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The International Journal of Psychiatry in Medicine

Integration of mental health comorbidity in medical specialty programs in 20 countries

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Manuscript Type:	Original Research Article
Keywords:	Curriculum development, Medical education, Comorbidity, Medical Illness, Mental Illness
Abstract:	<p>Methods:A systematic analysis was performed of the medical specialization academic programs of 20 different countries to establish which ones take into account mental health comorbidity.The criteria that were explored in the educational programs include:1)name of the medical specialties that take into account mental health comorbidity in curriculum design,2) name of the mental health content addressed by these programs. After independent review and data extraction, paired investigators compared the findings and reached consensus. Descriptive statistics evaluated the frequency of the data presented.</p> <p>Results:Internal medicine, family medicine, neurology, pediatrics and geriatrics were the specialties that included mental health topics in their programs. In four countries: Bangladesh, Serbia, the Netherlands and France, 50%of all graduate specialty training programs include mental health content. In ten countries:Germany, Sweden, the United Kingdom, Mexico, Belgium, India, Russia, Canada, Israel and Spain, between 20%and 49%of all graduate specialty training programs include mental health content. In six countries(Brazil, Chile, Colombia, Croatia, Kenya, and the United States)less than 20%of all graduate specialty training programs include mental health content.</p> <p>Discussion:The proposal that we have made in this article should be taken into account by decision-makers, in order to complement the different postgraduate training programs with mental health comorbidity that are frequently present with other physical symptoms.It is not our intention that the different specialists know how to treat psychiatric comorbidities, but rather pay attention to their existence and implications in the diagnosis, evolution and prognosis of many other diseases.</p>

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Integration of mental health comorbidity in medical specialty programs in 20 countries

ABSTRACT

Methods: A systematic analysis was performed of the medical specialization academic programs of 20 different countries to establish which medical specialties take into account mental health issues in the specialty curricular design and which mental health content these programs address. The criteria that were explored in the educational programs include: 1) name of the medical specialties that take into account mental health content in curriculum design, 2) name of the mental health issues addressed by these programs. After independent review and data extraction, paired investigators compared the findings and reached consensus on all discrepancies before the final presentation of the data. Descriptive statistics evaluated the frequency of the data presented.

Results: Internal medicine, family medicine, neurology, pediatrics and geriatrics were the specialties that included mental health topics in their programs. In four countries: Bangladesh, Serbia, the Netherlands and France, 50% of all graduate specialty training programs include mental health content. In ten countries: Germany, Sweden, the United Kingdom, Mexico, Belgium, India, Russia, Canada, Israel and Spain, between 20% and 49% of all graduate specialty training programs include mental health content. In six countries - Brazil, Chile, Colombia, Croatia, Kenya, and the United States - less than 20% of all graduate specialty training programs include mental health content.

Discussion: The proposal that we have made in this article should be taken into account by decision-makers, in order to complement the different postgraduate training programs with mental health issues that are frequently present with other physical symptoms. It is not our intention that the different specialists know how to treat psychiatric comorbidities, but rather pay attention to their existence and implications in the diagnosis, evolution and prognosis of many other diseases. The current fragmentation of medicine into ever finer specialties makes the management of comorbidity ever more difficult: a reorientation of post-graduate training might improve the situation.

1.- Introduction

The management of comorbidity and emerging diseases are the main challenges for medicine in the 21st century. The first requires, as a first step, changes in the organization of health services and in the training of health workers. While the second should be addressed by improving research aimed at the prevention and treatment of emerging diseases

The increasing prevalence of chronic illnesses has been accompanied by a concomitant increase in comorbidity (co-occurrence of two or more chronic health conditions). The success in prolonging life expectancy did not greatly increase the number of disease-free years: the years gained are years in which people tend to suffer from a variety of chronic diseases, impairments and disabilities. The simultaneous presence of comorbid diseases usually predicts a poorer prognosis for both conditions; it can lead to a greater number of complications, and makes treatment more complex¹⁻² and expensive³. It is important to point out the difference between comorbidity as the start of another clinical entity in the course of an existing disease, and multimorbidity, defined as the coexistence of several diseases with varying degrees of association in the same individual⁴.

