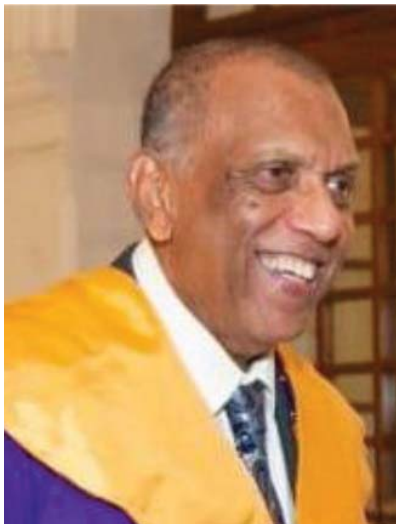
DOI: https://doi.org/10.4038/sljpsyc.v16i1.8631

Founder president of the Sri Lanka College of Psychiatrists Dr Kalyana Rodrigo

Interviewed by the current College President Dr Sajeewana Amarasinghe

SL J Psychiatry 2025; 16(1): 4-12



Dr. Kalyana Rodrigo

SA: Good afternoon, everyone, and I think good evening to you, sir, in Sydney. And today we are doing the fourth in the series of interviews with eminent consultant psychiatrists of Sri Lanka for the *Sri Lanka Journal of Psychiatry.* First, we had an interview with Prof. Samudra Kathriarachchi, our founder editor, followed by interviews with Prof. Diyanath Samarasinghe and Prof. Nalaka Mendis. And today, we have with us, Dr. Kalyana Rodrigo, who was actually one of the first MD trainees in Sri Lanka, one of the first people to pass the MD in the Sri Lankan system and worked as a senior lecturer in Peradeniya for many years, and pioneered mental health services in the Central Province and in the rest of Sri Lanka. He also became the founder president of the Sri Lanka College of Psychiatrists in 2000 and 2001. And in later years, he moved to Bermuda and to Australia. So, he has a wealth of experience in working in different mental health systems.

Sir, let me start the interview with; you know, our trainees and junior psychiatrists would like to know about your early education and work as a medical officer, and how you got interested in the field of psychiatry.

KR: Thank you for the introduction, Sajeewana. Actually, psychiatry saved me as a medical student. In my fourth year as a medical student in the Faculty of Medicine in Colombo I was getting quite depressed. And, I thought I had come to the wrong faculty. I did not like what I was observing. I am sorry to say, most of our teachers at that time were bullies, both surgeons and physicians. They were not very kind to patients, they were not nice to medical students, either.

I then went to do my psychiatric appointment with Prof. Channa Wijesinghe. I thought that this was different. He was polite to patients and very kind to them, and he was also nice to medical students.

I then decided to do psychiatry. I think I am correct in saying that I was the first in our group to decide to do psychiatry. And later, several others decided to do so while in Sri Lanka. All the others who decided to do psychiatry did so as a default when they went to England. They found that they could not find training positions in other specialities, but Psychiatry was an easy option. I was saved by Prof. Channa Wijesinghe and that is how I became a psychiatrist.

Following my internship, I wanted to get an appointment in psychiatry soon afterwards. However, that was not possible. I had to do a year and a half in a remote hospital. I was informed by a clerical officer in the Department of Health, "Doctor If you want to do psychiatry you need to state that you are making a career choice". I was very willing to make that choice and when I gave that letter to a senior director of health in the Ministry of Health, he asked me "Dr. Rodrigo, were you ill as a medical student?" He thought I had chosen psychiatry as a career because I was mentally ill. That was the attitude of administrators in Sri Lanka at that time.

I was glad to be given an appointment as a house officer in the psychiatric unit in Kandy General Hospital, where I met Prof. Angelo Rodrigo, and that started my training in psychiatry. Interestingly another person started doing

psychiatry the same day as I did and that was Dr. Ranil Abeysinghe. We walked into the psychiatric unit in Kandy on the same day in March 1977.

He was a lecturer, and I was a house officer, and as you mentioned earlier, we were the first two candidates to sit for the MD Psychiatry examinations in 1980 and 1981. We then proceeded to The Institute of Psychiatry in London and the Maudsley and Bethlem Royal Hospitals in 1982. And we did four years of training in London, at the Institute of Psychiatry, and returned in 1986, to take up positions as senior lecturers in psychiatry at the University of Peradeniya, Faculty of Medicine. That was the start of my career in psychiatry. We started trying to develop the psychiatric services in the Central Province, as you mentioned earlier. I worked in the psychiatric unit in Peradeniya and the Department of Psychiatry from 1986 to 2004, when I moved out to Bermuda and later to Australia During those years, Dr. Abeysinghe, Priyani Rathnayake and I, developed the Department of Psychiatry and the mental health services in the Central Province.

