Discussion

Mental health service provision in Malawi is critically low, with 4.5 full-time psychiatrists in the country and 2.5 psychiatric nurses per 100 000 people (compared with 11 psychiatrists and 104 nurses per 100 000 people in the UK) (Jacob *et al*, 2007). SMMHEP aims to address the treatment gap through education of students, staff and schools, and has helped produce three new Malawian psychiatry trainees.

Delivery of the new educational course was a positive experience for the volunteers but did present some challenges. Resources, such as textbooks, were limited and there were frequent power cuts. Practical difficulties during the Zomba residential attachment included the student accommodation, which lacked mosquito nets and cooking facilities.

Although this evaluation is of a relatively small number of students, there was a 100% return rate of questionnaires, showing that the new undergraduate programme, which includes a residential psychiatric hospital attachment, is a valuable and effective way for students to gain knowledge and skills. It also has a direct effect on reducing stigma and improving attitudes to psychiatric illness and psychiatry as a potential career path. The results of this survey appear positive and similar studies in Malawi support the finding that education improves attitudes to psychiatry (Beaglehole *et al*, 2008).

However, the reality is that although medical students would consider pursuing psychiatry, this interest is not translated into actual careers. In fact, only five graduates have chosen this path since the College first opened and postgraduate training continues to struggle to recruit people to specialise in psychiatry. It is therefore clear that ongoing work, development and support are required from SMMHEP and the College of Medicine to engage and encourage students to work in psychiatry in the future.

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RESEARCH PAPER

Hospital doctors' management of psychological problems at a Nigerian tertiary health institution

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A questionnaire was sent to all consenting doctors at the University of Ilorin Teaching Hospital, Nigeria. It asked about their management of psychological problems in their clinical practice. Over 90% would welcome more time to talk to patients and agreed that psychological and social factors should be routinely assessed and recorded for patients. Most respondents would refer patients with depression or disturbed behaviours. 'Ineffective treatment' and 'dislike of psychiatric referral' were not the main reasons for non-referral. A majority of the doctors had initiated treatment for anxiety and insomnia but not for alcohol withdrawal, psychosis, acute confusional state or depression. Doctors' awareness of 'the impact of psychological factors on the course of physical illness' was high. To sustain this high level of awareness and encourage referral, in-house psychoeducational training of hospital doctors should be intensified. In addition, an increased doctor/patient ratio, public education to reduce stigma and a well developed liaison psychiatric service are imperative.

https://doi.org/10.1192/S2056474000000787 Published online by Cambridge University Press

We are grateful to all the staff of UITH, Ilorin, who participated in the study, for their patience and cooperation during the period of data collection.

Adequate management of psychological problems by hospital doctors (other than psychiatrists) can determine the effectiveness (or otherwise) of liaison psychiatric services in the hospital (Deventer *et al*, 2008). Hospital doctors should aim to ameliorate seemingly minor but incapacitating psychiatric disorders and symptoms. Many patients who require psychiatric services are deprived of them because of non-recognition of their psychological problems by attending physicians and lack of referral (Dixon *et al*, 2001; Bartels *et al*, 2005). This can prolong suffering and lead to a deterioration of the patient's clinical status and to complications. Globally, psychological problems account for a significant proportion of disease morbidity and mortality, and have taken a significant toll on time lost due to morbidity, in terms of disability-adjusted life years (DALYs) (World Health Organization, 2012). Therefore, it is of interest to determine how psychological problems are managed. According to Faizen *et al* (2012), the attitude to psychiatry of non-psychiatrists and non-psychiatry resident doctors is crucial because of the large number of psychiatric patients who will present to them, directly or indirectly.

Morgan & Killoughery (2003) revisited a study by Mayou & Smith (1986) on hospital doctors' management of psychological problems in London hospitals. In their study, more hospital doctors were aware of the psychological needs of patients (Morgan & Killoughery, 2003). There appeared to have been improvement in liaison psychiatric services, as evidenced by an increase in the number of qualified psychiatrists at public health institutions in Nigeria. This improvement was expected to translate to more shared knowledge between mental and other health practitioners and better mental health services. Some doctors, however, although familiar with mental health issues, are likely not be too different from non-doctors in stereotyping and stigmatising mental illness. The negative attributes of these doctors could affect their practice when they encounter individuals with mental illness (Faizen *et al*, 2012).

The present study set out to replicate these previous studies, using the same methods in Nigeria, in order to ascertain whether a supposed increase in awareness of mental health issues and the introduction of liaison psychiatry had had any impact on the management of mental health conditions by hospital doctors.

