insights health

DEVELOPMENT RESEARCH

No health without mental health

The enormous gap between mental health needs and available services in developing countries has been well documented, culminating in the 2001 World Health Report. Of the 450 million people worldwide with mental health problems most live in developing countries. Mental and behavioural disorders affect one out of four people during their lives. Although treatment is not expensive, most people do not receive the treatments they need and governments on average allocate less than one percent of their health expenditure to mental health.

Five of the ten leading causes of disability and premature death worldwide are psychiatric conditions. Depression, anxiety, and alcohol and drug abuse are the most common mental disorders. Psychotic disorders such as schizophrenia and bipolar disorder, although less common, are profoundly disabling. It is no surprise, then, that mental disorders feature prominently in the list of leading causes of disability worldwide. Although children make up a large proportion of the populations of many developing countries, the number of people over 60 is growing. Mental disorders specific to childhood and, as **Prince** argues in this issue of *insights health*, ageing are perhaps the least acknowledged.

The right treatment

Many people with mental disorders do not seek help and families bear the brunt of the untreated condition and resulting disability. **Swartz** describes the significant impact of globalisation and social change on the risk of mental health. These changes are influencing how families are able to cope and as **Prince** points out, care in the home cannot be assured. For those few who do seek formal care, most will turn to primary or traditional medical care. In primary care, mental disorders can go undetected and patients may receive a cocktail of treatments, for example, sleeping pills for sleep problems and vitamins for tiredness. Treatment dealing with psychological and social aspects is rarely provided. Typically, only people with psychotic disorders or very disturbed behaviour are taken to specialist mental health services (if available). Here, care is heavily biased towards drug therapies and many out-of-date colonial-style mental hospitals remain the mainstay of specialist care services. **Thara** and **Thornicroft** bring to our attention the stigma, human rights violations and institutionalisation which characterise services for severe mental disorders.

This evidence has played a role in increasing the profile of international mental health. More countries are designing and implementing mental health policies. More donors are supporting mental health related work. More public health professionals and policy-makers are taking an interest in mental health issues. But the pace of reform is slow, and with every new challenge facing the public health sector, mental health is once again being relegated to the bottom of the agenda.

A global public health priority

Freeman shows how mental health is inseparable from HIV/AIDS, arguably the single most important global public health priority. People with HIV are prone to depression, cognitive impairment and dementia. **Rahman** describes how poor mental health, particularly depression, can be devastating for mothers and children. In South Asia, depression during pregnancy and after childbirth is strongly associated with low birth weight, poor growth and development and a higher risk of physical health problems in babies. Failure to thrive is a key public health challenge in the region, affecting more than one in three babies.

Evidence exists to link mental health with other public health priorities: stress and depression can predispose people to heart attacks or strokes for example, and up to half of these people will then suffer from depression and dementia. As highlighted in the 2004 World Health Report, substance abuse contributes enormously to the risk of road accidents, and depression can be an after effect. Violence is a global health priority; alcohol abuse and personality disorder frequently precede violence and, as **Silove** points out, depression, self-harm and post-traumatic stress disorders often follow.

Marginalisation and mental disorders are closely linked. Arguably, no other health issue has aroused such misunderstanding and fear, across history and cultures. As **Thara** and **Thornicroft** show, stigma lies at the heart of systematic discrimination against the mentally ill, from their exclusion from daily community activities to incarceration in institutions where basic human rights are ignored. Amongst the myths surrounding mental illnesses is the idea that they are linked to affluence and less

relevant in developing countries. Nothing could be further from reality. Virtually every study from around the world shows that those living in poverty are more likely to suffer from depression.

Globalisation has benefited millions, but as **Swartz** argues, not everyone has benefited equally. Economic and social change is accompanied by massive migration that disrupts social networks, increasing unemployment of small scale entrepreneurs and farmers, and reductions in spending on social welfare. The rising tide of suicides and premature mortality in some countries, as vividly demonstrated by alcohol-fuelled deaths of men in Eastern Europe, the suicides of farmers in India, and of young women in rural China and South Asia can, at least in part, be linked to rapid economic and social change. **Silove** draws our attention to the burden of conflict and displacement worldwide: it is the civilians and poor people who suffer the most and whose mental health is consequently affected.

