure of these meetings.

Notably, there is no standardized system for documenting CSA activities—such as diary entries, case logs, or structured reporting formats—and client feedback is not routinely collected. The absence of these mechanisms limits quality assurance processes, constrains the monitoring of service effectiveness, and reduces opportunities for systematic follow-up and continuous improvement in psychosocial care.

2.3 Transfers and Continuity of Care

Transfers emerged as a major operational challenge within the CSA system, with 81.8% of CSAs reporting that transfers disrupt long-term therapeutic relationships with service users**.** The ability of CSAs to build sustained, trusting relationships over time is one of their greatest strengths in community mental health promotion. Their residence within or near the same community allows them to conduct regular home visits**,** respond promptly to crises, and engage families with minimal difficulty or burden.

In a collectivist society such as ours—where community ties, familiarity, and shared cultural practices are central to wellbeing—CSAs working in the same area where they live has never posed a problem**,** provided they continue to uphold ethical boundaries and maintain confidentiality. Instead, it has consistently been an advantage**,** strengthening rapport, ensuring continuity of care, and enhancing the effectiveness of mental health interventions at the community level.

3. Service User Feedback and Unmet Needs

From the 20 service users surveyed:

- 95% of **service users** reported that the support provided by the CSA was **very helpful**.
- Only 5% reported limited benefit, mainly due to irregular visits.

Users expressed high emotional trust in CSAs, citing accessibility and shared community identity as reasons for comfort.

However, they also identified unmet needs that exceeded CSAs' scope or resources:

- 45% requested more frequent home visits.
- 30% requested financial assistance or livelihood support.
- 20% requested employment-related help.
- 15% requested expanded counseling sessions or family involvement.

These findings illustrate that service users perceive CSAs as first responders and social connectors within a fragmented service landscape.

4. Qualitative and Integrated Findings: Emergent Themes

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Thematic analysis yielded three major themes explaining the systemic conditions shaping CSA work. Integration with quantitative data confirmed consistent cross-strand convergence.

Theme 1: Erosion of Role Identity through Task Drift and Transfers

A majority of CSAs (90.9%) reported being diverted to general health duties that dilute their psychosocial role. Qualitative narratives described feelings of identity confusion and undervaluation:

"As Community Service Assistants, we have been expected to carry out duties that are typically assigned to Health Service Assistants. At times, HSA colleagues expect us to take on their responsibilities too, which has led to misunderstandings and occasional conflict."

Frequent transfers and mixed role expectations diluted the CSA identity, undermining service continuity.

This theme aligns with quantitative evidence showing widespread non-mental-health assignments and discontinuity in care delivery, highlighting institutional misclassification as a root cause of inefficiency.

Theme 2: Capability Gaps and Informal Learning

Limited training left most CSAs ill-equipped and lacking confidence to carry out essential mental-health interventions in many community settings, including schools and other public institutions.

This theme underscores the capability–supervision gap, where motivation is strong but technical skill and guidance are lacking—a pattern common in task-shifting programs globally (Patel et al., 2018).

Theme 3: Operational Frictions and the Limits of Reach

Operational constraints—particularly lack of transport, resources, and allowances—restricted CSAs' ability to maintain regular outreach.

"We use our own bicycles to visit patients, but the distances are great and we get no transport allowance." (CSA participant).

Quantitatively, 45% of users requested more home visits, confirming that logistical barriers directly influence service availability. This shortage of operational support manifests as lower contact intensity, reduced follow-up, and inequitable access—especially in remote divisions.

Mental health professionals noted that such conditions contributed to burnout and attrition:

"They continue out of passion, not support. But passion cannot sustain a workforce forever."

Joint Integration: Quantitative–Qualitative Convergence

The convergence of both data strands reinforced three central findings (Table 1).

Table 1. Joint Integration of Quantitative and Qualitative Findings

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Quantitative Indicator	Qualitative Theme / Mechanism	Interpretation / Policy Implication
90.9% assigned non-mental-health duties	*Theme 1: Role identity erosion / task drift*	Misclassification dilutes mental health focus → CSAs should be recognized as a distinct cadre.
90.9% received initial formal training but no continuity of training	*Theme 2: Capability gap*	Lack of structured training limits care quality → establish standardized curricula and supervision.
45% of users requested more home visits	*Theme 3: Operational constraints*	Lack of transport and allowances limits outreach → allocate logistical support.

This triangulated matrix demonstrates how numerical trends (e.g., task drift, transfer rates) align with experiential accounts of systemic fragmentation.

The joint analysis indicates systemic misalignment between CSAs' assigned roles and the expectations of the mental health system. While motivation and community trust are strong, organizational fragility—marked by limited training, poor supervision, and unstable posting—severely caps program effectiveness.