In 2019, according to the Global Burden of Disease Collaborators, mental disorders are among the top ten factors that produced the highest number of disability-adjusted life years in the world in the last 30 years⁵. Despite the fact that diseases such as ischemic heart disease, diabetes, stroke, chronic kidney disease and lung cancer are in the first places; mental disorders are often comorbid with such noncommunicable diseases, which worsens their prognosis and the increasing costs associated with their treatment. In addition to the fact that people with mental disorders live 10 years less than people without mental disorders, and non-communicable diseases are the leading cause of their death.

Adults with medical multimorbidity, usually defined as ≥ 2 concurrent chronic conditions – for example cardiovascular disease and diabetes – (⁶⁻⁷, have high rates of healthcare utilization and associated costs⁸.

The comorbidity of mental-physical diseases has become a major problem in medical practice, as it is present in approximately 30% of individuals⁹. In persons over the age of 60, comorbidity has become the rule rather than an exception¹⁰⁻¹¹. Scott et al¹² analyzed 17 countries from the World Mental Health survey and reported a consistent pattern of associations between mental disorders and subsequent development of chronic medical

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3 conditions, with odds ratios ranging from 1.2 (95% CI, 1.0-1.5) to 3.6 (95% CI, 2.0-6.6).
4 Recent research indicates a bidirectional relationship with common risk factors (eg, adverse
5 experiences in early childhood) and shared etiopathogenesis, and the results of the others
6 impact through neurohormonal and behavioral pathways among some of the
7 noncommunicable diseases and mental disorders (eg, depression). The pathways linking
8 mental and physical comorbidity are complex and bidirectional such that, a physical disorder
9 may cause a mental one¹²⁻¹⁴, a mental disorder may place a person at risk for a physical one,
10 and some mental and physical disorders share risk factors, such as chronic stressful social
11 life situations, physical inactivity, overweight, smoking, substance use disorders and
12 endocrine dysregulation. Additionally, social conditions like poverty and adverse life events
13 are risk factors for both types of conditions, perhaps due to biological mechanisms and an
14 unfavorable environment.
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16
17 The relationship of mental-physical disorders holds the potential for a population health index
18 that can gauge the effect of prevention programs at the community level. A study by
19 Cawthorpe found the median cost of physical disorders to be 2.9 times higher in the group
20 with any International Classification of Diseases psychiatric disorder, in comparison with the
21 group without psychiatric disorder¹⁵. In the USA, a major study of 30,022 adults showed that
22 the risk of functional disability in people with diabetes was 2.42 times higher than in people
23 without diabetes; that in people with depression alone it was 3 times higher than in people
24 without depression; and that the risk for those who had depression and diabetes, the risk was
25 7.15 times higher than for people who had neither diagnosis¹⁶. When depression is present,
26 the cost of treating diabetes is 4.5 times higher¹⁷.
27

28
29 Living with medical comorbidity often includes taking multiple prescription medications and
30 careful management of individual illnesses. Comorbid substance use disorder (SUD) can
31 have profound negative effects on pre-existing chronic diseases, since different substances
32 of abuse have been associated with a wide range of physiological effects (cardiovascular,
33 gastrointestinal, hematological, pulmonary and neurological) that complicate the evolution,
34 clinical management and prognosis of chronic diseases. Furthermore, many adults who are
35 in treatment for SUD receive fragmented medical care for their other chronic conditions¹⁸.
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38 Chronic medical diseases, mental illness, and substance use frequently are interrelated and
39 represent a compound multimorbidity placing individuals at even higher risk for adverse
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3 outcomes including increases in healthcare utilization. Therefore, such comorbidity must be
4 taken into account when developing effective care for medical comorbidity¹⁹.

5
6 While the association between physical and mental disorders continues to grow, medicine is
7 fragmenting into increasingly limited specialties. There are few residency programs that train
8 in evaluation and assessment of mental disorders (like internal medicine) and their training is
9 often inadequate or incomplete²⁰. While clinicians may be aware of comorbidity, they may
10 also feel pressed for time and powerless to handle problems, as well as lacking confidence
11 or strategies to address all problems. Training should take into account that doctors can
12 control and limit the interview as a way to avoid emotional difficulties. In other words,
13 physicians increasingly treat problems and / or disorders in which they received little training
14 during residency.