For many years, there was little evidence that anything could be done. However, a number of clinical trials from across the developing world demonstrate the efficacy and cost-effectiveness of local treatments for depression, schizophrenia and substance abuse. Studies now show that community care for schizophrenia is feasible and effective. Antidepressant and psychosocial treatments for depression are successful. **Silove** points out that faced with conflict, local communities often have their own mechanisms to increase resilience and promote healing. He argues for the strengthening of social policies which focus on culturally appropriate healing strategies. **Verdeli** shows, on the other hand, that treatments originating in developed countries can be adapted and implemented successfully in developing countries. In rural Uganda, inter-personal group therapy, a low cost treatment delivered by people with no previous mental health training, was highly effective against depression.

The moral case

The moral case, put simply, is that it is unethical to deny effective, feasible and affordable treatment to millions of people suffering from treatable disorders. There is no health without mental health. We should prioritise depression, not because it co-exists with HIV/AIDS, but because planning an HIV/AIDS initiative without a mental health component discriminates against a highly vulnerable group. Mental disorders must be included in programmes directed at promoting poor people's health and improving economic conditions in developing countries. Community and primary treatment programmes are not costly to implement and must be supported by donor agencies. The challenge for the mental health community is to cross its professional boundaries and step closer to its colleagues in public health and seek support for international mental health in collaboration with other health disciplines ■

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See also

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Making matters worse

Links between HIV/AIDS and mental health

HIV/AIDS sufferers and children whose families are infected with the virus may suffer mental health problems arising directly or indirectly from living with the virus. HIV infected people have to deal with the stigma attached in some communities to being HIV positive. Partners, family and friends, may experience psychological stress from having to nurse sick relatives and deal with multiple deaths.

Mental illness can arise as a direct consequence of HIV infection. For example, HIV enters the central nervous system in the early stages of infection and a significant number of people with HIV develop a reduction or impairment of the brain's cognitive function, such as HIV dementia or minor-cognitive disorder. Impairment increases as the disease progresses. Antiretroviral therapy can reduce the prevalence of HIV related dementia by stopping the spread of infection.

Mood disorders are common in people with HIV/AIDS:

- In three South African studies, major depression was diagnosed in between 35 and 38 percent of HIV/AIDS sufferers.
- In one study, an additional 22 percent were diagnosed with dysthymia – a form of mood disorder characterised by a lack of enjoyment in life.
- 'AIDS mania' (usually featuring inappropriate excitement) appears in the late stages of AIDS and is estimated to occur in around 1.4 percent of cases.

People who abuse substances and suffer from severe mental illness are at increased risk of infection. Moreover some HIV/AIDS sufferers may be at risk of becoming substance abusers or developing severe mental illness. Infected people may turn to alcohol and drugs to psychologically manage their disease. Psychosis may occur in late stage AIDS, though this is rare.

Coping with being HIV positive can be made more difficult by the reactions of communities and even friends and family. People who are rejected or discriminated against may become more depressed. This can result in a more rapid progression of the disease. Even where people have not been discriminated against, fear of rejection and discrimination can lead to them being unable to live a normal life.

Antiretroviral therapy can reduce the prevalence of HIV related dementia by stopping the spread of infection.

Many children will lose their parents to HIV/AIDS. This is not only traumatic in itself but many of these children may not be integrated into new families. This could have devastating consequences for their mental health, both as children and as adults:

- In a Zambian study, 82 percent of people who care for children of AIDS sufferers noted changes in the children's behaviour during their parents' illness. Children stopped playing, became worried, sad and too tired to help at home.
- In Uganda, children were reported to feel despair or anger and were scared their parents would die. Once the parent died, orphans in Uganda and Mozambique suffered more depression.
- In Tanzania, 34 percent of orphans had contemplated suicide.
- In South Africa, AIDS orphans experienced more physical symptoms and were likely to have nightmares. 73 percent suffered from post traumatic stress disorder.
- Because of the ongoing presence of HIV/AIDS within families and communities, these traumatic consequences may occur many times over.