Explanatory Synthesis: The COMS Model

The findings collectively informed the development of a Capability–Opportunity–Motivation–System (COMS) explanatory model.

Component	Status in Mullaitivu CSA Program	Implication
Capability (knowledge, training, supervision)	Low to moderate	Needs structured training, regular supervision, and case review mechanisms.
Opportunity (resources, stable environment)	Constrained	Operational barriers and transfers limit reach and continuity.
Motivation (intrinsic commitment, community trust)	High	Strong foundation for workforce engagement and retention.
System (policy, recognition, institutional alignment)	Weak	Misclassification and lack of cadre recognition hinder sustainability.

This model provides a systemic explanation for the coexistence of high community satisfaction and low structural stability. The imbalance between motivation and systemic support results in high relational performance but low institutional resilience. This model is elaborated further in the Discussion to interpret systemic implications.

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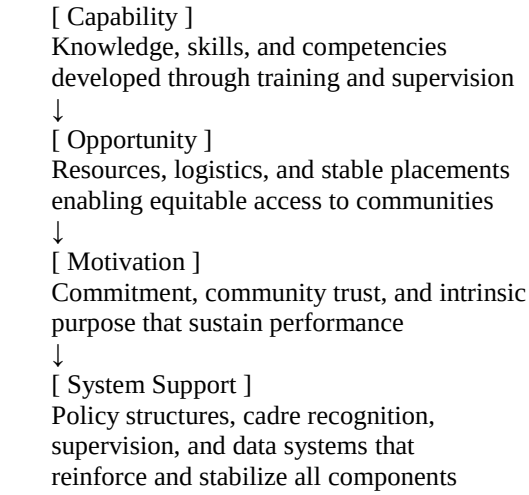
7. Summary of Findings

- High relational effectiveness: CSAs are trusted, culturally congruent, and emotionally available to service users.
- Structural instability: Transfers, lack of cadre recognition, and operational neglect disrupt consistency and morale.
- Capability limitations: Training and supervision gaps undermine quality and safety of psychosocial care.
- Systemic misalignment: Policies and human resource structures fail to reflect actual mental health service demands.

Collectively, these findings highlight that CSAs' strength lies in community engagement, but their weakness lies in system design—a duality that defines the paradox of post-conflict community mental health service delivery.

Figure 1
Capability–Opportunity–Motivation–System (COMS) Model for Understanding CSA Performance



Interpretation. The COMS model illustrates how CSA performance emerges from the interaction of individual factors—Capability, Opportunity, and Motivation—within broader System supports. Weakness in any component undermines overall program effectiveness.

DISCUSSION

The findings reveal a paradox: high community trust coexists with institutional fragility. From a psychiatric lens, CSAs function as relational anchors in traumatized communities, providing culturally congruent psychosocial support. From a systems perspective, however, their impact is constrained by weak role classification, inconsistent supervision structures, and policy misalignment.

This dual interpretation underscores a critical lesson for post-conflict health reform: Community trust alone cannot sustain mental health systems. Institutional scaffolding must reinforce relational work.

The proposed Capability–Opportunity–Motivation–System (COMS) framework therefore reflects both:

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• Clinical realities of frontline mental health delivery
• Governance principles of workforce stabilization and implementation fidelity

By aligning these domains, the CSA model can evolve from a compassionate but fragile initiative into a resilient institutional mechanism for psychosocial recovery.

Interpreting High Satisfaction amid Constrained Capacity

The finding that 95% of service users rated CSA support as "very helpful" reflects the enduring value of relational, proximate care in post-conflict contexts. In settings marked by trauma, displacement, and mistrust of formal institutions, psychological recovery begins with human connection (Miller & Rasmussen, 2010). CSAs' linguistic fluency, cultural familiarity, and consistent presence fostered a sense of safety and belonging that professionalized interventions alone often cannot provide.

However, this high satisfaction likely reflects relational access rather than therapeutic intensity. Similar to findings from Somasundaram & Sivayokan (2013), the supportive role of lay mental health workers often achieves stabilization, but not sustained remission of trauma symptoms, in the absence of structured therapeutic training. This underscores the importance of developing competency-based training to translate relational empathy into evidence-based psychosocial interventions.

Role Identity and Continuity as Core Implementation Levers

The high prevalence of task drift (90.9%) and risk of transfer (81.8%) represents an erosion of professional identity that directly compromises care continuity. From an implementation science perspective, this phenomenon reflects low implementation fidelity—where organizational ambiguity causes deviation from intended program design (Fixsen et al., 2005).

Globally, successful task-shifting models in mental health (Patel et al., 2018; van Ginneken et al., 2013) emphasize role clarity, supervision, and continuity as non-negotiable pillars. When community cadres are absorbed into broader administrative functions, they lose both their psychosocial focus and the longitudinal relationships that underpin trust-based care.