SA: So, we'll come back to that later, sir. Yes, I mean, interestingly, Prof. Nalaka Mendis too said that it was because of the interaction with Channa Wijesinghe as a medical student, that made him take up psychiatry. So, Channa Wijesinghe has influenced quite a few people.

So, we'll come back to your service development later, but I would be interested, sir, I think we are interested to know, even you were one of the first two trainees to do the MD Psychiatry program in Sri Lanka, so, can you tell us about the training you underwent then, and how it contrasts with the current training programs, and the exams, and things like that.

KR: In 1977, we commenced our training in psychiatry and at that time the process of postgraduate training in psychiatry was to complete two years of psychiatry in Sri Lanka. Following these candidates were given leave to proceed to the U.K. to complete the MRCPsych examinations. The Ministry of Health annually advertised positions for psychiatric trainees to go abroad. Annually two were selected, based on seniority in the service and were sent to the U.K. to do the MRCPsych. As we finished two years, two people were selected. I was the third in the selection, so I missed out. But the person ahead of me resigned,and he gave me a letter saying, "I have no objection to Dr. Rodrigo being given the next position". I went with this letter to the Ministry of Health. I thought I would be the next person to go abroad. Unfortunately, the then Director of Health Services, said "No, that process is over, we will not be giving you that position. Sorry, Dr. Rodrigo. You have to wait for next year's advertisement". When the next year came that system was suspended. For a period there were no further training opportunities for psychiatrists.

Fortunately for us, the PGIM was established, and a Board of Study in Psychiatry was appointed Prof. Angelo Rodrigo was the chairman of the Board of Study. Initially the board concentrated in setting up the MD Psychiatry examination process. Prof. Angelo Rodrigo said "study the textbooks". And we read a couple of textbooks. There were no formal courses. When we were thinking of sitting the examinations the GMOA protested and said, "No, we don't want this system". They said "This is a step back, and it will prevent our members from getting training abroad". We went against that GMOA decision. We were labelled as blacklegs, sitting the first PGIM examinations against the GMOA decision. Fortunately, we were successful and then proceeded to complete the MD Psychiatry Part 2 examination the following year.

We were initially given a scholarship to go to Chandigarh, India. Dr. Abeysinghe and I were not very keen to just go to India. We had hoped to go to the U.K. Fortunately, the then president of the British College of Psychiatry, Dr. Thomas Bweley was one of our examiners in the MD part two examination. I wrote to Dr. Thomas Bewley to seek his assistance in getting training positions in the U.K. He wrote back to inform us that he has arranged training positions for both of us at the Institute of Psychiatry. He also persuaded the WHO to give us scholarships. This enabled Dr. Abeysinghe and I to go to London under a WHO fellowship as clinical assistants at the Institute of Psychiatry. Six months later we were able to get employment in the NHS as registrars in the Maudsley and Bethlem Royal Hospitals. The PGIM director was not pleased with us for stepping out of the WHO scholarship and accepting paid positions, but fortunately, Prof. Angelo Rodrigo and others on the board supported us. We were able to continue with our training and do the membership of the Royal College of Psychiatrists. We returned in 1986 to commence work as senior lecturers in Psychiatry, that was the beginning of the MD Psychiatry program. There was no organized programme.

SA: Okay, so there was a lot of debate about this foreign training. When was this foreign training established?

KR: Since we were given the WHO fellowship, candidates who successfully completed the MD Part 2 were offered training positions abroad, mostly in the UK, and I think some also went to Australia. We were the first guinea pigs in this system. I am glad to say that the program has evolved. On our return we both became examiners in the part one examination, and then subsequently examiners in the part two. I am very happy to observe that the MD Psychiatry program has really flourished. However, we continue to lose psychiatrists to the rest of the world, now mostly to Australia, I think.

SA: Yes, sir. Now what has happened is most of those who go to Australia don't come back, and I mean, they just come back and take the board certification and go

back. But after 2009, the trend changed, you know, a lot of people stayed back. And about 60% stayed back with the end of the war. And then again, now with the economic crisis, we are finding that almost 90% are going back. Do you have any ideas about this? How can we retain these young psychiatrists, at least for 5 years in Sri Lanka?

KR: I have no magic answers. Except to say that they should be asked to serve at least for a limited period and repay for the free education which was provided by the country. All education primary, secondary, tertiary, postgraduate is provided free in our country. The least we can do is to be grateful and serve the country for at least a short period.