Mental health problems are a critical aspect of the HIV/AIDS epidemic for both infected and affected people. As mental health problems often hinder effective adherence to antiretroviral treatment, it is necessary to include mental health care as part of HIV/AIDS treatment. Equally, mental health practitioners need to understand that patients increasingly have HIV/AIDS related symptoms. Programmes are needed to deal with mental health in vulnerable or orphaned children. While work with children who have developed mental health problems is vital, the most important thing is preventing children from developing mental health problems. Families should be supported to take in and care for orphans, whilst orphans themselves need help to adjust to new and sometimes difficult situations ■

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Globalisation and mental health

Globalisation affects the way people live and work. It is hardly surprising, then, that globalisation and its related social and economic changes affect the mental health of individuals and countries. Economic and social change has left many people without incomes and has led to a breakdown in traditional family and community structures as the most able travel miles to live in crowded, polluted slums in search of work.

Waste disposal problems, traffic congestion, pollution and high crime rates make slums tough places to live and add to the chances of people suffering mental health problems. People living in the slums of Islamabad and Dhaka, for example, are prone to mental distress as well as poor physical health as they try to survive in cramped homes with inadequate access to clean water.

Social change caused by globalisation can have a detrimental effect on people in the following ways:

- As families reduce in size and fathers migrate to cities in search of work, mothers of young children can no longer rely on family support and protection against postnatal and other forms of depression. In Khayelitsha, a village near Cape Town, South Africa, 34 percent of migrant women who had recently given birth were suffering from untreated postnatal depression – approximately three times the average rate in developed countries.
- Older people may find themselves without the support of their children and grandchildren who leave the family home to find work, and are less likely to be cared for when mentally ill.
- Women in poor countries are particularly vulnerable to the effects of globalisation on their livelihoods and their roles in maintaining family cohesion. They often disproportionately bear the burden of changes associated with globalisation. The suicide rates amongst young women in China (50 percent of global suicides) and South Asia are mainly attributed to abuse, forced marriage and harsh market-orientated economic reforms.
- Suicide committed by men who have lost their livelihoods, often due to their or their employers' inability to compete in the global market is on the rise amongst factory workers in Eastern Europe and farmers in South Asia.

Globalisation and the media worldwide influence how people understand and experience mental disorder. People in developing countries adopt Western labels for mental disorders and treatment, including psychotherapy and psychotic medicines. The success of Western pharmaceutical companies in developing countries, where drug use for mental disorders is historically low, is a cause for concern. During the economic crisis of 2001 to 2002 in Argentina, for example, there was an increase in prescriptions for antidepressants, apparently as an antidote to insecurity and vulnerability; it is unlikely that pharmaceuticals would have been so widely used in such circumstances a generation ago.

Although globalisation affects those in wealthier countries as well – including through media exposure to violence and trauma – the clear priority is to understand more about how globalisation affects the mental health of people living in poorer countries, and to develop ways of supporting them. The following steps need to be taken:

- develop and disseminate research on the impact of globalisation on mental health
- include mental health assessments in impact studies of globalisation
- influence multinational companies to provide mental health support to employees and their families in developing countries
- support and develop initiatives to empower women as caregivers, focusing on literacy and skills development ■

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'For the sake of the child, look after the mother'

The World Health Organisation's theme for World Health Day 2005 is 'healthy mothers and children'. While the physical health of women and children is emphasised, the mental and social dimensions of their health are often ignored in developing countries. However, recent evidence suggests that the mental and physical health of mothers and children are linked, and that one cannot be possible without the other.