Method

The data for this study were collected as part of a larger study to determine hospital doctors' management of mental illness and the psychological impact of their work on the doctors, particularly in terms of their alcohol use (Issa *et al*, 2012). The study was carried out at the University of Ilorin Teaching Hospital (UITH), a tertiary centre that provides health services for Kwara State and surrounding states (Nigeria is a federation of 36 states). Questionnaires together with information sheets and consent forms were distributed to all doctors in the service of the hospital except those in the department of behavioural sciences. One questionnaire covered: sociodemographic information (age, gender, marital status); professional qualification; receipt of treatment for any form of emotional disturbance by the participants or their relatives; and working conditions (e.g. membership of workplace leisure or social clubs, perceived cordiality with co-workers and patients, perception of workload, and satisfaction with remuneration). They also completed a questionnaire (the same used by Mayou & Killoughery) on their management of psychological problems in their clinical practice, on which this report is based.

The ethics and research committee of the hospital approved the study protocol.

Results

Questionnaires were distributed to 350 doctors: 100 house officers, 150 resident doctors and 100 senior doctors (i.e. medical officers and consultants). Responses were received from 241 (68.9%), of whom 134 (55.6%) were aged 35–45 years, 182 (75.5%) were male, and 202 (83.8%) were married. The largest number of respondents were from the department of internal medicine (35 or 14.5%), followed by department of surgery (32 or 13.3%).

About half (109 or 45.2%) of the respondents had 3–10 years' working experience. About three-quarters (190 or 78.8%) had had 4–8 weeks of exposure to mental health training at undergraduate level, while 181 (75.1%) had had no exposure at postgraduate level. Most of the respondents (221 or 91.7%) had no personal history of mental illness and the majority had no family history of it (180 or 74.7%).

General attitudes to mental illness and medical responsibility for its management

Over half of the respondents believed that 'emotional and social aspects of care enhanced their job interest' while less than 40% agreed that 'management of emotional issues is solely a medical responsibility' (Table 1).

About a quarter of the doctors agreed that they have major roles in the management of depression (Table 2). Just under half would take responsibility for the management of acute confusional state, while over two-thirds would take responsibility for drug overdose, a fifth for chronic drinking problems, less than a fifth for disturbed behaviours but over half for the emotional care of dying patients.

Time constraints and assessments of psychological problems

Over 90% of the doctors would 'welcome more time to talk to the patients' and agreed that 'psychological and social factors should be routinely assessed and recorded for patients' (Table 1). However, about a quarter of the doctors agreed that it was 'impractical for hospital doctors to assess and treat emotional problems', and on this item there was the largest difference between the

https://doi.org/10.1192/S2056474000000787 Published online by Cambridge University Press

Table 1

Questionnaire responses in the present study and two comparison studies: percentage agreement with statements

Statement	Present study	Morgan & Killoughery (2003)	Mayou & Smith (1986)
Psychological factors can influence the course and outcome of physical disorders	92.5	96	77
Emotional and social aspects of care enhance job interest	58.1	58	66
Management of emotional issues is solely a medical responsibility	39.4	25	33
I would welcome more time to talk to my patients	90.5	92	78
It is impractical for hospital doctors to assess and treat emotional problems	22.8	52	46
Psychological and social factors should be routinely assessed and recorded for in-patients	92.9	78	Not reported
When psychological factors appear to be an important cause of the presenting problem, I confine myself to physical assessment	16.2	16	35
I should concern myself with emotional care of regular attenders with chronic physical illnesses	68.9	80	60
Hospital doctors should be able to use psychological methods such as listening/reassurance	94.2	88	'Most'
Hospital doctors should be able to use psychological methods such as discussion of anxieties and problems	91.7	94	'Most'
I frequently discuss emotional problems with relatives	73.9	73	55
I use cognitive or behavioural methods of treatment	63.9	36	<25
Hospital doctors should be able to use psychotropic drugs	71.8	78	81
I use antidepressants frequently or occasionally	20.3	60	43
I would like more contact with psychiatric services	57.3	78	Just over half
I would like to know more about what psychiatry has to offer in the management of medical or surgical patients	83.8	73	Not reported
Psychiatrists have little to offer in a general hospital	4.1	5	24

Table 2

Agreement with statements that major responsibility for common types of psychological problems lies with hospital doctors (other than psychiatrists): percentage of the present sample ($n = 228$), with responses from Morgan & Killoughery (2003) and Mayou & Smith (1986) respectively in parentheses

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
Depression	4.4 (10, 5)	20.6 (21, 21)	4.4 (10, 20)	49.1 (49, 41)	21.5 (9, 3)
Acute confusional state	4.4 (27, 17)	42.5 (51, 59)	11.8 (7, 13)	32.5 (9, 10)	8.8 (7, 1)
Overdoses	16.2 (24, 7)	55.7 (37, 29)	9.2 (9, 33)	15.8 (19, 27)	3.1 (10, 3)
Chronic drinking problems	5.7 (6, 5)	14.9 (24, 20)	8.8 (18, 33)	43.0 (36, 38)	27.6 (16, 5)
Disturbed behaviour	7.0 (4, 3)	9.6 (19, 25)	6.6 (23, 35)	42.5 (34, 34)	34.2 (20, 3)
Emotional care of dying patients	15.4 (15, 10)	43.2 (59, 23)	12.8 (14, 26)	25.6 (8, 37)	3.1 (3, 4)

present findings and those of the two earlier (UK) studies. In the present survey, 16.2% of doctors would 'confine themselves to physical assessment only' even when psychological factors appeared to be an important cause of the presenting problem.