15
16 A solution from medical education consists of developing and implementing a comprehensive
17 curriculum in physical and mental comorbidity during training as medical specialists²⁰. The
18 context of the current pandemic, followed by extensive restrictive public health measures
19 (such as isolation, quarantine, and monitoring) can cause significant distress resulting in the
20 emergence of mental disorders such as depression in previously unaffected populations.
21 Therefore, the current context demands a call for a significant change in the education of
22 residents in practical skills to manage common difficulties of patients, such as anxiety,
23 depression, substance abuse and chronic pain²¹. In addition, there is a gap in the literature
24 related to the evidence for the integration of medico-mental comorbidity into the medical
25 residency program and how these curricula can meet training needs²².

26
27 The only way to ensure an appropriate attitude towards comprehensive patient care, in any
28 medical specialty, is to work in a cooperative and interdisciplinary manner. Therefore, the
29 training must incorporate some explanation of the comorbidity and the potentially dangerous
30 implications of not identifying it within the consultation.

31
32 The biopsychosocial model of health care, awareness of comorbidity (physical-mental)
33 inclusive approaches on promotion and prevention aspects in mental health, doctor-patient
34 relationship and ethics should be included in the different training programs.

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36 The current fragmentation of medicine into increasingly fine specialties makes the
37 management of comorbidity even more difficult: a reorientation of postgraduate training could
38 improve the situation. In our current context, a reorientation in the curriculum is urgent, since
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3 health care providers have an essential role in the treatment of emotional outcomes as part
4 of the response to the pandemic COVID-19 and control measures (eg quarantine and
5 distancing Social). Future specialists need to acquire sufficient knowledge to diagnose and
6 treat (or refer) common psychiatric diseases. The main objective of this study was to establish
7 which medical specialties take mental health into account in the design of their training
8 programs, and what mental health topics they address.
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17 2.- Methods.

18 This document analysis systematically analyzed the medical specialization academic
19 programs of 20 different countries. The searching criteria that were explored in the
20 educational programs include:
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- 23 1. Which specialty programs addressing mental health comorbidity in their training
24 program?
- 25 2. How many specialties include the following mental health comorbidity in their regular
26 postgraduate program: affective disorders, anxiety disorders, substance use disorders,
27 and alcohol use disorders?
28
- 29 3. What other mental health topics are included in the different medical specialty
30 programs?
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36 Operational definition. Mental health content was defined as the specific mention in the
37 curriculum of each academic program of depressive, anxiety, substance use disorders
38 comorbid with medical pathology. As well as the express mention of the study of the doctor-
39 patient relationship in the practice of the specialty.
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44 2.1. Document collection

45 For each of the 20 countries: 1. all medical schools in the country were searched, 2.- once all
46 schools were identified by country, all graduate programs associated with each school were
47 identified, and 3.- then their study plan for each of the programs was analyzed.
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50 Study plan and medical specialty programs were requested through invitations, searches on
51 institutional websites and communications from all medical schools in the participating
52 countries. For countries with multiple medical schools, each website was independently
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3 searched for relevant documents. To be included in the analysis, documents had to be
4 retrievable from an institution. Otherwise, schools were excluded from the study.
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10 2.2 Data extraction process

11 The data extraction form was created in Excel and was designed to extract documented
12 information. The majority of items on the form appeared as check- boxes to indicate the
13 presence or absence of criteria. Those related to the proposed criteria were extracted for
14 analysis. The initial draft of the data extraction form was created by three coauthors (GH,
15 DPGS, NB), and was subsequently reviewed and revised by four groups of four investigators
16 (16 investigators in total) extracted data from the available papers using the final form. After
17 independently extracting the data, each group of investigators compared the entries, resolved
18 discrepancies by consensus, and submitted a final data extraction form for each medical
19 school reviewed.
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27 Data were organized and analyzed using IBM SPSS statistical software, version 26 (IBM
28 Corporation, New York, NY, USA). Descriptive statistics evaluated the frequency of the data
29 presented.
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34 3.- Results

