



**Institute of Psychiatry** at the Maudsley

**Report of the Second Annual  
International Mental Health at the  
Institute of Psychiatry**

**“Mental Health and the Millennium  
Development Goals”**

**August 31<sup>st</sup> – September 2<sup>nd</sup> 2005**

The second annual International Mental Health at the IoP Conference was held in London at the Franklin Wilkins Building Conference Centre in August/September 2005, cosponsored by the World Health Organization.

## SUMMARY

**The Pre-Conference Day** included two participatory workshops

1. Sharing experiences of mental health research in resource poor settings (led by Jane Gibson)
2. Bridging Research and Policy in International Development (led by Shoba Raja, Research Director, Basic Needs)

**The main conference** spanned three days

- |                         |                   |  |
|-------------------------|-------------------|--|
| August 31 <sup>st</sup> | Plenary sessions  | – Mental Health and the Millenium Development Goals          |
| Sept 1 <sup>st</sup>    | Parallel sessions |  |
| Sept 2 <sup>nd</sup>    | Plenary sessions  | – Mental Health NGOs<br>- The aftermath of the Asian Tsunami |

The post conference one week **Short Course in International Mental Health** was an initiative created by Martin Prince and the IoP in partnership with Vikram Patel and the London School of Hygiene and Tropical Medicine.

All elements were well attended, with very positive feedback.

Participants appreciated the opportunity to network with colleagues sharing an interest in International Mental Health. One delegate said “the conference was great opportunity to share experience and knowledge on methods and practising research. I hope we can continue the network”.

The diversity of countries and disciplines represented was widely commented upon; “excellent range of people – interests and backgrounds /professions but also countries”.

The venue and the scheduling offered opportunities for real interaction. Our aim is to maintain and indeed develop all of these aspects in next year’s 3<sup>rd</sup> Conference; the dates for which are now fixed – 30<sup>th</sup> August – 1<sup>st</sup> September 2006

## REPORT

### **Plenary session – Mental health and the Millennium Development Goals**

Our main theme in 2005 was the salience of mental health to the Millennium Development Goals (MDG). By 2015 all 191 UN member countries have pledged to eradicate extreme poverty and hunger, achieve universal primary education, empower women, reduce child mortality, improve maternal health, and combat HIV/ AIDS, malaria and other diseases. Mental health may not be mentioned as an explicit focus for any of the 10 MDGs but it was clear by the end of the conference that the unwritten goal – better mental health for all – would be highly relevant to achieving progress with many of them.

Sir Andy Haines, Director of the London School of Hygiene and Tropical Medicine, opened the conference with a keynote address reviewing the MDGs and progress towards attaining the goals. Eight out of 18 of the MDG targets are health related. However, key health domains: non-communicable disease, injuries, and particularly, mental health were omitted. Only the MDGs of halving the numbers living in poverty and without access to clean water stand a good chance of being achieved. Progress on other targets is patchy, with sub-Saharan Africa and Eastern Europe being particularly unlikely to meet targets on infant mortality or reduction in infectious disease. More people, 5 million, were newly infected with HIV in 2003 than any previous year, according to UNAIDS. Reviewing the possible impact of mental health upon achievement of MDGs, Sir Andy drew attention to

- Links between poverty and poor mental health, mediated through insecurity, hopelessness, rapid social change, risks of violence and physical ill health
- Links between maternal mental health and infant failure to thrive – these may be exacerbated by the hostile environment in a low income country – a depressed mother who cannot breast feed may need to purchase infant formula milk, get water from the nearest tap, find firewood, boil the water and feeding bottle, and repeat 3 to 4 times a day.
- Links with maternal mortality - maternal depression is a common cause of morbidity in mothers and is associated with great suffering and disability. Suicides are amongst the most important cause of death in young women in developing countries. In rural south India, suicides accounted for 50-75% of all deaths in young women, with rates of 148/100000 for women aged 10-19 years.