If I did not have that free education. I would not be a doctor. and I think, Medical practitioners in Sri Lanka should at least work for a few years in Sri Lanka before they look for employment elsewhere. Though, I cannot be hypocritical about this, because I too have left Sri Lanka.

SA: You have done more than your share of work in Sri Lanka. So, I think, if everybody stays at least for 4 or 5 years, we can run our Sri Lankan system without much difficulty. And, they also would be better off, because I always tell them, "if you stay for five years, you don't have to do the Australian exams".

KR: That's right.

SA: And they're all worried that they won't have jobs in Australia, but in the state sector in Australia, correct me if I'm wrong, I don't think they'll ever get filled, isn't it? The state sector in Australia will continue to have vacancies.

KR: Australia and the U.K. and even the USA, will never have been sufficient psychiatrists, and they will always be draining psychiatrists from the rest of the world. But I have something to say about that, too. It may be a blessing in disguise. We will talk about that later.

SA: I know that although you were a university psychiatrist your main interest was in community psychiatry, and I know you did a lot of work and development in psychiatry in Sri Lanka. So, we would like you to talk a little bit about your work in Sri Lanka.

KR: I realized that when we came back, there were only about 20 psychiatrists for 20 million people, so one psychiatrist per 1 million people, or thereabouts. My colleagues and I thought that it is unlikely that we will have the recommended number of psychiatrists per 100,000 people. We thought that we should train other clinicians, other medical officers, midwives and other health workers in trying to both diagnose and manage common mental health problems, and even seriously mentally ill people. That is the reasoning that led me to develop the Central Province Mental health system. I managed to persuade the director of the provincial health services to set up a committee on mental health services. The Chief Minister of the Central Province gave us an old hospital in Deltota.

That was not the best way to start a community mental health service, but we were beggars, so whatever was given, we accepted. I thought, "We shall develop the first residential mental health service centre in Sri Lanka for the mentally ill people". We then established the Delta Rehabilitation Service Unit. We also started training medical officers in the Central Province to manage mentally ill people. The Kandy Hospital and the Peradeniya Hospital psychiatric clinics were very crowded. We would see something like 200-300 people for a morning, and that was not practical. Most of the patients were seen by a registrar or a house officer, and all they did was repeat the medication. Only a few people were seen by psychiatric trainees or the consultants. We thought, if we train clinicians in the periphery and start satellite clinics, some of these patients may not have to travel all the way to Kandy or Peradeniya from all parts of Central Province, sometimes even away from the province, these patients could be seen locally and managed locally.

That was the beginning of the province-wide mental health care system, and I am happy to say that the psychiatrist who have come after us has developed this further, and that there are now many clinics, not only in the Central Province, but in the other provinces too, I think. Most base hospitals now have a psychiatric clinic, don't they?

SA: And in fact, sir, you'll be happy to know that there are psychiatrists in Teldeniya, Rikillagaskada, Gampola, Nawalapitiya, Kegalle. At least we are running with acting psychiatrists and senior registrars who have finished training. So, we are running those services.

I would also like to know, you had an interest in addiction psychiatry. I can still remember in early years, I think, as a medical student, I can remember that you were appointed to head a national task force on addiction, by the President.

KR: I work for 2 days a week at the President's office. Prof. Diyanath Samarasinghe, Prof. Colvin Gunarathne and others had drafted a wide-ranging act in relation to the use of all addictive substances. My task was as the head of the task force on alcohol, tobacco, and other addictive drugs to present this to the Parliament and get it enacted. I had discussions with the Speaker of the house at the time and the opposition whip, Mr. W.J.M. Lokubandara, Mr. Ranil Wickramasinghe, the Leader of the Opposition. They all said, not a problem, bring this Act, we will pass it unanimously.

Mr. Richard Pathirana was the leader of the house. I rang him and said, Sir we want you to table this act in the order paper to be discussed and debated in the parliament. I informed him that I have assurances from the opposition that they will support the passage of this act in the Parliament,

I was surprised when he said, "Doctor, I'm sorry. I have orders from above not to table this act".

I said again "I am working in the President's office and, I've been given this task by the president herself".

"Well, we have had other directions, Doctor. I've been instructed not to table this act", he said.

The then President Mrs. Chandrika Kumaratunga Bandaranaike appointed us as a task force to table this act and get it through the Parliament. However, she has instructed the leader of the house not to table it. She used this apparently to gain some political advantage from the tobacco and alcohol industry. I do not know how that happened, I'm not going to make any allegations.

