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# Mental health training needs of physicians in Bangladesh: Views from stakeholders

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ABSTRACT

Bangladesh is a lower-middle-income country with a high burden of mental health conditions and inadequate health systems. Prior research in similar settings has found that training physicians in mental health literacy can contribute to reducing the mental health treatment gap and strengthening the mental health care pathway. This study explores the need for mental health training for physicians by gathering stakeholders' perspectives and proposes recommendations for designing a mental training program in the context of Bangladesh.

Key informant interviews were conducted among psychiatrists (n = 9), and mental health entrepreneurs (n = 7); one focus group discussion was conducted with psychologists (n = 8); and one-on-one interviews were held with physician (n = 17). Due to the COVID-19 restrictions, all interviews were conducted online, recorded and transcribed. Transcriptions were analyzed thematically, utilizing both an inductive and deductive approach.

The data analysis from forty-one stakeholders generated three major themes and eight subthemes. Stakeholders perceived that the inadequate mental health system and low mental health awareness among physicians significantly contribute to the mental health treatment gaps. Stakeholders emphasized the need to include mental health training for physicians to increase skills related to identification and management of mental health conditions. Stakeholders suggested some basic components for the training content, feasible modalities to deliver the training, and implementation challenges. Recommendations included utilizing online training, ensuring interesting and practical content, and incorporating certification systems. At a systems level, stakeholders recommended including a mental health curriculum in undergraduate medical education, capacity building of other healthcare workers and increasing awareness at the policy level.

There is clear agreement among stakeholders that implementing mental health training for physicians will promote universal health coverage and reduce the mental health treatment gap in Bangladesh. These findings can support creation of policies to strengthen the care pathway in countries with limited resources.

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**List of abbreviations**

| | |
|---|---|
| COVID-19 | Corona virus disease 2019 |
| DMCH | Dhaka Medical College Hospital |
| FGD | Focus Group Discussion |
| IDI | In-depth interview |
| IRB | Institutional Review Board |
| KII | Key Informant Interview |
| LMICs | Low- and middle-income countries |
| MBBS | Bachelor of Medicine, Bachelor of Surgery |
| mhGAP | Mental Health Gap Action Programme |
| NIMH | National Institute of Mental Health |
| NGO | Non-governmental Organization |
| WHO | World Health Organization |
| UHC | Universal Health Coverage |

## 1. Background

Mental illness accounts for approximately one-third of the global burden of disability and represents a significant public health concern (Vigo et al., 2016). Low- and middle-income countries (LMICs) account for 70% of this burden globally (Rathod et al., 2017). In Bangladesh, the estimated prevalence of mental health disorders among adults varies between 6.5 and 31% of the population (Hossain et al., 2014). Despite this high burden, mental healthcare-seeking behavior is low among the general population due to stigma and inadequate mental health literacy (Hasan et al., 2021). The allocated health budget for mental health is 0.44% of overall government healthcare spending, while mental health expenses account for 64% of out-of-pockethealth expenditure, as treatment is typically not covered by government or private insurance (Hasan et al., 2021) In Bangladesh, mental healthcare is unavailable in primary, secondary, and even in peripheral level health care facilities (Nuri et al., 2018; Uddin et al., 2019). Tertiary mental health facilities are centralized in urban areas, largely inaccessible and unknown to rural populations (Hasan et al., 2021; WHO, 2021; WHO, 2007; Rashid et al., 2021). The situation is exacerbated by the scarcity of healthcare workforce trained in mental healthcare; 0.16 psychiatrists and 0.34 psychologists for 100,000 population (Hasan et al., 2021). Low rates of mental health literacy among healthcare professionals mean that individuals with poor mental health who present with medically unexplained psychosomatic symptoms, remain undiagnosed (Uddin et al., 2019; Edwards et al., 2010). Health care providers, especially general physicians, have not received adequate training in mental health, leading to under-diagnosis and lack of onward referral to appropriate support (Hossain et al., 2014; Edwards et al., 2010; Shidhaye et al., 2013).

Mental health literacy refers to an individual's knowledge and beliefs about mental disorders, which aids their recognition, management, and prevention of mental health conditions (Jorm, 2000). Low mental health literacy among health care providers have been found to contribute to stigmatizing behavior toward individuals with mental illnesses, in turn dissuading help-seeking behavior (Henderson et al., 2014; Thornicroft et al., 2007; Elyamani and Hammoud, 2020). Among healthcare providers in Bangladesh, there is a significant stigma associated with mental health; studies conducted on physicians have reported shame, lack of confidentiality, and the fear of job loss associated with seeking mental healthcare (Rashid et al., 2021; Hasan et al., 2020; Mahmud et al., 2020). Stigma has been implicated in onset of stress, depression, and burnout among physicians and compounded by limited self-care knowledge (Rashid et al., 2021; Hasan et al., 2020; Mahmud et al., 2020; Bansal et al., 2012). The importance of proper mental health literacy among health professionals has been highlighted in several past studies as playing a significant role in increasing awareness, increasing access to treatment, and providing better quality mental healthcare services to communities (Kassa et al., 2014; Minty et al., 2021; Salama et al., 2021). It is an essential strategy to achieve universal health coverage (UHC) worldwide (Koly et al., 2021; Marangu et al., 2014). Providing mental health literacy training would also build the capacity of the healthcare workforce by reinforcing their resilience and practicing self-care (Koly et al., 2021; Marangu et al., 2014).