In Mullaitivu, such instability has psychosocial costs: the frequent transfer of CSAs disrupts therapeutic bonds, erodes community trust, and negates cumulative knowledge about local family systems—precisely the relational capital that differentiates CSAs from clinical practitioners. Reclassifying CSAs as a distinct mental health cadre with minimum tenure security would therefore represent not merely administrative reform but a therapeutic intervention at the system level.

Capability and Supervision as Multipliers of Quality and Safety

With 90.9% of CSAs reporting initial formal mental health training, the absence of ongoing, structured training highlights a significant capability gap. It is commendable that NGO-led training programmes are conducted from time to time and that the district mental health team continues to make efforts to build CSA capacity; however, these initiatives remain intermittent and lack a consistent framework. This challenge is further compounded by the severe shortage of psychiatrists in the Northern Province—serving a population of approximately 1.3 million—which restricts the availability of specialist-led training and supervision. These findings echo global evidence indicating that undertrained lay workers, despite their commitment, risk functioning as 'empathic generalists' rather than effective therapeutic agents (Rathod et al., 2017)."

A minimum standard training package—covering trauma-informed care, crisis triage, and basic counseling—would enhance both competence and confidence. Importantly, training must be embedded

within a supervision ecosystem that includes reflective case review, peer mentoring, and structured feedback loops. Evidence from task-shifting initiatives in India and Uganda indicates that regular supervision not only improves clinical outcomes but also protects worker mental health by reducing moral distress and burnout (Jordans et al., 2016; Patel et al., 2018).

Thus, capability-building in Mullaitivu should be conceptualized not as a one-off training event but as a continuous learning system—linking skill acquisition with psychosocial safety for workers themselves.

Operational Enablers as Determinants of Equity of Access

Operational barriers—particularly lack of transport, allowances, and basic materials—emerged as structural determinants of inequity in service reach. Although modest in appearance, these logistical constraints have disproportionate effects: they limit home-visit coverage, restrict follow-up intensity, and isolate the most remote households.

The absence of such enablers transforms the geography of care into a geography of exclusion. Evidence from other post-conflict settings, such as Nepal and Sierra Leone, shows that when outreach resources are insufficient, community programs inadvertently reproduce inequities by favoring populations living closer to clinic hubs (Iemmi, 2019; Ventevogel, 2018).

Therefore, small-scale logistical investments—such as transport allowances, communication tools, and resource kits—represent equity interventions rather than operational niceties. They expand the spatial and relational reach of the mental health system, allowing psychosocial care to penetrate beyond administrative boundaries.

Integration of Mental Health and Socioeconomic Recovery

Service users' frequent requests for financial and employment assistance (30% and 20%, respectively) underscore the inseparability of mental health from the broader social determinants of wellbeing—poverty, displacement, and livelihood loss. These findings reinforce Miller and Rasmussen's (2010) assertion that in post-conflict contexts, daily stressors perpetuate psychological distress. Mental health recovery, therefore, cannot proceed in isolation from socioeconomic recovery.

Integrating CSA activities with livelihood programs, microfinance initiatives, and disability welfare schemes would operationalize a holistic biopsychosocial approach aligned with the WHO's *Building Back Better* framework (WHO, 2022). Such intersectoral collaboration could elevate CSAs from supportive listeners to active facilitators of social reintegration, transforming psychosocial care into a platform for resilience and empowerment.

This alignment with global frameworks (Barry et al., 2019; WHO, 2013) strengthens international evidence that sustainable mental health systems must directly address social determinants of wellbeing through coordinated, cross-sectoral action.

The COMS Model: A Systemic Interpretation

As detailed in the Results section, the COMS model illustrates how capability, opportunity, and motivation interact within weak system structures to shape CSA performance. This framework explains how frontline psychosocial systems function under structural constraint, where individual motivation temporarily compensates for institutional deficiencies. Such reliance on intrinsic commitment is admirable but unsustainable: without policy reinforcement, capacity-building, and structural recognition, morale and service quality inevitably erode.

Strengthening capability through standardized training, expanding opportunity through logistical support, and embedding system recognition through cadre reform would collectively transform a fragile, person-dependent program into a resilient institutional structure. These dynamics parallel the adaptive systems of safety, justice, and role identity described in Silove's (2013) ADAPT framework, demonstrating that stabilizing role identity and institutional trust is fundamental to psychosocial recovery in post-conflict societies.

Theoretical and Global Implications

This study contributes to three interlinked theoretical and policy debates:

1. Task-Shifting Efficacy: Successful task-shifting depends not only on delegating tasks but also on redistributing authority, supervision, and institutional recognition. Without structural anchoring, task-shifting risks devolving into *task-drifting*.
2. Community Resilience Frameworks: The findings affirm that community mental health workers act as social bridges, rebuilding trust networks in conflict-affected communities (Somasundaram & Sivayokan, 2013; Norris et al., 2008). Yet resilience is not purely communal—it must be institutionally scaffolded through stable structures and supportive policy environments.
3. Implementation Science: By linking individual motivation with system-level dysfunction, the study highlights that implementation fidelity and sustainability hinge on policy design, not merely training quality (Fixsen et al., 2005).