The WHO representative, in fact, at that time, asked me to arrange a meeting with the president to discuss a possible WHO award. If the act was enacted, it would have been a landmark achievement and an example to the rest of the world.

The act was never tabled while she was in power. I later heard that it is tabled by the Jathika Hela Urumaya later. I resigned from that post because I realized that the task force was not going anywhere. I went back to Peradeniya and started the first smoking cessation and alcohol clinic, and I also started the first residential alcohol treatment unit in Mampitiya.

SA: Okay, sir. That was the first thing, the first alcohol treatment unit.

KR: I think it is still operating. Unfortunately, the clinic in Peradeniya is not functioning. However, I am pleased to say that in Canberra, I started the first and only smoking cessation clinic in the Australian Capital Territory. I chaired a working group and made all the inpatient units smoke-free. Later the two hospitals in Canberra went smoke-free. I was instrumental in getting the psychiatric units in the Australian Capital Territory smoke-free. I conducted that clinic for nearly five years, but unfortunately, again when I retired, the clinic did not have a successor. I am glad to say that I think, by getting these units smoke-free has improved the health of the patients and the staff more than any other action I have taken.

SA: Okay, so it's good to hear that you have pioneered the first medium-state rehab unit, as well as the first alcohol rehabilitation unit. I think you were campaigning for alcohol-free, you know, conferences and even as a medical student, I can remember you were campaigning for anti-alcohol, has had some success, hasn't it?

KR: I'm glad to see that.

SA: College functions were made alcohol-free, isn't it? And you started that trend.

KR: I am glad to say that research has vindicated my position on alcohol. If you have read the Lancet paper on alcohol consumption published in 2018. This is a study done over 25 years. This study found that the safest alcohol consumption is zero alcohol. The Canadian government and the Australian government acting on the basis of this research study, state the safest alcohol consumption is zero alcohol. Earlier, these national guidelines stated that a person can have two standard drinks on a couple of days a week. But they do not say that anymore.

SA: I think the U.S. Surgeon General has also called for health warnings on alcohol, isn't it?

KR: It should be similar to the message stated on packs of cigarettes, I am not saying we should be prohibitive. The prohibition policy has not worked anywhere in the world. However, do not promote alcohol or cigarettes or any drug. We should say that all these drugs are injurious to health, and give accurate information to people, but do not allow the industry to promote alcohol or cigarettes, or any other drug for that matter.

SA: Digressing a little bit, I want to move to cannabis and legalization, which I think is a big campaign in Sri Lanka, and I recently went to Australia. One of my batchmates was the GP who was saying, "I'm a cannabis prescriber". And, you know, it is becoming a big thing in Australia, and even in Sri Lanka. What do you think about this trend towards legalization of cannabis?

KR: Cannabis prescribing and legalization of cannabis are two different issues. The policy of legalizing substance use has had a variable history. Countries like the Netherlands, which legalized cannabis and Portugal, another country which legalized substance use with variable results. I do not claim to have an answer. This is a very complex issue. I think the UN and the WHO should sit down again, ask, the question "what is the best policy about substance use?" Prohibition of alcohol and legalizing some drugs as illicit drugs, has not worked. We need to look at it more scientifically and see what the best approach is in reducing substance use among people. It is a complex issue, and I do not think there's one single answer. But total prohibition, or total legalization are too simplistic policies. It is a complex problem and requires a complex set of policies to address it adequately.

About cannabis prescription, I have many reservations about that. I think that the evidence is not all that great, not just for cannabis, but for all psychoactive drugs. There is a lot of work and push for promoting ketamine nasal spray. Cannabis and Ketamine clinics are opening up all over Australia, and a lot of the psychiatrists are jumping on this bandwagon. This brings me to the place of psychotropic drugs, both antipsychotic and anti-depressants particularly.

Despite billions of dollars invested in neuroscientific research, they haven't achieved much to change clinically useful evidence, and this is not my opinion. It is the opinion of the ex-NIMH head, Dr.Thomas Ansell, who was the head of the NIMH for 13 years. He said "we have poured over $20 billion, and we have nothing to show". He is not saying that neuroscientific research is not useful. He said "A lot of good work has been done. But nothing has translated to clinical practice". And therefore, he is saying that we need to have a shift in the way we manage patients.

This brings me to say a few words about the Critical Psychiatric Network. Have you heard about that?

SA: Yes, yes.