Studies with detailed statistics about the number of physicians trained on mental health care provision have not yet come out of Bangladesh. Previous reporting by the World Health Organization (WHO) indicates Bangladeshi physicians receive only 4% of their training in mental health (WHO, 2007). The WHO Mental Health Gap Action Programme (mhGAP) has been adopted by the ministry of health and provided to a scarce number of physicians from limited areas of Bangladesh. (Tarannum et al., 2019; Momotaz et al., 2019). This study aims to explore the need for mental health literacy training for Bangladeshi physicians through gathering perspectives of stakeholders. It also aims to conceptualize strategies and recommendations for developing and implementing a mental health training program for physicians of Bangladesh. This study aims to explore the need for mental health literacy training for Bangladeshi physicians through gathering the perspectives of stakeholders'. It aims to conceptualize strategies and recommendations for developing and implementing a mental health training program for physicians of Bangladesh.

## 2. Methods

### 2.1. Study setting

The population of Bangladesh is over 163 million. Mental healthcare provision is limited to one tertiary care center (National Mental Health Institute-NIMH) situated in the capital, Dhaka, one 500 bed-mental health hospital located in the northern district, Pabna, and 69 mental health hospital outpatient facilities. Rural health services depend entirely on physicians, although the current number of physicians does not yet meet the population demand (5.26 physicians/10,000 people) (Razu et al., 2021).

### 2.2. Study design and participants

The study utilized qualitative methodology for gathering perspectives of stakeholders who are involved in mental and general healthcare in Bangladesh on the need to train physicians in mental health literacy. Participants included three types of stakeholders: mental health specialists (psychiatrists and psychologists), mental health advocates from civil society organizations (mental health entrepreneurs), and general health service providers (physicians). Stakeholders were affiliated with various governmental and non-governmental organizations (NGOs), ensuring diverse experiences. To gain an extensive and comprehensive understanding of complex phenomena, the study implemented three qualitative methods: key informant interviews (KII) among psychiatrists and mental health entrepreneurs, a focus group discussion (FGD) among psychologists, and in-depth interviews (IDI) among physicians.

### 2.3. Data collection process

Stakeholder were recruited through phone calls and invitation emails with detailed information were sent to those who expressed interest. Participants consented through e-mail, and consent procedures were repeated verbally at the start of the interviews. Research staff (JS, MSH, SFA, MRT) hold master's degrees in public health, social science, and nutrition, have 2–3 years of experience in qualitative data collection, and were trained by the lead author (KNK) in qualitative data methodology. Semi-structured interview guidelines were developed for the KIIs and FGD, which focused on collecting sociodemographic information, stakeholders' associations with mental healthcare, perspectives about the impact of pandemic on mental health of physicians, mental health

literacy of physicians, suggestions for mental health capacity building, potential modes of training, receptiveness to online training, and possible barriers and solutions to training implementation (Appendix A). To understand unique needs of physicians for training programs, a separate interview guideline was developed, comprised of questions related to sociodemographic information, professional experience, current level of mental health knowledge and practices, personal mental state during the pandemic, and the development of a comprehensive mental health training program including potential content, modes of delivery, and challenges and facilitators to implementation. Interviews where data collection was conducted and recorded via the videoconferencing platform "Zoom". Recordings were transcribed by three research staff with the prior transcription experience. This study adhered to the consolidated reporting criteria for qualitative studies (COREQ) (Appendix B) (Tong et al., 2007).

### 2.4. Data analysis

Thematic analysis was conducted on transcriptions and consisted of familiarization, coding, generating themes, reviewing themes, defining themes, labeling themes, and organizing findings (Braun and Clarke, 2012). Using a combination of deductive and inductive reasoning, a mix of expected and unexpected codes were identified. Data saturation reached when no new data emerged from the interviews. Transcriptions were coded separately by coding team (JS, MSH, MRT and SFA) before common data for each code was systematized to establish themes and subthemes. Researchers (KNK, EC, CB, JS, MSH, MRT, SFA) gathered for a 2-hours analytic session to discuss each team member's themes and subthemes for triangulation and to settle discrepancies. Analyses were congruent between researchers, providing empirical support for the robustness of data interpretation and analysis. The combined deductive and inductive approach enabled themes to be linked to research aims and interview questions while also being led by results. It is important to note that findings were translated from Bengali to English, raising the possibility that some semantics may be lost to translation.

## 3. Results

In total, 41 stakeholders participated in this study. Analysis of the interviews and FGD generated three major themes and eight sub-themes (Fig. 1). Of the stakeholders, over half were female (n = 24). All psychiatrists (n = 9) provided services in tertiary care facilities and (n = 4) had more than 6 years of experience and were based in the capital city Dhaka (n = 7). All of the eight psychologists had more than 6 years' experience providing counseling services, and majority were (n = 6) based in Dhaka. The majority (n = 5) were affiliated with NGOs, and rest of them (n = 3) were with government facilities. All mental health entrepreneurs (n = 7) were based in Dhaka and engaged with raising mental health awareness and providing psychosocial supports. Among the physicians (n = 17), majority (n = 11) had been involved in healthcare for 5 or more years. All physicians were based at governmental health facilities, with the majority (n = 15) numbers from secondary and tertiary level hospitals. Physicians were from all 8 geographical divisions of Bangladesh, with most from outside of Dhaka (n = 10). Five were general physicians, while the rest (n = 12) worked in COVID-19 care, surgery, medicine, or dentistry.

Interviews and focus groups generated three major themes and eight sub-themes (Fig. 1). The themes were (1) current mental healthcare landscape among physicians, (2) needs assessment of mental health care training for physicians, and (3) recommendations. Apart from the mentioned quotes, others are given in supplementary section (Appendix C).

