Burden of mental illness and the need for better undergraduate education in psychiatry

Mental and behavioural disorders are thought to affect one in four of all people at sometime during their life [1]. The seminal World Health Report 2001 entitled, *Mental Health: New Understanding, New Hope*, pointed out that 450 million people around the world suffer from mental or neurological disorders or from psychosocial problems [1]. Globally, depression, substance abuse, mental retardation, schizophrenia, epilepsy, Alzheimer's disease and the problems of childhood and adolescence are commonly encountered. Mental disorders and medical illnesses are interrelated. For instance, co-morbid depression is higher among patients with physical ailments such as cardiovascular disorders, neurological disorders, diabetes, infections and cancers [2]. Similarly, schizophrenic patients suffer from premature mortality and the main contributory causes are ischaemic heart disease and carcinoma, which seem to be poorly recognized and under-diagnosed [3]. These disorders are often missed and mismanaged due to poor knowledge and stigmatizing attitudes about mental ailments amongst health care professionals. In many psychiatric disorders, early identification and intervention lead to good outcomes and economic gain to societies, whereas long delays in treatment are associated with a poor prognosis [4].

The prevalence of psychiatric illnesses in Sri Lanka is significant. It has been estimated that about 2% (approximately 400,000 people) suffer from serious mental disorders [5]. Available data suggest about 10% are afflicted with more common psychiatric ailments while the prevalence of depression ranges from 9-25%. Sri Lanka also has one of the world's highest suicide rates amongst youth [6], and neuropsychiatric disorders are estimated to account for about 11.5% of the overall burden of disease [7].

Low- and middle-income countries may be more vulnerable to the consequences of mental health disorders because services are inadequately developed and many health professionals are not properly trained [8]. A WHO survey found that a considerable proportion (76.3 - 85.4%) of patients with serious mental disorders in developing countries received no treatment during the year prior to interview [9]. Moreover, natural protective factors such as close family networks, family support in times of adversity and other coping strategies in low- and middle-income countries tend to disappear with economic development and socio-cultural changes, and this in turn, makes matters worse.

Dealing with the burden of mental and behavioural disorders

It may be thought that only those with specialist knowledge in psychiatry should deal with mental and behavioural disorders. The grim reality is that the

number of psychiatrists in Sri Lanka is woefully inadequate to do so. For instance, in 2011, Australia had 12.76 psychiatrists working in the mental health sector, per 100,000 population and the USA had 7.79 psychiatrists per 100,000 population, whereas Sri Lanka had only 0.29 psychiatrists per 100,000 population [10]. There are many reasons for this shortage. Over the last few decades, although many postgraduates were trained in psychiatry, a large proportion has not returned to Sri Lanka after overseas training. Others have worked in Sri Lanka for a few years and then migrated in search of better prospects.

In addition to brain drain, psychiatry as a career choice appears to be less popular when compared with other medical disciplines all over the world. For example, in the UK, about 4-5% of graduates opt to do psychiatry [11]; in the US, the figure is about 3-4% [12]; and in Israel about 6% of students enter psychiatry residency programme [13]. In Sri Lanka only about 2% of undergraduates expressed a desire to take up psychiatry [14] and this figure is low in many other developing countries. The double issue of brain drain and poor career choice is encountered in other South Asian countries as well [15, 16].

Lack of a proper referral system and poorly developed multidisciplinary teams in developing countries also make it difficult for psychiatrists to deliver their services optimally. Developing psychiatry services in the community has been suggested as a remedy for some of these major drawbacks and problems. The WHO advocates incorporating psychiatry into primary care in order to provide better care for the mentally ill in the community, as there are many advantages of doing so. It has been suggested that mental health care should be included in training curricula so that general health professionals acquire essential skills [1]. In Sri Lanka too, the need to establish a comprehensive community based service and treating people with common mental ailments in primary care has been emphasized [5, 17].