KR: It was started in the UK, by Johanna Moncrief and several other psychiatrists in 1999. She has also published a book in 2008 titled "The myth of the Chemical Cure: A critique of Psychiatric Drug Treatment". There was also a multi author *British Journal of Psychiatry* editorial published in 2012, calling for a shift from a very technological, biologically oriented psychiatry to a much broader way of managing psychiatric patients. A more recent book published in 2024 titled Conversations in Critical Psychiatry by Awais Aftab is worth mentioning. I think this dependence on psychoactive substances with very little evidence to support it is problematic; we still don't know how antipsychotic drugs work. We still do not know how antidepressants work. We still do not know how ECT works.

This group is keen to say that they are not anti-psychiatry but suggest psychiatrists to become more open and transparent about our practice. We should acknowledge the gap in scientific knowledge about mental disorders and the actions of psychoactive substances. And make better use of antipsychotic drugs. There are a lot of studies now showing that long-term antipsychotic use is not necessarily positive.

There are several studies, particularly those reviewed by Harrow (2018) in the USA. They have shown some patients who have not been on antipsychotics have done better than the patients who have been on antipsychotics. And they are saying, of course, some patients will need long-term antipsychotic, but not all of them. So, we need to really look at who will benefit from antipsychotic therapy, from antidepressant therapy.

There is really no evidence for efficacy of antidepressants for mild to moderate depression. The pharmaceutical industry has not published all the negative studies, and so they have, I think, persuaded and sometimes even corrupted psychiatric practice. I think psychiatrists must look at it very critically. What is the best use of psychoactive drugs? And particularly antidepressants and antipsychotic medication and use it more judiciously and more relevantly.

I don't know whether you have heard about the comments made by the editor-in-chief of the *New England Journal of Medicine,* Dr. Marcia Angel (2009) She states *'The problems I have discussed are not limited to psychiatry, although they reach their most florid form there. Similar conflicts of interest and biases exist in virtually every field of medicine. Particularly those that rely heavily on drugs or devices. It is simply no longer possible to believe much of the clinical research that is published, or to rely on the judgment of trusted physicians or authoritative medical guidelines. I take no pleasure in this conclusion, which I reach slowly and reluctantly over my two decades as an editor of the New England Journal of Medicine'*. A damning indictment on medical research.

Dr. Richard Horton (2015) Editor of the *Lancet* has made a similar statement about medical research; I am unhappy to say that even in Australia polypharmacy is quite common. I have just completed two days a week position in community mental health practice. Most of the patients in these units are on 2 or 3 antipsychotic medications, and when I said "this is not rational", the clinicians say, "Doctor, you are a locum, you are here only for a short time. Please do not touch our medication regimens". These patients are not socially functional. They are just existing in dilapidated Department of Housing units with very little social capital. Community mental health clinicians are far too dependent on the use of anti-psychotic medications. Their main role is dishing out antipsychotics, both orally and intramuscularly. I think we must change that.

In the developing world, two WHO studies (2008) have shown that patients in developing countries do better than those in the OECD countries. While no signal factor can explain these outcomes it is interesting to note that only 16% of patients were on continuous antipsychotic medication while 61% of those in high income countries were on long term antipsychotic medications.

Long-term antipsychotic medication use is not necessarily beneficial. The guidelines state that if you diagnose schizophrenia, then those patients need lifelong antipsychotics. This may need to be revised based on the studies which has shown not all patients need such lifelong regimens I think the College of Psychiatry in Sri Lanka should really look at how best

can we serve our patients, and how best can we use antipsychotics more rationally and more democratically. Maybe even invite people from the Critical Psychiatry Network to come and discuss how best we can help our patients. We need to really change the way we are practicing psychiatry, not just in Sri Lanka, but all over the world. We have come to a sort of a standstill, after Clozapine, nothing new has come across. We are dependent far too much on medication-oriented therapy, and we need to revise this practice to see whether we can help these people to develop their social capital, get them to have a purpose in their lives, and to live in a safer environment.

SA: Right. So, slightly moving and keeping on the same topic, but slightly moving a little away. Now, you have been a psychiatrist at work for extensive periods of time, both in Sri Lanka and in Australia? And, you know, in Sri Lanka, most of our young psychiatrists were trained in Australia. And there is a tendency to, you know, in developing our mental health policies, our mental health acts, so some might copy the Australian system and try to remodel it here, which hasn't been successful because of the lack of finances and things like that. But what we can easily see is that there is, you know, our policies and acts are trying to be… So, what do you think of the different strengths of the Australian system and the Sri Lankan system, and what are the contrasts?