### 3.1. Current mental healthcare landscape among physicians

As stakeholders shared their perceptions about the state of mental healthcare among physicians, two major subthemes emerged (1) inadequate mental health systems and (2) mental health literacy and practices of physicians.

#### 3.1.1. Inadequate mental health systems

Stakeholders reported inadequate support at the system level for mental healthcare. Combined with poor mental health literacy, the mental healthcare pathway becomes impaired at a population level. The dearth of mental health professionals, especially psychiatrists, compared to the overall population was mentioned by stakeholders. Inadequate integration of mental health in the public health system and the absence of designated positions and job opportunities for psychiatrists contribute to the ongoing shortage of required human resources. One stakeholder stated:

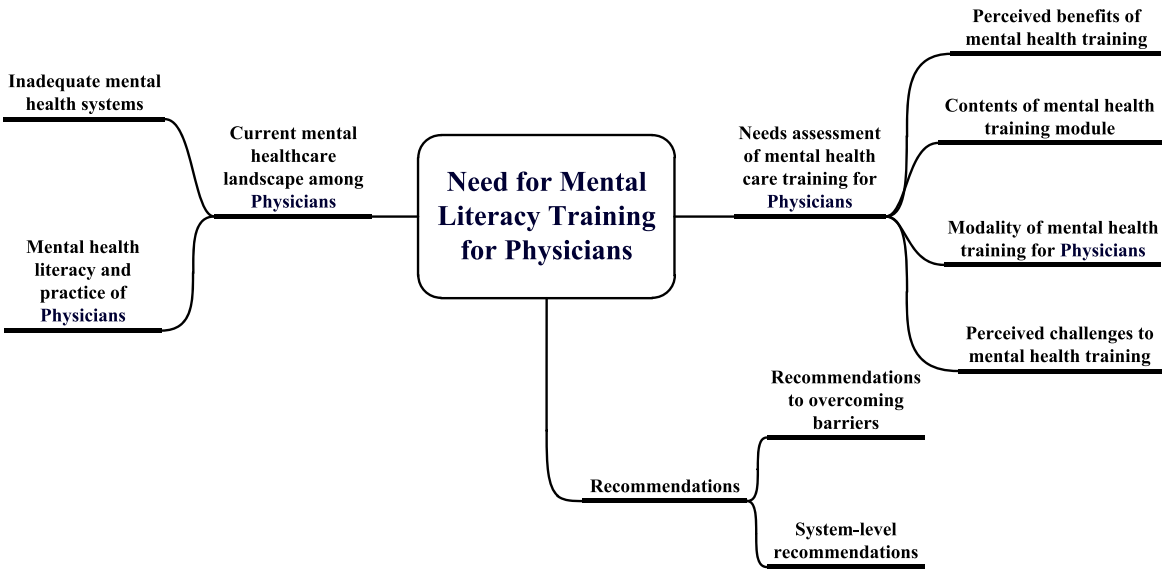


**Fig. 1.** Thematic Distribution of the findings.

"The community level healthcare facilities are not at all equipped to provide mental health services. The number of psychiatrists is very low: only 250 psychiatrists for the entire population. The integration of mental healthcare in the public health system is yet to be done."

– Entrepreneur #05, Male

When asked about the current scarcity of mental health service providers, the stakeholders linked the situation to the significant shortage of capacity building opportunities. Regarding the reason behind the low mental health literacy of physicians, majority stakeholders mentioned insufficient curriculums about mental health at the undergraduate level, minimal durations of internship placements, and scarce opportunity for practical applications for any existing mental health theories taught. While some physicians recalled attending small scale mental health trainings hosted by NGOs, most claimed that larger-scale governmental training was limited due to low prioritization of policymakers and lack of funding. In addition, physicians reported there is little inclination among professors to train undergraduate medical students to identify mental health issues and provide psychosocial support; further research needs to be conducted to elucidate the reason. Echoing other stakeholders' concerns, physicians identified the lack of prioritization of mental health, inadequate mental health curriculums, and work pressure as some major systemic pitfalls. A physician stated,

"There were no proper training guidelines on mental health and psychiatry. As we spent only seven days at the internship placement, we don't have any experience with patients who have severe issues like schizophrenia or bipolar disorder. Also, we never found any seniors or teachers who could guide us in understanding poor mental health symptoms and counseling patients."

– Physician #09, Female

Due to severe workloads, even if a few physicians had some expertise in addressing poor mental health symptoms in patients, the majority of stakeholders claimed that they would be unable to do so. Physicians have such a limited amount of time to counsel on physical health issues, which limits their ability to discuss their patients' underlying mental health concerns. Furthermore, a few psychiatrists stated that a large number of patients in primary care facilities compromises patient privacy, further hindering patients' desire to share their mental health issues with the physicians. Moreover, due to a lack of psychotropic medications available in rural facilities, physicians were unable to provide psychiatric treatment to the patients. Patients also face distance and transportation challenges as most services are limited to tertiary facilities of major urban cities. As a result, physicians frequently encounter difficulties in making mental health referrals.

"We have to refer patients to tertiary level medical colleges that are located in other distant urban areas as there are no mental health services at primary care facilities. Patients are unable to seek continuous care due to the long distance and lack of transportation facilities."

– Physician #04, Female

### *3.1.2. Mental health literacy and practice of physicians*

Under subtheme 3.1.2, topics such as a lack of awareness, avoidance of addressing mental health issues, low prioritization of mental health issues in primary care, poor identification of psychosomatic symptoms, low rates of referrals, and short durations of consultations were noted.