Undergraduate medical training in psychiatry in Sri Lanka

Better undergraduate medical training in psychiatry can serve to improve knowledge of psychiatric conditions among general medical practitioners. It would also attract more and better quality graduates into specializing in psychiatry. Many medical schools in Sri Lanka have realised this and changed their curricula. For example, the Faculty of Medicine, University of Kelaniya has expanded psychiatry clinical training in an organized manner to include eight weeks in the final year and two weeks in the third year, in addition to didactic lectures and tutorials, while behavioural sciences and mental health are introduced from the first year. This is a significant development in undergraduate medical education, particularly with regard to attitudinal change concerning mental health and

improving knowledge of human behaviour. Early exposure of students has been shown to facilitate a positive attitudinal change which may also improve recruitment of good quality graduates to do psychiatry [18].

The importance of a high quality training programme

Inspiring, motivating or enthusiastic role models influence positively and encourage medical students to take up psychiatry as a career [19]. It has been suggested that a more positive attitudinal change towards psychiatry among final year students may have been influenced by pre-clinical teaching in psychiatry; this could have prevented deterioration of attitudes during the clinical years, along with a structured, organized module consisting of interactive lectures and small group workshops compared to didactic lectures and an unstructured attachment [20]. A study conducted at the Faculty of Medicine, University of Kelaniya also showed favourable attitudes towards psychiatry at the commencement of the final year clerkship which is likely to be due to the subject being introduced in an organized and structured manner during the first four years [21]. Learning activities included small group discussions and problem based learning in addition to didactic lectures and the two-week clinical attachment during the third year. The results of this study also suggested that exposing students to a final year clinical attachment in psychiatry improved their attitudes towards the discipline.

A recent review highlighted the importance of actively maintaining interest in psychiatry throughout the undergraduate education in order to improve attitudes towards psychiatry and to improve career interest [22]. Another study has demonstrated that the majority of students appreciated primary care based teaching compared to teaching in hospital settings and also developed a positive attitudinal change as a result of it [23]. Students benefit from community based attachments as they see the milder end of the spectrum of mental illnesses and the tendency towards stereotyping of patients with severe mental illnesses is reduced. Exposure to subspecialties also improves attitudinal changes. Students favoured more integration of psychiatry into the undergraduate curriculum with the feasibility of teaching in diverse settings [24].

The quality of the training programme or attachment is more important than, for example, the duration of training [25]. Factors such as poor quality teaching and non-receptive staff reinforce development of negative attitudes amongst medical students. The quality of teaching, enthusiasm of clinical teachers, a holistic approach and the scientific basis of psychiatry also influence students' attitudes [26]. Dissatisfaction of graduating students about the psychiatry clinical attachment is a concern as it may adversely influence recruitment potential [27].

Future directions

Although there is wide disparity at present in the nature of undergraduate training and assessment in psychiatry between the eight state medical schools in Sri Lanka, the need for a greater degree of uniformity in training, evaluation procedures and examination format has been recognized by all departments of psychiatry.

The importance of co-operation and collaboration amongst medical schools in the country, as well as internationally, in order to adequately address issues related to undergraduate psychiatry teaching has been pointed out [28]. The need to identify a core curriculum for undergraduate psychiatry education has been highlighted and detailed guidelines were developed by the World Psychiatric Association together with the World Federation of Medical Education in order to address key issues. The proposed curriculum incorporates objectives in important areas, such as, attitudes, knowledge, skills, assessment and training of teachers. It is also agreed that psychiatry should be a major component of any medical curriculum [29].

There is an urgent need to agree on a core curriculum in psychiatry for undergraduate medical students in Sri Lanka, and to arrive at a consensus regarding the timing and procedure for examination in psychiatry. Including psychiatry as the fifth subject, in addition to medicine, obstetrics and gynaecology, paediatrics and surgery, when compiling the common merit list for placement of medical graduates for internship, would be a major milestone. The next milestone may be the inclusion of psychiatry as an option for internship.

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