KR: When I was in Sri Lanka, along with other psychiatrists we presented several drafts to the Ministry of Health, and to the Ministry of Justice to implement a new mental health act. Though I was disappointed that we could not implement a new mental health system, I am not so unhappy now.

SA: It still held up, so it still held up in the health minister's office, yeah? Yeah, they" re not giving us some meetings, and so recently we met the Prime Minister, and she said she'll try and talk to him.

KR: I think it's best not to have a mental health act. Because mental health acts are coercive. I grant that some patients can be a danger to themselves and to others. However, we have functioned without a Mental Health Act for more than a century. I do not think our patients are any worse treated than the others. Of course, what we do in our units is technically illegal.

I am not too unhappy about not having an act. For example, in Trieste, a city in northern Italy where a very charismatic psychiatrist did away with large mental health hospitals. Their mental health service is seen as the gold standard for community mental health care. The longest period they will have a patient under a treatment order is one week. They think that is best, because most mental health acts tend to undermine the autonomy of patients. I think we should really think again before we hurry into a Mental Health Act.

In Australia, the Mental Health Act is used quite extensively, and I think in most units, 20-30% of patients are under some form of treatment order and given antipsychotic medication with questionable results. Most of the patients I see in the community services are not living, they're existing. They're not living as full citizens. Most suffer from a metabolic syndrome. Secondary to second generation antipsychotic use. Very little is done about that. We really must look again and again about what is the best way to use antipsychotic medication and other psychoactive medications. We have gone too far on the neurobiological basis, when we really have no good evidence.

We still have no scientific explanation about schizophrenia. Our diagnostic system is still very subjective. Long way to go. Therefore, we should be more humane, humble and accept that many of our interventions lack robust scientific evidence. However, that at present that is the best we have. There is empirical evidence that some of the drugs help some patients. We must decide for how long? And for what or how many patients? Do all these people need medications? And hence my reservations about the new developments in pushing Ketamine or cannabis, or any other psychoactive substance; be very hesitant. There was enthusiasm for psychedelic MDMA in the treatment of PTSD, but subsequent research has shown that the initial claim that it cured PTSD is not really borne out.

SA: So, on the same topic, I think there is a movement. I think it's starting especially in Ireland, where they did not have a mental health act, but to treat psychiatric patients under a normal treatment act. You know, under the normal Capacity Act.

I think there are experts in the WHO, who are promoting it, and I think even Sri Lankan psychiatrists are supporting that to have the capacity for all illnesses, not just for mental health.

KR: I would agree. I think we should give serious consideration to such an approach.

SA: So, I mean, it's been delayed. I think the current Prime Minister is keen on the act. But I think even she's unable to. We had a meeting with her, and she was asking, but even she's unable to push it through the Health Ministry to the legal draughtsman. So, it's a long way to go. Some of the young forensic societies, they've got to… they're there, they've formed a new act, I think. The draft is that, but there's a long way to go through the legal department and cabinet.

KR: My humble suggestion is do not be in a hurry. Sit on it.

SA: In fact, we are fortunate, we have a Prime Minister who has worked in mental health, very keen on mental

health, and she met the council for about one and a half hours in parliament about child mental health. She's very keen to do something about this.

SA: Slightly different topic, sir. Now, you worked at the university psychiatrist at a time with psychiatry wasn't even a separate paper. We can still remember your favourite story about teeth! k, you wondered while the mouth has a faculty, and the brain does not even have a department. And how you drew the human being with a large mouth and small brain, right? So, what are the challenges you all had, and how did the teaching evolve during that time, you know, to what it is today? And now it is a separate subject, and, you know…. Psychiatry is a very popular and separate final year subject.

KR: I think the lack of knowledge about psychiatry, perhaps frightened most people. I think it was based on that fear and anxiety about 'what psychiatry actually is?'. And I think, I'm glad to say that most faculties have now changed that position and see the importance of mental illness and mental health. The division of mental illness and physical illness is a pseudo one. People do not become mentally ill or physically ill. For our benefit, our convenience, we have decided to say, these are mental illnesses, and these are physical illnesses. All illnesses have a mental aspect and a physical aspect.

I think if we promote a more holistic view, then both general physicians, surgeons and psychiatrists can be pragmatic in their approach to treatment and recovery.

When we see a patient with a diagnosis of schizophrenia, we should not only look at his emotions, their thoughts, behaviour, but also look at his physical and social health. Psychiatrists are generally guilty of not looking after the physical health of our patients, and hence my particular interest in smoking cessation. Most of our patients with serious mental illness, at least in Australia die due to morbidity caused by substance use, mostly by cigarette smoking.