Many stakeholders posited that most physicians do not understand the importance of mental health care which is problematic as people tend to first seek care from general physicians for undiagnosed mental health conditions. Some psychologists stated mental health is a major component for optimum health and is very crucial for treatment success. Physicians elaborated that it was critical for them to understand their patients' mental health needs so that they could advise them on treatment options, prognoses, and overall well-being through counseling. They also stated that physicians' lack of mental health literacy relates to failures in detecting psychosomatic symptoms and suboptimal referral options. Such issues could lead to treatment delays and worsening of mental health conditions. Psychologists reported that only some physicians refer patients to psychiatrists when they observe no improvement in patients' well-being after a long-term treatment. Physicians also claimed that identifying self-harm and suicidal behavior in patients becomes difficult due to their poor understanding of mental health conditions. One of them said,

"Before committing suicide, many people have visited physicians about their poor mental health, but unfortunately, due to poor understandings about suicide, physicians could not identify the self-harm indicators in their patients."

– Physician #06, Female

Stakeholders stressed that short consultation times and a poor understanding of available psychosocial supports further add to patients not getting treatment. Many physicians lack the skills needed for proper counseling and referral skills. When combined with low prioritization of mental health among physicians and patients, physicians become hesitant to identify mental health issues and provide management. The unwillingness of the physicians to address emotional distress of patients and inappropriate prescribing behavior was reported by the psychologists. Instead of providing referrals, inappropriate prescribing behavior, such as administering sedatives and relaxing drugs to patients, was cited as common practice. Psychiatrists claimed that stigma is what often prevents proper referral among physicians who do have some knowledge.

"Stigma about mental health among physicians is a significant issue. Physicians feel hesitant to ask about mental health. Culture plays a huge role here. Some physicians think mental health issues do not exist and medicines can treat all health issues. On the other hand, some think there is no cure for mental illnesses. All these factors affect their medical practice."

– Psychiatrist #02, Male

Stigma at the community level was also found to dampen the desire of medical students to pursue psychiatry. Low levels of support, opposition from family, and fear of being mocked as a "Physician for the mad" by society were cited as some major stigma-influenced concerns. Additionally, physicians voiced their perception that the prognosis of those with poor mental health is hopeless and reduces their interest in pursuing psychiatry. On top of societal and family stigma, some stakeholders postulated that physicians are unable to understand their own mental health needs due to the lack of mental health literacy. Extreme workloads for physicians add to their stress and cause them to ignore their deteriorating mental state. Beliefs that seeking mental health support could jeopardize their career also lead them to maintain secrecy about poor personal mental health.

"We physicians have a lot of stigmas inside ourselves like we are sending our family members to counseling but the physician himself/herself is not coming to the counseling. A lot of physicians are going through extreme distress, yet they don't seek support. Also, they fear losing their position and career. So, they don't want to disclose the fact that they need mental health support."

– Physician #05, Male

### *3.2. Needs assessment of mental health training for physicians*

Highlighting the low mental health literacy, all the stakeholders reported the need for mental health training among physicians. When

asked about this, four main themes emerged from the guided questions. Conversations began with discussions of the (1) perceived benefits of having such mental health training, and then progressed onto what potential (2) contents of these trainings would look like, (3) the best ways to provide these trainings, and (4) possible challenges to receive these trainings.

#### 3.2.1. Perceived benefits of mental health training

All stakeholders agreed on the need to train physicians in mental health. By improving mental health literacy, stakeholders believed the training would enable physicians to provide primary psychosocial support to the general population, including identifying psychological distress, providing proper referrals, and counseling patients. Training would increase knowledge about symptoms indicating poor mental health and enhance positive attitudes toward mental health. Training would facilitate a better understanding of the use of psychotropic medicines, identification of psychological risk factors, and proper referral mechanisms. Some stakeholders even suggested that training would help combat the community-level stigma associated with mental health; counseling patients about their mental health would improve physician-patient relationships, increasing mental health awareness within the population through word-of-mouth, eventually becoming common knowledge.

> "Mental health training would help us understand the importance for mental health. When patients get regular support from physician in terms of mental health, it will gradually reduce stigma in society. Also, this will increase mental healthcare-seeking behavior among the population."
>
> – Physician #04, Female

Stakeholders suggested that training physicians could aid in providing universal coverage of mental healthcare by task-shifting services that have only so far been provided by mental health professionals. Psychiatrists were also confident that physicians with training would have the capacity to detect mental health issues early and provide prompt referrals to services. One of the psychiatrists mentioned,

> "Physicians, especially from the rural regions, should be trained on the basics of mental health so that they can provide psychosocial support. Training will improve their knowledge to identify common mental issues among patients and increase referrals. Thus, primary care centers should be established as the first step service provider of mental health."
>
> – Psychiatrist #05, Male

#### 3.2.2. Contents of the mental health training module

When stakeholders were asked to suggest fundamental components for a potential future mental health training program, the majority stressed the need for training physicians on prompt recognition of severe mental illnesses and risk indicators for suicide. Identifying symptoms indicative of poor mental health and psychosomatic complaints were also cited frequently. Some psychiatrists insisted that physicians need extensive guidance on administering various psychosocial assessment measures to identify mental health conditions accurately. Other stakeholders placed higher importance on building capacity to provide basic mental health management and promote self-care. According to stakeholders, proper management by physicians for undiagnosed psychosomatic conditions and common mental disorders would reduce the burden of mental health disorders:

> "It is easier to identify patients with severe mental illnesses, but a large number of people who are underdiagnosed are suffering from Common Mental Disorders. Also, many patients present with psychosomatic issues at the primary and secondary facilities. The training module should include the criteria for identifying mental health conditions of patients and administering different assessment tools."
>
> – Physician #11, Male

Other stakeholders deemed training physicians on basic counseling skills as paramount. According to psychologists, conducting a proper history intake, maintaining effective communication with patients, and providing psychosocial support other than symptomatic treatment are essential skills that physicians need. Some psychologists mentioned physicians should be trained in counseling skills such as listening actively, being empathetic and non-judgmental. The administration of these techniques would ensure a better physician-patient relationship. Some mental health entrepreneurs insisted on adding training content that would aid physicians in providing appropriate referrals to mental health professionals. Physicians need a better understanding of the different roles that mental health professionals play. Services that aid physicians in making proper decisions for referrals would produce better outcomes for patients seeking guidance in navigating their mental health conditions.