35 The materials describing 1036 postgraduate specialty programs that were examined showed
36 that internal medicine, family medicine, neurology, pediatrics and geriatrics were the
37 specialties that included mental health topics in their programs with some differences between
38 the 20 countries, for example: Neurology include mental health comorbidity on 17 different
39 countries vs Geriatrics that include mental health comorbidity on 8 different countries (See
40 Figure 1).
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47 INSERT FIGURE 1
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51 The percentages of mental health content found in the postgraduate programs from the 20
52 countries included in this survey were: 1) In four countries: Bangladesh, Serbia, the
53 Netherlands, and France, over 50% of all postgraduate specialty training programs included
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3 mental health content; 2) In ten countries: Germany, Sweden, United Kingdom, Mexico,
4 Belgium, India, Russia, Canada, Israel, and Spain, between 20%-49% of all postgraduate
5 specialty training programs included mental health content; 3) In six countries: Brazil, Chile,
6 Colombia, Croatia, Kenya, and the United States, 20% of all postgraduate specialty training
7 programs included mental health content. (See Figure 2)
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12 INSERT FIGURE 2
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15 Croatia and Russia do not have medical specialties that include affective disorders in their
16 academic programs. Belgium, Brazil and Kenya do not have medical specialties that include
17 psychosomatic disorders in their academic programs, whereas Germany, France and Croatia
18 do not include anxiety disorders in their academic specialty programs. Bangladesh, Mexico,
19 the Netherlands, Israel, Serbia, and Spain include mental health issues in more than 10 of
20 their medical specialty programs (see Figure 3).
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27 INSERT FIGURE 3
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29 Brazil, Croatia and Russia do not have medical specialties that include substance use
30 disorders (SUD) or alcohol use disorder (AUD) in their academic programs. None of the
31 medical specialty programs in Kenya include AUD. Belgium, Chile, Colombia, England,
32 France, Germany, and the United States do include AUD and SUD, but only in less than five
33 medical specialty programs. (See Figure 4)
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41 In Serbia, Mexico, Bangladesh, the Netherlands, Russia, England, France, Sweden, and
42 Spain, more than 10 different programs address other mental health topics, such as the
43 doctor-patient relationship, violence, medical ethics, medical responsibility,
44 neuropsychological syndromes, etc.
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48 4.- Discussion

49 It is of great concern that only four of the 20 countries in our study contemplate mental health
50 in over 50% of their postgraduate specialty training programs, while this percentage falls
51 below 20% in six countries.
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3 In recent years, the increasing prevalence of chronic, often comorbid conditions requires that
4 patients receive care from multiple providers in a variety of settings. Intensified specialization
5 has sought to generate greater interdependence among clinicians and promote cross-
6 fragment coordination, however, it has exacerbated fragmentation by increasing the number
7 of narrowly trained specialists. "Fragmentation" in healthcare services means a systemic lack
8 of coordination that spawns inefficient allocation of material and human resources.
9 Fragmentation adversely impacts quality, cost, and outcomes¹⁴. The healthcare system is
10 suffering from what George Halvorson calls "clinical linkage deficiencies"²³. This systemic
11 fragmentation is difficult to dislodge, because it is steeped in the history and culture of
12 medicine and embedded population-wide within the current system — operationally,
13 financially, and in the clinic.

14
15 The comorbidity of a mental and physical condition may impact the mode of presentation,
16 clinical severity, response to treatment, and burden of illness of both conditions. New insights
17 in biology, physics, human organization, and other fields have led to understanding complex
18 systems as more than the sum of their parts²⁴. However, because of our fragmented
19 understanding of the natural world, systems, and human interactions, health care has not
20 kept up with these advances²⁵. Specialized information has expanded without an
21 accompanying expansion in our ability to integrate, prioritize, and personalize narrowly
22 construed information.

23
24 Fragmentation often involves multiple providers and organizations, with deficient coordination
25 among the parties, that may lead to suboptimal care, including important healthcare issues
26 being inadequately addressed, poor patient outcomes, and unnecessary or even harmful
27 services that ultimately both raise costs and degrade quality²⁶⁻²⁷.