Cigarette smoking is the biggest killer. In Australia, about 20,000 people die because of smoking. It beats all the other mortality causes put together. In Sri Lanka too I think the number is about the same. Very few psychiatrists think addressing smoking in their patients is their responsibility. But I think that's one of the main things a psychiatrist or a mental health clinician can do to persuade a patient to stop smoking and stop using other substances. Every psychiatrist should be able to manage substance use issues. I think we should not copy western models. We should have models which suit our country.

SA: Again, moving to your role as the president of the College of Psychiatry, the first president. So, it was the Sri Lanka Association, wasn't it? Sri Lanka Psychiatric Association. So, under your leadership, I think we were very junior trainees at that time. It became the Sri Lanka College of Psychiatrists. And would you like to talk a little bit about the challenges during that period, and how you established the college?

KR: I was fortunate to be the inaugural president, but it is not only my actions, but those of the entire community of psychiatrists at that time which transformed our association to a college. I think, Prof. Raveen Hanwella was the secretary, if I'm not mistaken. Dr. Ghambheera Harischandra, Dr. Karunarathne, Dr. Kulanayagam to name a few worked very hard to make the College of Psychiatry a reality. There was really no opposition from the Psychiatric Association. The formulation of a constitution and forming the college was not opposed by anybody in the association, and I was the fortunate inaugural president.

SA: Yeah, I can remember the inaugural session, and it was in Taj Samudra, where we had almost an international conference. Now, as the first president, and as somebody looking from outside, now you know, you said that maybe the college has been pursuing the Mental Health Act, which you say is probably not worthwhile. So, what should the college focus on, as somebody looking at it from outside? What are the areas that the college should focus on in the coming years in Sri Lanka?

KR: I think, as I said earlier, have an open and critical view about how we practice psychiatry in Sri Lanka and elsewhere in the world. I am not saying that we should stop looking at the neurobiological and neurocognitive basis for mental illness and their treatment but look at what is possible at the moment. Particularly the recovery model and getting our patients to become more functional citizens in their community and to have a purpose in life. That is my humble suggestion, that we should not depend only on psychoactive drugs. Unfortunately, in the OECD countries most community psychiatric units, are basically interested in making patients comply with antipsychotic medication regimens. Very little of psychosocial interventions are done. We should make these people more functional in the community. Develop their social capital. Get them back to work.

If you have an act, use the act very sparingly only for patients who pose a danger for themselves to others. Otherwise, treat as many patients as possible on a voluntary basis.

SA: I agree. Now, there are many Sri Lankan psychiatrists, young psychiatrists in Australia. And they've formed an organization, and they're very keen to help Sri Lanka. So, what are your suggestions for them? I mean, what can the Sri Lankan psychiatrists in Australia do to support Sri Lanka? What sort of things can they do?

KR: So, I think that whenever they can come back to Sri Lanka, and maybe run training programs, run workshops, and help the Sri Lankan colleagues in training psychiatrists and other clinicians. I think that should be the main role in supporting the Sri Lanka College of Psychiatrists in developing mental health services in Sri Lanka. And maybe some of them can come and even work for a short period, if they can.

SA: So, in fact, we have now a slightly different trend. We have got quite a few psychiatrists who are based in Sri Lanka and who are doing locums in Australia. We've got one colleague who is in Kurunegala, so she's helping with the university there. So, that seemed to be a new trend, where, you know, even some base themselves in Sri Lanka.

KR: Are you talking about telehealth?

SA: No, no, no, they go to Australia for 3 months and come back for 3 months, like that.

KR: I was not aware of this.

SA: So, basically, they are locum psychiatrists in Australia, but they spend half the year here and half the year there.

KR: That might be more workable and useful for both countries.

SA: Unfortunately, other places are also not very flexible enough, you know, especially the Health Ministry. The Health Ministry is not flexible, you know, to utilize these psychiatrists. So, we are trying to at least think whether the university system can be supported by some of them. So, already getting some of them to support the university system.

KR: I think the Ministry of Health and the government are under political pressure. If they allow doctors to go out, they will be criticised for allowing medical practitioners who have been trained at the expense of the country to seek employment elsewhere. I think you might have to persuade the ministry and the government and the people that this is a bit of a win-win situation.

SA: I mean, where we can retain psychiatrists, isn't it?

KR: Yes, retaining psychiatrists by allowing them to go and work abroad and earn some money. Because personally, if a young psychiatrist says, "I want to leave the country, because I want to think about my children, their education", I can't say "no". Honestly, I can't tell them, "don't do that".