Mothers often suffer from depression after childbirth. It affects approximately 10 to 15 percent of mothers in developed societies. These figures are double in developing countries and depression ranks among the top five disabling mental or physical disorders worldwide. There is evidence that maternal depression badly affects the psychological and intellectual development of children.

Recent studies from South Asia suggest that maternal depression may also have serious consequences for a child's physical health. In rural Pakistan, for example, the risk of being underweight or stunted at six months is four times higher in children whose mothers are depressed than children whose mothers are not depressed. This data suggests that the incidence of infant stunting would be reduced by 30 percent if maternal depression was eliminated from the population. Infants of depressed mothers also have lower birth weight, higher rates of diarrhoea, and are less likely to be immunised. These studies also show that depression during pregnancy is linked to low birth weight. Thus, maternal depression makes an important and possibly major contribution to poor foetal and infant growth and morbidity in low income countries.

Maternal depression affects infant growth and illness in a number of different ways:

- Mothers lead a less healthy lifestyle and do not seek adequate care between conception and birth.
- Maternal disability in the postnatal period results in deficient physical and emotional care and psychosocial stimulation of the infant.
- Lack of family support and financial independence could weaken the mother's ability to adequately care for her child.
- In South Asia, marital violence and the birth of a girl child are associated with an increased risk of depression in mothers. The higher prevalence of postnatal depression in mothers of female children suggests that neglect of women's mental well-being is perpetuated from birth from one generation to the next.

There is a widespread lack of awareness of mental illness and its social origins. Women's mental health remains low on the agenda of policy-makers in the developing world. Highlighting the benefits of good maternal mental health to the infant's physical health could be a strong selling point for policy-makers to divert resources to services that could directly benefit women's mental health.

Health workers, using simple checklists, can identify depression in a community with relative ease. More specifically, these instruments can help identify mothers whose infants are at greater risk of poor health. Resources can then be targeted at these groups.

Health workers can be taught simple mental health techniques to more effectively engage with mothers and provide counselling, practical help and advice on child health. Encouraging positive interaction between depressed mothers and their children is likely to benefit not only their physical, but also psychological and cognitive development.

Child health programmes in developing countries must not direct policy agendas away from important maternal health needs. Programmes such as the World Health Organisation's Integrated Management of Childhood Illness strategy rely heavily on the mother for infant feeding, sanitation, immunisation, health education and health seeking behaviours. Unless attention is given to maternal mental health, the effectiveness of these programmes will be reduced.

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Mental health care for older people: what role for primary care?

In 1990, 58 percent of the world's population aged 60 years and over lived in developing countries. By 2020 this will rise to 67 percent. In developing countries the number of people over 60 will increase by 200 percent compared to 68 percent in the developed world. This will be accompanied by unprecedented economic growth and changes in social structures and the pattern of family life. How will these changes affect the care and support of older people with mental health conditions?

Dementia and major depression are two of the leading contributors to disease in older people. Dementia, most commonly caused by Alzheimer's disease is characterised by a progressive loss of intellectual abilities, typically leading to death five to seven years after diagnosis. Worldwide, dementia alone accounts for 11 percent of years lived with disability. This is more than stroke (10 percent), cardiovascular disease (5 percent) and all forms of cancer (2 percent).

In developing countries, older people often live in large family households where caregiving roles and responsibilities may be shared. Nevertheless, family caregivers experience psychological and economic strain. Furthermore, traditional family structures are under threat from changing attitudes towards older people, the education and employment of women, migration, declining fertility, and HIV/AIDS, which has 'orphaned' elderly parents and children. Without state provision, family support for older people may fail.

Primary health care does not meet the needs of the elderly mentally ill, who need a diagnosis, a comprehensive home-based needs assessment, and longer term monitoring and care. Instead they tend to receive a clinic-based service orientated to the diagnosis of 'treatable' physical conditions. In poorer countries, perhaps because of the inadequacy of government services, families of people with dementia are paradoxically more likely to resort to expensive private medical services.