Together, these insights position the CSA program within global discussions on building adaptive, resilient, and culturally grounded community mental health systems in low-resource and post-conflict settings. By bridging psychosocial theory with implementation science, the study demonstrates how community-based programs can serve as laboratories for post-conflict social innovation and sustainable systems transformation.

Strengths, Limitations, and Future Directions

Strengths of this study include its census-based CSA sample, multi-perspective triangulation, and mixed-methods integration through joint display matrices. Data collection in local languages enhanced ecological validity and captured cultural nuance.

However, limitations include the small quantitative sample size, potential self-report bias, and confinement to one district, which may limit generalizability. Future research could expand to other Northern and Eastern provinces, employ longitudinal or quasi-experimental designs, and incorporate outcome measures such as symptom reduction, functioning, and service utilization.

A promising direction would be to evaluate a "strengthened CSA package"—including cadre recognition, standardized training, structured supervision, and transport provision—through a pragmatic cluster trial or stepped-wedge implementation design.

Ethnographic or participatory approaches could further illuminate how CSAs negotiate identity and legitimacy within complex bureaucratic hierarchies.

Future multi-district studies could also explore gender-specific challenges within the CSA workforce, particularly the impact of caregiving roles and safety concerns on field mobility.

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Practice and Policy Implications

1. Institutional Reform:

   Recognize CSAs as a distinct mental health cadre, anchored within the National Mental Health Directorate, with clear job descriptions and career pathways.

2. Training and Supervision:

   Develop a national training curriculum grounded in trauma-informed care, brief interventions, and ethical practice. Establish periodic case supervision sessions led by regional mental health professionals, including psychiatrists and MOMHs.

3. Operational Support:

   Provide transport allowances, outreach budgets, and psychosocial toolkits to ensure equitable service coverage.

4. Integrated Service Models:

   Embed CSAs within cross-sectoral initiatives linking mental health with livelihood, disability, and social protection programs.

5. Monitoring and Evaluation:

   Introduce a standardized data set (activity logs, referral completion, follow-up rates) and quarterly quality circles for feedback and learning.

Together, these reforms would transform the CSA program from a compassionate but fragile workforce into a sustainable pillar of Sri Lanka's community mental health system.

These strategies align with WHO's (2022) mhGAP implementation guidance and provide adaptable blueprints for replication in South and Southeast Asia and other post-conflict nations.

CONCLUSION

The findings affirm that Sri Lanka's Community Service Assistants embody the human face of post-conflict mental health care—trusted, accessible, and deeply rooted in the communities they serve. Yet, their effectiveness remains capped by structural neglect. By institutionalizing support for CSAs, Sri Lanka can pioneer a scalable model for community-based mental health in post-conflict contexts—one that transforms individual dedication into collective resilience and systemic healing.

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Ethical Considerations

This study was conducted as an independent service evaluation within an existing government community health structure. Consistent with national ethical guidelines, formal IRB review was not required, as no interventions were introduced and all data were anonymized and collected within the scope of routine professional duties. Nevertheless, the research adhered strictly to the ethical principles of voluntary participation, informed consent, confidentiality, and non-maleficence in line with the Declaration of Helsinki (2013, as amended in 2018) and WHO ethical guidance for social and behavioral research. All participants were fully informed about the purpose of the study, their right to decline participation, and the use of anonymized data. No personally identifiable information was collected or reported.

Consent to Participate and Publish

Verbal and written informed consent was obtained from all participants prior to data collection. Participants were informed that their anonymized responses may be used for academic publication.

Competing Interests

The author declares no known financial or personal conflicts of interest that could have influenced the conduct, analysis, or reporting of this study.

Author's Contributions

Dr. P. P. G. I. Krishangani contributed to conceptualization, field coordination, participant recruitment, clinical supervision insight, quantitative data collection, and primary qualitative data interpretation based on frontline psychiatric experience.

Dr. D. L. A. H. Shammika contributed to research design refinement, theoretical framing, policy analysis, integration of implementation science and governance perspectives, joint interpretation of findings, manuscript restructuring, and critical revision for intellectual coherence.

Both authors collaboratively developed the analytical framework, interpreted results, revised the manuscript, and approved the final version for publication.

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Data Availability Statement

The dataset generated and analyzed during the current study is not publicly available due to privacy and confidentiality considerations but is available from the corresponding author, Dr. P. P. G. I. Krishangani, upon reasonable request.

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