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29 Research evidence consistently demonstrates that people with chronic diseases are two to
30 three times more likely to experience mental health problems than the general population¹⁸.
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3 Medical specialization (ME) plays a key role in contemporary medicine and the role of the
4 specialist should not be questioned. ME emerged as a result of the shift to pathological
5 anatomy (medical model divides the body into parts in which different types of doctors have
6 to specialize), the emergence of medical technologies, and due to urbanization.
7
8 Specialization is a way to improve healthcare outcomes, by applying greater knowledge and
9 experience on specific diagnostic and therapeutic problems. This represented important
10 advances in the treatment of diseases previously considered incurable, as well as in
11 increasing life expectancy. Adequate communication between specialists is essential to avoid
12 distancing from integrated medicine
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14
15 In particular, cardiology, endocrinology, pneumology, infectiology, rehabilitation medicine,
16 and orthopedics do not include mental health content in their academic programs. In the
17 majority of the surveyed countries, there is strong clinical evidence that these specialties may
18 benefit from teaching mental health topics to postgraduate residents, given their close
19 relationship with cardiovascular diseases, diabetes, chronic obstructive pulmonary disease
20 (COPD), and chronic musculoskeletal disorders³⁰⁻³⁶.

21
22 Cardiovascular prognosis is less favorable for patients with comorbid mental health diseases,
23 for instance, an association with depression increases acute exacerbations per year by 50%,
24 as well as mortality rates³¹⁻³⁴. People with comorbid diabetes-depression have an increased
25 risk (> 20%) of unfavorable health outcomes and premature mortality^{30, 34}. Mental illness can
26 also have a major impact on symptoms and outcomes for people with COPD (regardless of its
27 severity): psychiatric comorbidity in these patients is associated with poorer health status,
28 increased breathlessness, and an increase in mortality rates^{30, 36-40}. There is also evidence
29 for a higher prevalence of mental disorders among people with other conditions, including
30 asthma, arthritis, cancer, HIV/AIDS, and others^{37,38}.

31
32 Finally, it is also important to take into account child maltreatment (CM) as the most important
33 preventable cause of psychopathology. There is a palpable relationship between adversity
34 early in life and adult health status³⁸.

35
36 Studies show that comprehensive care that avoids diagnostic-therapeutic fragmentation
37 improves a patient's evolution, prognosis and quality of life^{4, 9-10}. Appropriate management of
38 mental and somatic comorbidity, at the individual and at the public health level, will require a
39 significant reorientation of medical education.
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3 Psychiatrists are no better than other specialists at identifying comorbid conditions. This is
4 most clearly demonstrated in the creation of a sub-discipline called liaison psychiatry. No
5 other medical discipline has a similar subspecialty; there is no liaison cardiology or
6 pulmonology because any specialist is expected to deal with the physical problems of their
7 patients. Psychiatrists often overlook or under-treat a comorbid physical illness, omitting a
8 medical examination that could inform them of the presence of another illness. Given that
9 cardiovascular, cancer, neonatal and musculoskeletal disorders rank above mental health
10 morbidity statistics worldwide, it is expected that in the future psychiatrists will acquire
11 sufficient knowledge to diagnose and treat (or refer) non-psychiatric diseases and that,
12 therefore, the discipline liaison psychiatry is unnecessary. We are still far from this goal. The
13 academic training program of a psychiatrist must be based on an epidemiological profile and
14 include the most common chronic degenerative diseases. A future study regarding the
15 inclusion of physical health content in psychiatric training would be interesting in the future.
16 Worldwide efforts are needed to convince decision makers, educators, clinicians, healthcare
17 institutions, and insurance providers, not only that mental-physical comorbidity is not an
18 exception but nearly a rule, but also that it constitutes one of the most urgent challenges for
19 public health authorities.

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21 Not only should undergraduate education be a target for the objective of integration, it is
22 therefore unavoidable that specialists in all disciplines also assume some responsibility for
23 dealing with the issue of mental comorbidity in the patients whom they treat.