> "Most people delay seeking mental health care due to the lack of guidance and referral. Training on proper referrals will encourage physicians to be aware of different mental health professionals and services. Also, this will build their capacity to guide patients about need-based services and better follow-up."
>
> – Entrepreneur #01, Female

Finally, some stakeholders prioritized training physicians on self-care. Recognizing the workload and burnout of the physicians, the stakeholders insisted that promoting self-care through training would result in increased prioritization of the mental health of self and patients. Moreover, contents on self-care could help them guide their patients to take care of their well-being.

> "The promotion of self-care is important among doctors. The majority of the doctors suffer from burnout and stress, but they don't care about their well-being. Training the doctors to understand the importance of self-care will enable them to prioritize personal and patients' mental health."
>
> -Psychologist #02, Female

#### 3.2.3. Modality of mental health training for physicians

Considering the total number of physicians in Bangladesh, the stakeholders were asked to share their perceptions of the feasibility of various ways of delivering mental health training. Some stakeholders emphasized face-to-face training, while others preferred an online mental health training module. Stakeholders who emphasized face-to-face extensive mental health training for a significant time felt it would ensure optimal communication, have higher acceptance, result in improved knowledge retention, and allow advanced monitoring. Hands-on training would allow observation of people with poor mental health, helping to develop a clinical eye. However, some stakeholders pointed out the high costs associated with face-to-face training as a major challenge, including increased time and use of already scarce resources. Also, stakeholders noted that face-to-face training would limit training to a certain number of physicians of a particular geographic area. The length of time recommended for training also varied from days to months among stakeholders:

> "It is better to arrange training for physicians at specialized mental health care facilities for 1–2 months to get a practical understanding of the mental health issues and development of a clinical eye. The existing face-to-face mental health training is facilitated by a limited number of NIMH mental health experts. It is tough to cover all

physicians through this training. It is also worth mentioning that these are time-consuming and require a large amount of funding, which is a big challenge in our country."

– Psychiatrist #07, Female

The majority of stakeholders noted the potential of an online modality of a mental health training. An online mode of mental health training would make it decentralized, easily accessible all over the country, and inclusive for all. Some entrepreneurs and physicians insisted it would be easier for physicians to enroll in the training by reducing the issues of traveling a long way and helping balance a work-life schedule. Because of the scarcity of psychiatrists and the dire need for mental healthcare at the community level, many stakeholders highlighted the benefits of rapid deployment possible through online mental health training:

"The scarcity of psychiatrists, along with the rapid rise in mental health conditions during the COVID-19 pandemic, necessitates prompt intervention, such as the capacity-building of physicians. In terms of the rapid training of a large number of health professionals, an online mode of mental health training can play a huge role while also considering protective measures for COVID-19."

– Psychologist #07, Male

#### 3.2.4. Perceived challenges to mental health training

Stakeholders voiced major concerns regarding how physicians would receive mental health training. Some physicians noted that the inadequate number of physicians compared to the overall population increases the workload at the primary care facilities. Extremely heavy workloads, compounded by stress and lack of time management, reduce the feasibility of training uptake among physicians and compromise the full participation of physicians in capacity-building initiatives. Additionally, some stakeholders also shared that physicians hold negative attitudes toward mental health training due to a lack of mental health awareness and stigma. Perceived low importance of mental health among physicians may reduce their participation in online mental health training. Some stated that physicians tend to show little interest in training that does not provide practice-based learning opportunities. Some stakeholders questioned the long-term effectiveness of such training as most trainings had no monitoring and evaluation components to assess physician's changes in knowledge, attitude, and practice after training. Monitoring of physician's performance regarding mental health care after training was indicated by some psychologists as necessary to reaching successful outcomes from the training.

"Most mental health training in Bangladesh nowadays gives little emphasis on the practical exploration of mental health symptoms and management of conditions, which causes the physicians to lose interest in complying. Also, just providing training is not enough; assessment of the gained knowledge and monitoring the practical implementation of the training is very important for training to be successful in the long term."

–Psychologist #02, Female

However, in terms of face-to-face training, some entrepreneurs pointed out that asking physicians to travel to distant facilities with unreliable public transportation could also be a significant challenge for receiving in-person mental health training. When asked about the challenges of an online modality, stakeholders noted technological difficulties. Unstable virtual network connections and too few digital technologies in rural areas would cause severe interruptions and other challenges for online training. Some psychiatrists added that interruptions and other challenges for online training. Some psychiatrists added that interruptions during training could break concentration and demotivate the physicians. One of them stated,

"The most critical challenge of online training is poor network and communication technology. Due to poor network, most of the training and meetings can suddenly get disconnected which breaks concentration and reduces learning opportunity."

– Psychiatrist #03, Female

### 3.3. Recommendations

Stakeholders were also asked to brainstorm recommendations on how to best implement mental health training and overcome the barriers they identified. In doing so, they identified (1) recommendations to overcome training-specific barriers, as well as (2) recommendations to reach systemic barriers.