Fortunately efficacious interventions are available

- Antidepressants lead to quicker recovery and are cost-effective in general health care settings in India - Patel et al, Lancet 2003
- Stepped care interventions delivered by non-medical health workers in primary care are effective for depression in low income women in Chile - Araya et al, Lancet 2003
- Group interpersonal psychotherapy delivered by village counsellors is effective for depression in rural Uganda - Bolton et al, JAMA 2003

Sir Andy Haines concluded

- Although not an explicit target mental health influences a number of the MDGs (1,2,3,4,5,6)
- Mental health issues are neglected in the development agenda
- There are major hurdles to be overcome in capacity building for mental health service delivery and research
- There is a need to fill gaps in evidence, particularly in Africa
- There is a need to develop and strengthen health systems (inc. addressing migration of health workers)

### *HIV/ AIDS*

Melvyn Freeman (South Africa), Sylvia Kaaya (Tanzania), and Frances Cowan (Zimbabwe) addressed the MDG objective of reducing the burden of infectious disease, particularly HIV/ AIDS. Melvyn drew attention to the population impact of the HIV pandemic – people living with HIV/ AIDS, carers, children left vulnerable and orphaned. Adverse mental health can be a cause as well as a consequence of HIV seropositivity. Sylvia Kaaya described the relevance of mental health services to the promotion of health sexuality, the prevention of HIV/ AIDS transmission, adjusting to HIV positive status, and health promoting practice in persons living with HIV/ AIDS taking examples from the situation in Tanzania. Frances Cowan described a pragmatic community-based adolescent reproductive health intervention – the Regai Dzive Shiri Project – a community randomised trial run in 30 rural communities in Zimbabwe. The aim is to reduce the incidence of new infection over a four year follow-up period.

### *Maternal and Child Health*

Atif Rahman (Rawalpindi, Pakistan and Manchester, UK) and Anthony Costello (Institute of Child Health, UK) addressed the MDGs relating to maternal health and infant mortality. Atif Rahman summarised the impressive body of evidence that maternal depression influences birthweight and subsequent infant growth and development. Early treatment of antenatal and postnatal depression could benefit infants as well as mothers – he described the ‘Thinking Healthy Programme’, being carried out in Rawalpindi, Pakistan. The focus for Anthony Costello’s work was prevention of infant mortality through facilitator supported community groups in Nepal. The intervention was associated with a remarkable 30% reduction in infant mortality and 78% reduction in maternal death. Anthony made the point that social learning theory predicts heightened effectiveness of community level interventions of this kind with the effect amplified and extending even to those not directly exposed.

### *Closing session*

Jospeph Mbatia from the Ministry of Health in Tanzania described the government’s strategies for addressing the MDGs through a National Strategy for Growth and Reduction of Poverty. This is a multisectoral, multiagency approach, recognising that poverty is multidimensional in its nature – priority areas include education, health, water, agriculture, rural roads, judiciary and land.

Subsequent round table discussion revealed considerable common ground between mental health specialists and those working in child health, reproductive health, infectious disease and public health. Psychosocial interventions could impact upon key health-related development indicators that were already recognised priorities. Psychological, cognitive and behavioural principles could usefully inform the design of interventions in these areas. Broadly-based community-level interventions, such as those targetting HIV in Zimbabwe and infant mortality in Nepal might have effects on generic health outcomes mediated through improvements in mental health.

#### *Closing keynote address*

Prof Norman Sartorius (ex Director of the Department of Mental Health and Substance Use, WHO, Geneva and ex-President of the World Psychiatric Association) presented from an original perspective – assuming the achievement of the MDGs, what might be the threats to public mental health? The achievement of the Millennium Development Goals (MDG) could improve the mental health of the world's population. The process of achieving them, however, also holds risks for progress in the field of mental health. For example universal free education might 'create' or, more accurately, reveal an epidemic of learning disability. Poverty alleviation will create losers as well as winners as income differentials increase, and those with mental health problems are 'left behind'. Prof Sartorius reminded us that our focus upon achievement of the MDGs as an unarguable 'good' may lead to unattended consequences.

#### SUBSIDIARY THEMES

Our 2005 conference had two subsidiary themes

- 1) The role of non-governmental organizations (NGOs) in promoting international mental health
- 2) Responding to major disasters – the experience of the Asian Tsunami

#### **NGOs**

Jane Gibson had carried out an appraisal of the levels of awareness and the engagement of mainstream NGOs in mental health and psychosocial programmes. We were fortunate to have two key presentations (Chris Underhill and Shoba Raja) from a UK based mental health specific NGO, Basic Needs describing their innovative community-based programs in Sri Lanka, Ghana, Uganda and India. CAFOD was represented by its director of policy, George Gelber who described their role in addressing the MDGs.

Jane Gibson remarked that the extent and nature of UK NGO involvement in international mental health is not well known, and there have been few opportunities to share best practice and identify priorities. It was thus decided that an exploratory review of mental health and UK based international NGOs would be undertaken. Semi-structured interviews were carried out with respondents from 19 UK based international NGOs. Topics included areas of operation, examples of programmes, methods of evaluation, funding, and future priorities. 'Psychosocial' intervention was interpreted very differently by

different agencies and individuals. Many NGOs felt deskilled in dealing with mental health outcomes although recognizing that they were highly salient to their generic programmes. Most welcomed the idea of a resource centre to facilitate networking between NGOs with an interest in this area and mental health specific NGOs and specialists with the capacity to advise and assist.