24
25 Education and training on psychosocial issues should be provided to health system leaders
26 and health professionals on the front line of COVID care. Some patients will need a referral
27 for formal mental health assessment and treatment, in some cases immediate (suicidality),
28 while others may benefit from supportive interventions designed to promote well-being and
29 improve coping. In addition, there should be no substantial differences in the treatment of
30 COVID-19 infection between patients with a previous diagnosis of a mental disorder and
31 those without a diagnosis of mental disorder.

51 - Conclusion

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53 Comorbidity is a term that has been borrowed from physical medicine. Its original meaning
54 indicated the presence of at least two diseases. The co-occurrence of these diseases
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3 complicates diagnosis and treatment; and raises questions about the etiology and the mutual
4 interdependence of diseases^{36, 39}. This in turn calls for the involvement of different medical
5 specialties in patient care, in order to clarify the questions raised and provide comprehensive
6 treatment.
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10 The challenges of responding effectively to compounded mental and physical health needs
11 are part of a larger problem regarding the care for people with comorbidities of any kind.
12 Current service models are often orientated around single diseases and fail to provide well-
13 coordinated care to a great and growing number of people with multiple health problems.
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16 For physicians it must be fundamental to treat each patient as a whole. At present, however,
17 specialist doctors tend to focus only on their particular area of study, making it impossible to
18 care adequately for patients who have other types of health problems. It thus becomes
19 especially important for primary care physicians to understand the bases of attention in
20 psychiatry, as they are the first point of contact for patients. Knowing how to identify
21 psychiatric pathology would enable primary care physicians to detect it opportunely, prescribe
22 initial treatment, and adequately refer cases that need more specialized attention.
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29 No method can be developed to reliably determine the quality of psychiatric education and
30 training worldwide because each country has its own epidemiology of mental illness.
31 However, it is recommended that the institutions that regulate postgraduate curricula in each
32 country consider the incidence and prevalence of these diseases in order to include them in
33 the curricula of different specialties, paying special attention to psychiatric education for
34 residents of primary care medicine. It is desirable to include mental health topics, as well as
35 rotations in the psychiatric clinic area³⁶, in postgraduate curricula as befits the needs of each
36 country, so that psychiatrists and other specialists share the responsibility of detecting and
37 treating mental illness opportunely.
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44 Some specific mental health topics could be added to the curriculum in many countries
45 carefully according to epidemiological needs, avoiding their impact on other aspects of the
46 program. The curriculum is a zero-sum game, which means adding one thing may require
47 removing another.
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51 Awareness of mental health must be integrated into all aspects of health and social policy,
52 into the planning of the healthcare system and into the provision of primary & secondary
53 healthcare. The proposal is to integrate (within medical training programs) common mental
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3 health problems in the routine care of people affected by other chronic non-communicable
4 diseases (such as cancer, diabetes and cardiovascular disorders), HIV / AIDS and maternal
5 health care. Integrating physical and mental comorbidity into medical education programs
6 offers the opportunity to treat " the whole patient ", with a better overall cost-effectiveness
7 than an approach in which mental health, acute physical health and Chronic, reproductive
8 health problems, infectious and chronic pain are addressed without effective knowledge and
9 communication among health professionals. An integrated care model is often more attractive
10 to patients and family members who are concerned about the stigma that is still associated
11 with mental and substance abuse disorders.

12
13 The proposal of the present article is to complement the pre-existing programs with
14 annotations in mental health, since it is not intended that the different specialist doctors know
15 how to treat all psychiatric diagnoses, but that they know their existence, implications in the
16 diagnosis and prognosis of other diseases, as well as the changes in the clinical evolution
17 generated by the medical and mental comorbidity.

18
19 An integrated medical education approach to address mental health in for example: the
20 context of HIV care, maternal mental health, and chronic non-communicable diseases is
21 based on the conviction and growing evidence of the efficiency, effectiveness, and cost
22 savings of an integrated medical care⁴¹. Prevention and early intervention also reduce the
23 global burden of mental and physical comorbidity. An integrated approach that seeks to
24 prevent conditions that affect mental and physical health would share common strategies; for
25 example, reducing alcohol consumption and smoking and promote physically active
26 lifestyles⁴².