#### 3.3.1. Recommendations to overcoming barriers

To mitigate the challenges of receiving mental health training, most stakeholders suggested implementing an online training modality, as it would result in low resource consumption while allowing the training to be accessible to a large number of physicians at once. Online training would also ensure easy enrolment, which would be welcomed by physicians receiving the training. To promote better participation from the physicians, some stakeholders suggested the government should enforce mandatory participation of physicians. Additionally, some physicians proposed that validation and accreditation of online mental health training would increase the interest of physicians because it would be listed on their resumes as acquired professional competencies. Some stakeholders contend that providing official governmental certification would also encourage physicians to pursue the training:

"If physicians are awarded certification, they will be more inclined to partake in online mental health training. Also, if the training is validated and accredited by the government, physicians will utilize this as validation of their professional accomplishments."

–Physician #09, Female

Stakeholders suggested that in addition to the online mental health training, the arrangement of practicums in mental healthcare that utilizes assessments and monitoring could ensure better comprehension among physicians. Some stakeholders suggested creating interactive, interesting, and readily accessible online training materials to reduce monotony and provide a friendly learning environment. Visual training materials like checklists of common mental health concerns and symptoms, short videos explaining counseling methods, and role-plays could make training more participatory. Some also mentioned the importance of making the content easily accessible at any point in time after training so that physicians can refer back to the material:

"The online mental health training materials can be made interactive through adding checklists about mental health issues, formatting it as a presentation, added videos and visual materials so that training seems interesting. This will reduce monotony and improve learning."

– Psychologist #06, Female

#### 3.3.2. System-level recommendations

Stakeholders shared insightful solutions for strengthening the mental health system, including the development of an appropriate mental health curriculum for physicians, increased service availability, increasing policy-level awareness, and capacity-building for all levels of health care providers. Development of a robust undergraduate level curriculum was suggested through increasing psychiatric content and duration of internship placements. Stakeholders also suggested placing higher importance on psychiatry during undergraduate medical examinations. A physician stated that broader mental health curriculums would facilitate students' understanding about psychiatric support and services. Some psychiatrists insisted on increasing the duration of

internships at psychiatry departments to ensure opportunities for students to explore mental health issues more.

> "The syllabus of mental health curriculums should be vaster at the undergraduate level. The medical students should know about psychiatric emergencies, referrals, and mental health services. Also, the placement in the psychiatry department during internship needs to increase so that students can get a more practical understanding of psychiatric patients."
>
> – Psychiatrist #02, Male

Ensuring service availability to support physicians providing mental healthcare was insisted on as a priority by stakeholders. The majority of psychiatrists and psychologists suggested integrating psychiatric services at every health care facility and medical college and creating job opportunities for different mental health professionals at government-level hospitals. Guaranteeing the availability of psychotropic medications and coordination of services, in particular, was noted by psychiatrists:

> "There must be one medical officer appointed to provide mental health support at all hospitals, enableing easy referral for other physicians. Also, psychiatric medicines should be available at rural facilities. Additionally, we should focus on strengthening the department of psychiatry and promote opportunities for students so that they can feel interested in pursuing psychiatry."
>
> – Psychiatrist #09, Female

Some stakeholders mentioned increasing awareness at the policy level for supporting mental health training for physicians, which would in turn, support mental health care provision. Additionally, proper implementation of mental health policies and increasing system-wide awareness of suicide and other mental health issues were brought up by stakeholders. One of the psychologists stated,

> "The government should focus on training physicians to provide mental health to the overall population. Strong mental health policy should be implemented with specialized attention on suicide prevention and reducing the burden of mental health disorders."
>
> – Psychologist #06, Female

Other stakeholders expressed that the government should subsidize online mental health services to promote universal health coverage of mental health through increased accessibility. Some mentioned online services would improve opportunities for mental healthcare providers to offer their services to the general population. To create stronger referral systems and multisectoral involvement in improving mental health service provision, increased collaboration among mental health service providers would need strong governmental support and policy-level awareness:

> "Government should focus on increased collaboration between healthcare providers and mental health service providers. For strengthening the health system and ensuring total health, there should be a strong connection between physician and mental health service providers."
>
> – Psychiatrist #03, Female

Training different levels of health care providers, such as community health workers, alongside building the capacity of general physicians would contribute to a stronger mental health workforce. This would also encourage universal coverage of mental health services.

> "Besides training physicians, we can train people in para-counseling and psycho-social support training so that they can inform the general population about mental health and contribute to increasing mental health awareness within the population."
>
> – Psychologist #08, Female

## 4. Discussion

Through interviews with multi-level stakeholders involved in the mental and general healthcare system, this study confirmed the need for providing training in mental health to Bangladeshi physicians.

Stakeholders reported that low mental health literacy among physicians might be attributable to the absence of a comprehensive mental health curriculum and training program at the graduate level in Bangladesh. This finding aligns with Hasan et al., who reported that 7000 students graduate with medical degrees every year after spending only 20h on an academic psychiatry course and seven days on a psychiatric placement (Hasan et al., 2021). The participants also highlighted that mental health provision is negatively affected by insufficient infrastructure within the mental health system, including a scarcity of mental health professionals and logistics, such as drug availability, affecting the physicians' mental health service provision. The study findings suggested the need for mental health training and discussed the possible contents and modalities to deliver the training for physicians. In addition, recommendations for overcoming challenges at the system and individual levels for receiving the training were also reported. Findings suggest the need for mental health training and possible training contents and delivery modalities. Recommendations for overcoming training-related challenges at the system and individual levels were also reported.