Governments have sought to bolster family care through legislation or fiscal or social incentives. Instead, wider access to pensions would increase self-reliance, and compensatory benefits for caregivers and older people with mental disabilities would do much to redress their economic disadvantage.

Clinical interventions are available for a number of conditions. For late-life depression, antidepressants and multidisciplinary 'stepped care' have proved effective. For dementia, education and training for caregivers, behavioural management strategies for symptoms such as wandering and agitation, and the new anticholinesterase drugs for improving cognitive function have been successful. Although the evidence supporting these interventions comes from developed countries, there is no reason that findings cannot be broadly applied.

Evidence indicates that effective solutions must be based upon primary care, and should include:

- More training in the basic curriculum for primary care staff, which will help move beyond a policy focus on simple curative interventions. Much can be done by extending the role of generic multi-purpose health workers who already work in the community.
- Good quality residential care: important for those with little or no family support. Developing effective systems of registration and inspection, training for care workers, and provision of medical services are equally important.
- Tackling the lack of awareness and understanding of dementia as a brain disease so families can seek help and receive support from health services. Alzheimer's disease associations, such as Alzheimer's Disease International, create a framework for positive engagement between clinicians, researchers, caregivers and people with dementia. They raise funds, disseminate information and act as advocates with governments, policy-makers and the media.

The resource implications for chronic disease management are enormous. Developed countries have seen increasing proportions of their health budgets consumed in this way. Developing countries will be profoundly affected. The only question is the extent to which they can manage change ■

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Human rights
Does mental health care measure up?

Are people living with mental illness guaranteed the best available mental health care? Evidence suggests that they do not enjoy the same rights, in terms of self-determination and protection from exploitation and discrimination, as do people who do not suffer from mental illness. Some ethical codes do relate specifically to mental health – yet the transition from rhetoric to reality has so far been limited.

The United Nations (UN) Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care was adopted by the UN General Assembly in 1991. The principles stress the inherent humanity of people with mental illness. In addition, the 1996 World Psychiatric Association Declaration of Madrid sought to reverse the process of segregation and discrimination of people with mental illness. Both of these provisions combine rights to the freedom to access health and support services, and the need for protection from exploitation and discrimination.

Violations of even the most basic of human rights of mentally ill people still happen. Caged beds are used in several central and eastern European countries including the Czech Republic, Hungary, Slovakia and Slovenia – all members of the European Union since 2004. A report by the National Human Rights Commission in India exposed the gross violations of human rights in many mental hospitals. Basic human rights of people with mental illnesses are systematically disregarded in some countries: they have little power to resist or challenge the labels attached to them by others or to withstand the institutionalisation which severely limits their life opportunities.

Establishing and enforcing human rights are powerful tools in attempting to reduce stigmas attached to being mentally ill. Policy-makers need to:

- strengthen the self-advocacy arrangements of mental health service users, by offering financial support to self-help groups, which in the long term may allow service users to directly challenge discrimination
- recognise the magnitude of the public health impact of mental disorders and fund services accordingly: although mental and neurological disorders contribute to 12 percent of all diseases worldwide, services for the mentally ill attract less than two percent of health expenditure in developing countries
- develop robust independent organisational measures to inspect mental health facilities to ensure that they match or exceed minimum standards of care.

In the future it will be necessary to make legal challenges using, for example, disability, equal opportunity and civil rights legislation to establish test cases and legal precedents to ensure that established standards are met and kept to – for example mental health treatment and care should be as good as that for physical disorders in terms of the quality of staff training, staff to patient ratios and other performance indicators. The quality of service offered to people who are unwell or disabled should be equal whether they suffer from physical or mental disorders ■

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Mental Disability Advocacy Centre campaign against the use of cage beds in Central and Eastern Europe and Central Asia **www.mdac.info/cagebeds.htm**

Prioritising mental health care in war-torn countries

Armed conflict has affected over a billion people worldwide in the last 50 years, with most survivors living in low income countries. Mental distress is common during and after periods of mass conflict, but the number of people who require clinical treatment needs closer scrutiny, especially in relation to post-traumatic stress disorder (PTSD). In particular, the needs of those with severe mental disorder demands further attention.