SA: Yes sir, because I think so now, those days when you do two years overseas and come back, with that money, you can buy a house, you can buy a car. But now with inflation and the cost of living, that money doesn't go very far. They find it difficult to start life in Sri Lanka.

KR: That's right.

SA: And they decide, "okay, we're going to go back". So, that's I think, we cannot blame them at all. So, where we have a flexible system of allowing them……. when you refuse them leave, they just resign and go.

KR: Hopefully the Ministry of Health and the Sri Lanka College can negotiate a mutually advantageous solution.

SA: Yeah, what is happening is people who have gone to Australia, now a few of them have come back, like, Santhusha Wijekoon, and Hiranya, and even some of them are coming back, and they are trying to work a little bit here and a little bit there. So, that's a way of saying that.

KR: That is good to hear that.

SA: Anyway, sir, we have talked about a wide range of topics. I think we have covered the issue of migration, and I was going to ask you about migration of psychiatrists and what we can do about it, but I think we have covered that, isn't it? And I think… is there anything you'd like to talk about young psychiatrists, or how the way forward?

So, any final comments that you'd like to make about Sri Lankan psychiatry, or your comments or anything that we have missed out?

KR: My view is that we need to look at psychiatric practice more critically and be open about it, saying that our diagnostic system is not based on science and we still don't know how some of these interventions work. Therefore, be humbler and look at all the other possible interventions and not depend too much on the use of psychoactive medications which unfortunately is the trend both in Sri Lanka and elsewhere in the world. We should look beyond the technological aspects and the biomedical model to help our patients recover.

SA: So, thank you very much sir. As a young medical student, I can remember we really enjoyed your lectures. You were then an extremely attractive lecturer. I can still remember you saying that "it is going to be the next decade of the brain. If you want to win a Nobel Prize, you do psychiatry".

KR: I remember saying that. The brain is a very complex organ. We still haven't come close to understanding it. But it's not a thing to be embarrassed about. It's the complexity of the brain. Accept that and see how best we can help our patient despite this lack of knowledge

about how it works, and how our medications work. Psychiatrists should not be just prescribers of medications.

SA: Yes, I think, I can remember, Cunningham Owens, the editor of the *Companion*, about 5-10 years ago he came to Sri Lanka, until he gave a lecture called the Death of Psychopharmacology, where he said that, "you know, over the last 10 years or 20 years, we have not been able to make any headway". So, we haven't been really making any breakthrough since Clozapine. Of course, there is a lot of optimism about ketamine, isn't there?

KR: That appears to be the current situation. I was at a recent APA meeting. One seminar said "Ketamine is the new drug, go for it". While in the same conference another seminar presented the view, "Ketamine is rubbish".

SA: Okay. Okay.

KR: We need to be careful about claims of what so-called new drugs can do. I would strongly recommend for the Sri Lanka College of Psychiatrists to make contact with the Critical Psychiatry Network in the UK. Change the way we practice psychiatry in a more open, critical, democratic manner.

SA: We too have psychiatrists who think differently and critically, I mean few, like Prof Diyanaath Samarasinghe, although, I do not know whether they belong to the network, like Dr. Mahesh and Ganesh, and even one of the young people, like Dr. Vajira Dharmawardhana, who challenge the status quo. So, we have people like that, you know, we do have a few people who, challenge the status quo.

KR: I'm very glad to hear that. So hopefully these psychiatrists can persuade the rest to look at ourselves and our practices more critically

SA: So, thank you very much, sir. I think with that very thought-provoking statement let's conclude the session.

References

1. Burton, Robyn, Sheron, Nick. Lancet 2018; 392 (1015): 967-88.
2. Moncrieff, Joanna (2008) The Myth of the Chemical Cure: A critique of Psychiatric Drug Treatment. Palgrave Macmillan
3. Bracken P, at et al. The British Journal of Psychiatry 2012; 201(6): 430-4.
4. Aftab, Awais (2024) Conversations in critical psychiatry. Oxford University Press.
5. Harrow, Martin, Jobe, Thomas, Faull, Robert N, Yang, jie. Psychiatry Res. 2017; 256: 267-74. A 20 year Multi-Followup Longitudinal Study assessing whether antipsychotic medication to work functioning in Schizophrenia.
6. Angell,Marcia (2009) Drug Companies and Doctors: A story of Corruotion.
7. Horton,Richard. The Lancet. 2015; 385: 1380. What is Medicine's 5 Sigma
8. Jablensky A, Sartorius N. Schizophrenia Bulletin 2008; 34(2): 253-55. What did the WHO studies actually find.