Stakeholders confirmed that limited mental health literacy compromises the early detection of mental health conditions, especially in rural areas where people do not seek help for mental health, causing severe treatment delays affecting the disease prognosis (Ali and Agyapong, 2016; Bransfield and Friedman, 2019). Our study reported that physicians are also resistant to their mental health and well-being due to a lack of mental health literacy that affects their care-seeking behavior (Gold et al., 2016; Clough et al., 2019). Management of mental illness is also affected by physicians prescribing medicine to relieve somatic symptoms rather than psychosocial support. These practices are also widespread in countries with similar health systems due to a lack of proper mental health awareness and limited consultation time with physicians (Lehmann et al., 2021; Hutton and Gunn, 2007). Our study reported that overcrowding in facilities, exacerbated by the COVID-19 pandemic, inhibits physicians' abilities to have adequate consultation time to provide basic counseling. Short consultation time has been considered a significant challenge in the capacity of physicians to identify and provide basic support for mental health issues in developing countries (Lehmann et al., 2021; Hutton and Gunn, 2007; S ø vold et al., 2021).

Bangladesh is one of the LMICs with a high prevalence of mental health conditions, but the government healthcare does not include mental health coverage yet (Hossain et al., 2014). There are a few psychiatrists, mainly concentrated in urban areas, rendering mental health care less accessible to the rural population. Additionally, physicians in the peripheral regions often do not receive professional mental health training, which negatively affects their practice. Past evidence also shows that healthcare workers, especially physicians, usually do not get exposed to even basic mental health-related training programs, hindering the quality of the service (Elyamani and Hammoud, 2020; Ayano et al., 2017; Jones et al., 1989). In addition, psychotropic drugs are often unavailable in government facilities; therefore, physicians cannot provide some required mental health treatments to patients. This also contributes to the mental health treatment gap and corroborates findings from similar country settings (Gururaj et al., 2016; Sunkel and Viljoen, 2017; Hanlon et al., 2014). Lack of proper policy implementation and less prioritization in health agendas may contribute to Bangladesh's poor mental health system (Hasan et al., 2021). An inadequate mental health system is also one of the key reasons for the significant mental health treatment gap in other developing countries, such as India, China, Nepal, and numerous African nations (Rathod et al., 2017; Kumar, 2011; Qin and Hsieh, 2020; Petersen et al., 2017).

It is evident that physicians' reluctance to pursue psychiatry is affected by the broader physician community and families discouraging

it as a profession. This situation is exacerbated further by the scarcity of job opportunities for mental health professionals in health care facilities. This is consistent with other studies reporting that only 8.6% of medical students want to pursue psychiatry due to low respect for the specialty, relatively lower wages, and negative comments from social networks (Seow et al., 2018; Wiesenfeld et al., 2014). Additionally, the perception that mental health disorders require long-term treatment with no certainty of recovery serves as a demotivator for physicians in Bangladesh to deliver mental healthcare. A similar scenario has been reported in Canada, where negative attitudes and therapeutic pessimism compounded with low mental health literacy and training among health care providers have acted as a significant barrier to providing mental health care (Knaak et al., 2017). In light of the existing mental health context, stakeholders stressed the need to train physicians in mental health to be more skilled in identifying psychological distress, providing basic counseling, prescribing appropriate psychotropic medicines, and providing prompt referral services. These findings are supported by several studies from Afghanistan, India, Nepal, and Indonesia, which indicate that training increases knowledge and improves the attitudes of physicians towards mental health, enhance the quality of service, and reduce the substantial mental health treatment gap in a developing country like Bangladesh (Koly et al., 2021; Tirmizi et al., 2017; Maulik et al., 2016; Gupta et al., 2020; Citraningtyas et al., 2017). This study also highlighted that mental health training could employ a task-sharing approach to mental healthcare provision. This has the potential to make mental health services more accessible and available to the community given the extreme shortage of psychiatrists and other mental health professionals, ultimately promoting universal mental health coverage (Koly et al., 2021; Armstrong et al., 2011).

Stakeholders provided recommendations for the content of the training. They suggested modules on detecting poor mental health symptoms, improving basic management and referral skills, and self-care practices for physicians. These components were found to be successful in training conducted in various LMIC settings (Tarannum et al., 2019; James et al., 2019; Shidhaye et al., 2016; Patel et al., 2011; Acharya et al., 2017; Siriwardhana et al., 2016; Rahman et al., 2008). Heavy workload, time constraints, lack of motivation, distance, and technological issues were some of the perceived challenges to delivering training. These barriers have also been recognized in training delivered to health care professionals on maternal and newborn healthcare, oncology, autism spectrum disability, and non-communicable diseases (Jaeger et al., 2018; Kilic et al., 2014; Burke and Cocoman, 2020; Tumbwene et al., 2020; Byamugisha et al., 2020).

To overcome some of these challenges, stakeholders suggested online mental health training to allow greater geographic accessibility and effective usage of time and resources. The current training in mental health for clinicians in Bangladesh is limited to the district level. Meeting population needs, particularly during the ongoing pandemic, will require mass training within a short time, and this will only be possible via online delivery (Hasan et al., 2021; Elyamani and Hammoud, 2020; Koly et al., 2021; Barua et al., 2020; Gaspard and Yang, 2016; Jacob, 2011). Previous evidence supports the benefits of online training interventions for healthcare providers in mental health (Chen et al., 2020; Egan et al., 2018; Maguire et al., 2019; Mehrotra et al., 2018; Maulik et al., 2017). In addition, stakeholders recommended integrating an accreditation and certification system to increase motivation to undertake training. This aligns with past findings that certification and a letter of appreciation can act as career-building incentives and provide a sense of satisfaction in pursuing educational training despite heavy work schedules (Lehman and Concei çã o, 2013; Prytherch et al., 2013).