Advocates for mental health services in areas affected by conflict face several obstacles. Worldwide, mental illness contributes substantially to the burden of disease, yet funding for appropriate mental health services remains inadequate with constraints in funding and skills being particularly severe in low income countries.

Building consensus about mental health needs in conflict-affected countries has become urgent, particularly in relation to PTSD. People suffer from PTSD following exposure to life threatening situations. Symptoms include nightmares and flashbacks, avoidance of social interaction, withdrawal from family and usual activities, phobias of situations that remind the person of the trauma, and extreme anxiety. Do all persons with that reaction need treatment? Reservations include:

- During and after conflict, many people experience trauma, and 'symptoms' of PTSD are very common soon after exposure.
- PTSD symptoms may not be disabling or seen as a major problem in developing countries.
- The re-establishment of safety and security can allow for natural recovery.
- Local systems of healing and traditional cultures may be effective in healing psychological wounds.
- Standard treatments for PTSD devised in the developed world, such as cognitive behaviour therapy, require specialist skills or expensive medications (such as sertraline) and may be difficult to access in other countries.
- Other severe mental health problems such as psychosis, severe depression, organic disorders (delirium, brain injury, dementia), and epilepsy need attention.

There is emerging evidence from studies amongst Vietnamese refugees and in East Timor to suggest that PTSD-type symptoms may recover of their own accord if the political and social situation is stabilised. Mass psychological interventions (debriefing) are not necessary, nor are such broad-based strategies affordable and feasible in many countries affected by conflict. The best 'therapy' is sound social policy aimed at building peace, supporting the reunion of families and communities, promoting justice, providing opportunities for work, and re-establishing institutions that bring meaning and coherence to political, religious, spiritual and social life.

The best 'therapy' is sound social policy aimed at building peace

Trauma interventions need to occur at the right time. Rushing in to provide trauma therapies or awareness programmes soon after the conflict has ended is not needed. However, services should be alerted to the likelihood that some people with acute stress reactions, and later, chronic and disabling PTSD, will need attention.

Poor countries affected by conflict cannot afford or sustain multiple specialist agencies dealing with various aspects of mental health. Mental health activities need to be integrated and coordinated under one authority, usually the Ministry of Health. The highest priority is for the establishment of a network of community-based mental health services that are capable of dealing with a wide range of problems, including severe mental illness and severe or chronic traumatic stress disorders. These services need to interact with other areas of the health sector, traditional care systems and other services. In keeping with experience worldwide, developing and maintaining the necessary mental health skills is an incremental task requiring extensive in-service mentoring ■

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See also

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Glossary

Mental health disorders

Alzheimer's disease
The most common cause of dementia (see below); this disease is mostly seen in people over the age of 65.

Bipolar disorder
A disorder characterised by episodes of increased mental and physical activity (mania) alternating with episodes of depression.

Dementia
A disorder characterised by a loss of intellectual abilities, including memory, judgement, as well as changes in personality.

Dysthymia
A less severe type of depression.

Post-traumatic stress disorder
A disorder characterised by mental health symptoms following a traumatic event that is generally outside the range of usual human experience.

Stepped care
An intervention that consists of a number of components, for example group education, monitoring of symptoms and a structured drug programme, delivered on the basis of the needs of person.

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Treating depression

In the past 50 years there has been a rapid growth in the development and application of effective treatments for many child and adult psychiatric disorders in developed countries. However, the real challenge is to find how these treatments can best be adopted by developing countries with limited resources. Evidence from Uganda, Chile and India shows how low cost community-based mental health treatments can be successful and sustainable.