Attitudes to psychiatry, psychiatric treatments and barriers to referral

A large majority of the respondents agreed that hospital doctors should be able to use psychological methods such as 'listening/reassurance' and discussion of anxieties and problems (Table 1). About three-quarters agreed that 'hospital doctors should be able to use psychotropic drugs', but only 20% claimed to 'use antidepressants frequently or occasionally'. Very few respondents agreed with the statement 'Psychiatrists have little to offer in a general hospital', while more than half would like 'to have more contact with psychiatric services'. In addition, over 80% would 'like to know more about what psychiatry has to offer in the management of medical and surgical patients'.

Almost all the respondents would refer patients with depression (96.5%), disturbed behaviours (96.5%); dementia (67.8%) or acute confusional state (69.6%). However, significant numbers would 'not refer a patient because of a diagnostic problem' (60.5%) or 'non-compliance with treatment' (60.2%).

Only 9.7% of respondents gave 'ineffective psychiatric treatment' as the reason for non-referral of patients, and only 25.3% gave 'dislike for psychiatric referral', but 48.8% said it would be because of 'stigmatisation'. A substantial number of the doctors had initiated treatment in anxiety disorders (57.4%) and insomnia (73.3%), but most had not initiated treatment in alcohol withdrawal (91.5%), psychosis (88.1%), acute confusional state (78.6%) and depressive disorders (75.0%).

Discussion

A response rate of 68.8% was considered reasonable, considering the anonymous nature of the study, which seemed to have reduced

https://doi.org/10.1192/S2056474000000787 Published online by Cambridge University Press

researcher-influenced bias in completing the questionnaire.

The relatively few years of practice of most of the respondents in this study is likely explained by the younger ages of our respondents (most were under 45 years old). Traditionally in Nigeria, candidates are admitted to medical school after their secondary school education, unlike in some countries where a university degree is a prerequisite for admission. Thus, these candidates graduated as doctors while still young.

The Nigeria medical curriculum is designed to expose medical students to a minimum of 4 weeks of mental health education and clerkship. Graduate doctors therefore might not have acquired adequate training in basic mental health, which could adversely affect their practice. The postgraduate residency training that could further expose these doctors to mental illness is provided for only a few postgraduate specialties. For example, surgery and surgical subspecialties do not rotate through the psychiatric department during their residency training, although medically related specialties such as internal medicine and family medicine do include such postings. This gap in training has the potential to adversely affect mental health practice and management among these doctors after their qualification.

In this study a majority of the respondents did not report a history of psychiatric illness among themselves or their relatives. Similarly low frequencies of reported mental illness have been documented in previous studies (Phillips *et al*, 2000; Saunders, 2003) and this has been largely attributed to stigma (Saunders, 2003; Westbrook, 2011).

The management of common psychological problems

Awareness of the impact of psychological factors on the course of physical illness was high and comparable to the British studies. The doctors in this study, similarly to the previous studies (Mayou & Smith, 1996; Morgan & Killoughery, 2003), recognised that psychological factors could influence the course and outcome of physical disorders. This could be described as being good for mental health and its practice because the psychological health of physically ill patients is then adequately considered in the management of such physical illnesses, more especially if more time can be devoted to these patients. Similarly, well over half the doctors agreed that emotional and social aspects of care enhanced their job interest, as in the previous studies. Most of the doctors did not agree that the management of emotional issues was solely a medical responsibility.

The positive responses observed in this study could have resulted from medical training (both undergraduate and postgraduate) or from the positive impact of liaison psychiatric services.

A majority of the respondents in this study would 'rather not leave the care of depression to psychiatrists'. Over two-thirds disagreed that hospital doctors (other than psychiatrists) have the major responsibility for the management of depression (higher than in the British studies). In contrast, a majority agreed that non-psychiatrists have the major responsibility for overdose and for the emotional care of dying patients, but not for disturbed behaviours or chronic drinking problems, which were predominantly regarded as being in the realm of psychiatrists.

The reason for around half of the hospital doctors agreeing that they have the major responsibility for the management of acute confusional state could be that most causes of this disorder are physical, such as infection, surgical emergencies, head injuries and medication side-effects. This may reflect the traditional mind/body dichotomy, whereby medical disorders are regarded as diseases of the mind or body (Mehta, 2011).