27
28 Finally, we must not forget that the mental health implications of the COVID-19 pandemic
29 (protecting people with mental disorders from COVID-19, the anticipated increase in mental
30 disorders throughout the population, and the neuropsychiatric consequences of the disease)
31 require a greater focus on public interventions mental health. The notion that only
32 psychiatrists can provide treatment must be abandoned. Other forms of collaborative and
33 community-based approaches are required, through training of the general practitioner and
34 specialists.

6.- Contributors

GH, NS, DGS, NBF were responsible for the literature search, figures, study design, data collection, data analysis, data interpretation, and writing. The rest of the authors contributed equally to data collection, data interpretation, and writing.

7.- Conflicts of interest

All the authors declare no conflicts of interest.

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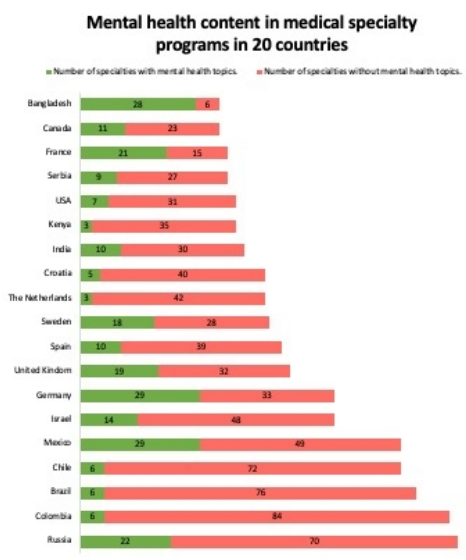


Figure 2. Number of medical specialties by country addressing mental health comorbidity: affective and anxiety disorders

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Figure 1. The main five specialty programs with mental health topics: distribution by countries.

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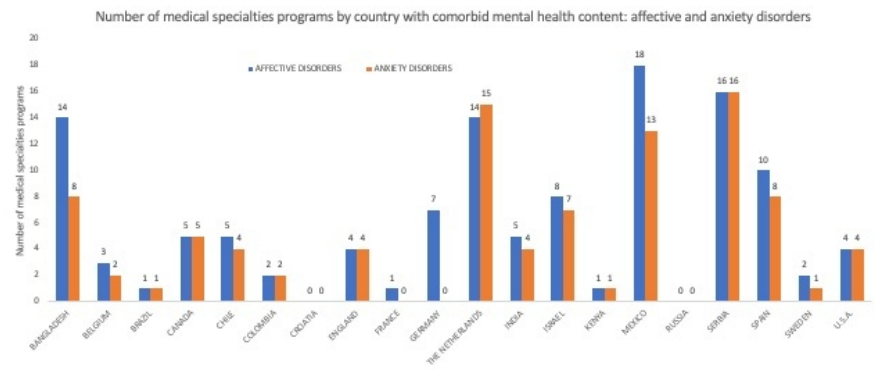


Figure 3. Number of medical specialties programs by country with comorbid mental health content: affective and anxiety disorders

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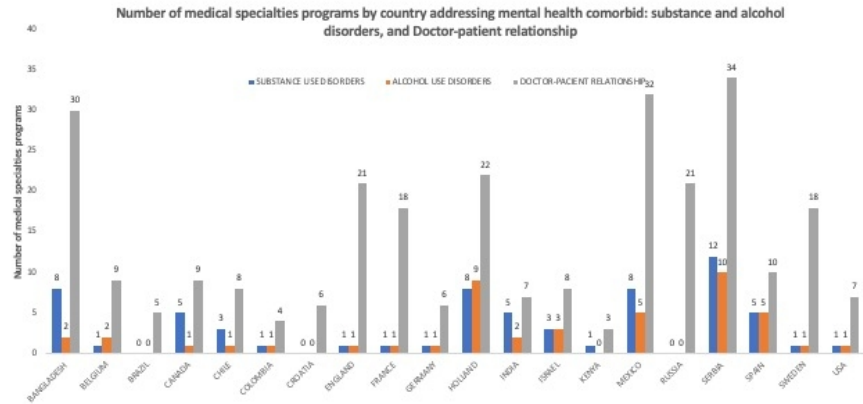


Figure 4. Number of medical specialties programs by country addressing mental health comorbid: substance and alcohol disorders, and Doctor-patient relationship

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