Interpersonal Psychotherapy (IPT), a psychotherapy for non-psychotic depression produced in the developed world and conducted with individuals and groups, has been effectively adapted for use in rural south-west Uganda. As well as being the most cost-effective treatment, IPT was chosen because it focuses on and views interpersonal crises, such as the death of a close family member, as triggers of depression. This is a technique culturally compatible with the communities in that part of Uganda.

Group leaders with no mental health care background were chosen from local communities to run the IPT programme. To make learning easier, an accessible easy-to-read IPT procedures manual was developed for the leaders. In addition, significant adaptations were made to the training process, and to the final content and implementation of the treatment. These adaptations included culturally sensitive ways of helping people mourn and handle disputes by assisting the person to get their point across whilst respecting the community's power hierarchy and code of communication. In a randomised clinical trial of 248 depressed people in south-west Uganda, IPT was found to be significantly more effective in reducing depression and improving the daily lives of people in comparison to those whose conditions were only assessed.

A common problem facing all community-based projects is that they may come to an abrupt end when studies assessing their effectiveness conclude, so that communities lose out. The Uganda project, however, has the continued support of its main sponsor, World Vision, and is still thriving after being accepted by the local community.

Two other clinical trials of depression treatments conducted in developing countries have demonstrated the feasibility and significance of interventions. A trial in India showed that low cost antidepressants were not only effective, but also reduced health care costs. In Chile, dramatic benefits were achieved with a 'stepped care' model for depression in women in primary care clinics.

For a treatment to be acceptable and effective in a community with limited resources it must address:

- how mental illness is expressed and understood by community members
- how mental illness affects people's ability to function in their communities
- where people seek help and who from
- how the community reacts to mental illness and those seeking help.

In addition, a number of significant differences in the effects and working of treatments across populations need to be taken into account. For example, how different drugs such as lithium or antipsychotics work in the body over a period of time.

Effective and sustainable treatment to alleviate mental suffering in poor communities does exist

Effective and sustainable treatment to alleviate mental suffering in poor communities does exist and the costs involved are relatively low. However, more support and funding are needed to help poor communities to adapt and use such treatment successfully ■

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'Treating depression in the developing world', Tropical Medicine and International Health (9): 539-541 by V. Patel et al, 2004
'Adapting group interpersonal psychotherapy for a developing country: experience in rural Uganda', World Psychiatry 2(2): 114-120 by H. Verdeli et al, 2003

SITES FOR SORE EYES

There are several websites concerned with international mental health. The United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care are central to international mental health www.unhchr.ch/html/menu3/b/68.htm The UK Institute of Psychiatry's Centre for International Mental Health www.iop.kcl.ac.uk/international is a cross-departmental centre for investigators actively researching in the area of international mental health. This site contains 60 current projects that can be accessed by region and by theme. The International Federation of Psychiatric Epidemiology www.sinica.edu.tw/~ifpe/overview promotes the acquisition, dissemination and application of epidemiological knowledge in the fields of psychiatry and mental health. The World Psychiatric Association website www.wpanet.org/home.html offers a range of information on mental disorders and health care services.

The World Health Organisation (WHO) website www.who.int/mental_health/en/ has material on mental health policy plans and programmes, investing in mental health (also available in French and Spanish), and child and adolescent mental health policies and plans. The WHO's World Health Report 2001 focuses on mental health and is available at www.who.int/whr/2001/en/ The WHO project ATLAS www.who.int/mip/2003/other_documents/en/EAARMentalHealthATLAS.pdf compiles and disseminates mental health resources and information. The list of publications is available at www.who.int/mental_health/resources/publications

Several international organisations provide up-to-date information on the key challenges in mental health. The World Federation for Mental Health www.wfmh.org promotes mental health worldwide. BasicNeeds www.basicneeds.org.uk is a charitable organisation that initiates programmes in developing countries designed to actively involve mentally ill people and their carers. The Mental Health and Development website www.mentalhealthanddevelopment.org has the e-journal produced by BasicNeeds that brings together information about mental health worldwide.

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