Stakeholders also provided suggestions for system-level changes to support the proper implementation of mental health training and strengthen the overall care pathway. These included adequate policy implementation, including a comprehensive mental health curriculum and mandatory internship for Medical Degree programs, and building alternative mental health workforce careers to bridge the treatment gap. Studies also support that task-shifting and task-sharing within all levels of healthcare would strengthen the mental healthcare pathway and mitigate the challenges associated with a shortage of mental health professionals (Koly et al., 2021; Armstrong et al., 2011). Basic mental health training should be commonplace among physicians and all the health care professionals as this stepped care approach can strengthen the overall mental health care pathway in Bangladesh and beyond.

## 5. Strengths and limitations

This study's major strength lies in engaging prominent stakeholders from the healthcare and the mental health systems of Bangladesh. Gathering perspectives from four different stakeholder groups aided in limiting subjective bias. Physicians were included from all eight divisions

**Table 1**
Programmatic implication of the findings in the context of Bangladesh.

| Areas of Interest | Constraints/Barriers | Existing facilitators | Opportunities for interventions |
|---|---|---|---|
| Mental health literacy and practice of physicians | • Low mental health literacy among physicians<br>• Existence of stigma<br>• Lack of self-care among physicians<br>• Absence of largescale and comprehensive mental health training | • Physicians providing health care at all levels of health care services<br>• Presence of mental health curriculum in undergraduate level<br>• Presence of mhGAP training arranged by NIMH at some of the districts | • Designing comprehensive mental health training for physicians<br>• Integrating mandatory regular mental health training for physicians |
| Inadequate mental health systems | • Lack of mental health professionals<br>• Lack of job opportunities for mental health professionals | • Existence of mental health act<br>• Presence of different levels of healthcare professionals<br>• Presence of mental health services at urban tertiary care facilities<br>• Presence of NGOs providing mental health supports | • Proper implementation of the mental health act<br>• Integration of mental health care in universal health coverage<br>• Capacity- building of community-level health workers |
| Implementing mental health training | • Heavy workloads at health care facilities<br>• Time constraints<br>• Low motivation among physicians<br>• High resource consumption of face-to-face training arrangements<br>• Poor information technology systems | • Patients with undiagnosed psychosomatic symptoms seek support from the different healthcare facilities<br>• Presence of information technology and telemedicine services<br>• Availability of internet in most geographic locations<br>• Basic understanding of the importance of mental health among health care providers | • Integration of task-sharing approaches by training health care workers<br>• Mandating mental health training for physicians<br>• Validation and accreditation of mental health trainings<br>• Inclusion of feasible training modalities appropriate to the setting<br>• Mass awareness campaign on increasing mental health literacy<br>• Using information technology in strengthening the mental health system. |

of Bangladesh to increase geographic variation within the sample. Stakeholders also had varying levels of experience, which helped to compile a wide range of knowledge. The research findings will be potentially applicable to other limited-resource settings to design appropriate mental health training programs.

However, results cannot be generalized due to the study's nature (qualitative design with a limited sample). Moreover, participants were purposively selected and interviewed online during the COVID-19 pandemic, which potentially increased sampling bias by limiting recruitment reach and overlooking those who may have only participated in face-to-face interviews. The study sample did not include every type of healthcare professional, such as community health workers and nurses associated with mental health service provision, resulting in social desirability bias. Moreover, mental health is a stigmatized and under-discussed topic, social desirability bias and inadequate awareness of the mental health system in Bangladesh could have limited points of view.

## 6. Programmatic implication of findings

We feel that efforts in particular areas are needed to strengthen the entire mental health system and reduce the treatment gap. As a result, Table 1 illustrates some of the possible areas where our government needs to address the constraints/barriers through existing facilitators and future intervention opportunities.

## 7. Conclusion

Considering the high burden of mental health issues and the impoverished mental health system in developing countries, integrating mental health training for physicians could be a feasible strategy to strengthen the mental health care pathway. In Bangladesh, adequate numbers of mental health care professionals cannot be trained soon enough, so a collaborative approach would be beneficial in meeting the population's needs. As the numbers of physicians are substantial and widespread, educating them about primary mental health care serves as an alternative option. These findings provide baseline evidence for further research, especially to measure the impact of mental health training on reducing mental health burdens. This study provides information to aid in designing appropriate training programs for physicians in Bangladesh and countries with similarly poor health systems.

## Ethics approval and consent to participate

The study was conducted in accordance with the Institutional Research Ethics guidelines and ethical guidelines involving human participation (i.e., Helsinki Declaration). Formal ethics approval was granted by the Institutional Review Board (IRB) of icddr,b (PR-21038). Informed consent was obtained from all participants.

## Availability of data and materials

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

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## Authors' contribution

Conceptualization: Kamrun Nahar Koly (KNK); Methodology: KNK and Monzia Mushtaq (MM), Helal Uddin Ahmed (HUA); Project Implementation: Shahriar Ahamed (SA), Jobaida Saba (JS), Syeda Fatema Alam (SFA), Md. Saiful Islam (MSI), Mohammed Raihan Tariq (MRT), MST Sadia Sultana (MSS); Analysis and interpretation of data: KNK, JS, MSH, MRT, SFA, Enryka Christopher (EC); Writing - original draft preparation: KNK, JS, MSH, Review and editing: KNK, EC and Cleo Baskin (CB); Supervision: KNK, All authors have read and approved the manuscript.

## Declaration of competing interest

The authors declare that they have no potential conflict of interest in the publication of this research output.

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## Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ssmmh.2022.100107.

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