Time constraints

As in the previous studies (Mayou & Smith, 1986; Morgan & Killoughery, 2003), a majority of the doctors would welcome more time to talk to their patients. This supports the notion that time constraints are a reason for non-psychiatrist doctors not making adequate diagnosis of psychological problems. Time constraints have been identified as a major factor preventing the diagnosis of mental disorder by general practice doctors (Alexander & Fraser, 2008).

A solution to this problem might be proper time management, because most of the doctors agreed that they should provide emotional care for regular attenders with chronic physical illnesses. Similarly, most did not agree that when psychological factors appeared to be an important cause of the presenting problem they would nonetheless confine themselves to physical assessment. Such assertions seemed to indicate the readiness of these doctors to participate in the assessment and treatment of patients with psychological problems and physical disorders. A psychoeducational programme aimed at improving the diagnosis and management of psychological problems by non-psychiatrist doctors and the use of short diagnostic instruments (to reduce evaluation time) would go a long way to overcoming time constraints.

A contributory factor is the inadequate doctor/patient ratio in low-income countries like Nigeria. In the year 2005, the doctor/patient ratios in Nigeria, Ghana, Kenya and South Africa were 28, 15, 14 and 77 per 100 000 population, and 151 and 134 in Seychelles and Tunisia, but about 333 per 100 000 population in Germany and France (United Nations Development Programme, 2006). A lower ratio would help overcome the time constraints reported by this cohort of Nigerian hospital doctors.

Attitude to psychiatry and barriers to referrals

Similar to the previous studies, all aspects of talking therapies were endorsed by the doctors, thus indicating positive (or improved) attitudes of the hospital doctors to patients who are

https://doi.org/10.1192/S2056474000000787 Published online by Cambridge University Press

mentally ill. Caution is needed here, however, as hospital doctors still require training on the use of psychotherapeutic methods. While listening and reassurance are skills that all doctors must possess, the use of cognitive and behavioural methods (claimed to be used by nearly two-thirds of respondents) should be reserved for specialists (i.e. psychotherapists). In fact, the use of such methods in previous studies (Mayou & Smith, 1986; Morgan & Killoughery, 2003) was much less impressive than the level reported in this study. A reason for this could be that the respondents in this study did not comprehend what was meant by cognitive and behavioural methods, as formal cognitive and behavioural therapies are not provided at the study centre. Contrary to this was the use of psychotropic drugs. As in the previous studies (Mayou & Smith, 1986; Morgan & Killoughery, 2003), respondents agreed that hospital doctors should be able to prescribe psychotropic drugs. While one would agree with the doctors on this unrestricted prescription of psychotropic drugs, this has to be done with extreme caution, so as to prevent dependency and tolerance (and any resultant iatrogenic psychological problems). The low proportion of respondents prescribing antidepressants (frequently or occasionally) was not surprising, given that, when compared with the two previous studies (Mayou & Smith, 1986; Morgan & Killoughery, 2003), a much smaller proportion agreed that hospital doctors had the major responsibility for the treatment of depression.

The cohorts' attitude to psychiatry was, however, encouraging. Their readiness to have more contact with psychiatric services and eagerness to know more about what psychiatry has to offer in the management of medical and surgical patients were satisfying. These attributes need to be reinforced for a more holistic management of patients with physical disorders. Psychiatrists have more responsibilities in general hospital settings in this regard.

Despite the readiness of the doctors to refer patients, many were not referring because of the perceived stigma.

Limitations of the study

Being a self-reported questionnaire study, it is not possible to determine whether the questionnaire responses accurately reflected actual clinical practice, and the study design was subject to social desirability bias (Morgan & Killoughery, 2003). However, the same questionnaire was used in the two British comparison studies.

Conclusion

The doctors in this study, similar to those in the previous studies, recognised that psychological factors could influence the course and outcome of physical disorders. Many were ready to take responsibility for the care of some organic mental disorders, such as acute confusional state, but much less so depression and disturbed behaviours. The respondents were, though, more receptive to 'assessing and treating emotional problems' than in the two British studies. Time constraint was recognised as a major impediment to the diagnosis of psychological disorders but the doctors expressed readiness for more contact with psychiatric services. While willing to refer patients with psychological problems to psychiatrists, stigma was identified as a barrier. Therefore, we suggest that in-house psychoeducational training of hospital doctors should be intensified. The training could include the use of brief diagnostic tools that would shorten the time taken to make diagnoses. Such training might also help disseminate information to the doctors on the use of psychotropic drugs and psychological therapies. Improving the low doctor/patient ratio is also advised. Addressing these issues could help ameliorate the problem of time constraint.

Lastly, well developed liaison psychiatric services where psychiatrists are incorporated within medical or surgical teams could help to solve the problems hampering referral for psychiatric evaluation.

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