Shoba Raja and Chris Underhill described BasicNeeds' programmes reaching out to 17,173 mentally ill people, through partnerships with NGOs and importantly with ministries of health. Operations in Africa and South Asia reveal that mental illness is widespread in poor communities where the majority remain untreated for many years resulting in loss of family productivity and income, exacerbating their poverty and impacting the economy. Yet there is little hands-on information available about their situation. Governments in Africa and Asia have given themselves the mandate of fighting poverty to meet the MDGs. But people with mental illness have been left out of this fight. There is no one to inform governments realistically about MH policy or practice needs. Community care/ deinstitutionalisation initiatives have remained ineffective mainly because there is very little research evidence available from developing countries that can inform policy makers in policy formulations and resource allocations.

### **Mental health needs and responses following the Asian Tsunami**

In a keynote address Shekhar Saxena (WHO Department of Mental Health and Substance Use ) described how the magnitude 9.0 (Richter Scale) earthquake that struck the area off the western coast of Sumatra on 26 December, at 7:59 am local time, triggered massive tidal waves that destroyed the lives of people in coastal areas in all countries around the Indian Ocean rim – from Indonesia to Somalia. The estimated death toll from the tsunami is 286,000 and 1.6 million people have been displaced. In Sri Lanka alone, 800,000 people have lost their homes. The scale of the disaster stunned the international community and prompted a huge relief effort involving governments, international aid agencies and locally based NGOs and civil society. In the aftermath of the disaster, the immediate needs of survivors were for search and rescue services, fresh water, shelter and medical attention.

The mental health needs of survivors is a crucial aspect of the rehabilitation phase. Families throughout the Tsunami affected areas have experienced severe trauma; family members have died or are still missing, homes and possessions have been destroyed and livelihoods decimated. An initial rapid assessment carried out by the World Health Organization in Sri Lanka, the Maldives and Indonesia, found that 5-10% of the affected population may develop stress related disorders as a result of the disaster. Up to 100,000 people may require mental health interventions. The WHO has pointed out that post-traumatic stress disorder per se is relatively rare. The majority of excess psychological morbidity attributable to the tsunami will be the 'common mental disorders'; depression, anxiety, somatisation and alcohol use disorders. These disorders are generally poorly managed in developing

countries, which have very limited mental health care resources. In Sri Lanka, for example, with a population of 19 million, there are 30 psychiatrists, 346 mental nurses, 13 social workers and only 4 psychologists working in mental health. They have a key role to play in advocacy, policymaking, planning, and training, but the bulk of the frontline work will fall upon primary health care and other community agencies, including the education and non-governmental sectors.

Hiranthi de Silva (Director of Mental Health), Chintha Munasinghe (Basic Needs, Sri Lanka) and Athula Sumatipala (Sri Lankan Government Adviser and Emergency desk coordinator) reported on the immediate aftermath, and longer term mental health and psychosocial consequences of the tsunami. We heard of the considerable efforts to plan and implement a coherent and sustained multi-sectoral response in Sri Lanka that would meet the needs of the affected communities. A national mental health policy has been developed. The policy sets out a vision for development of community mental health services and the closure of three psychiatric hospitals in Colombo. The policy has been subject to public consultation and a revised version and implementation plan have now gone forward to Parliament.

### PARALLEL SESSIONS

As well as the invited speakers, this year, for the first time we issued a call for abstracts on any topic related to international mental health. Our subsidiary themes were

- Meeting mental health needs in humanitarian relief operations
- Cultural issues in international mental health research and practice
- Stigma and exclusion
- Mental health interventions in the international context

We stressed that researchers, practitioners and policymakers from all sectors – academics, the health sector, national and international NGOs, governmental and intergovernmental agencies - were all welcome to participate and to present abstracts. (A primary aim for our conference is to promote networking, exchange of ideas and experiences, and generally to increase awareness of the salience of mental health to global health and human development). We were overwhelmed by the response; 55 oral presentations and over 30 posters were selected for presentation. The quality and scope of the work was impressive – all world regions were well represented with 27 countries in all. Countries from Africa, South Asia and Latin America predominated.

Brazil (9 presentations)

India (7 presentations)

Sri Lanka

Bangladesh

Tanzania (2 presentations)

Ethiopia (1 presentation)

Somalia

Ghana (2 presentations)  
Nigeria (2 presentations)  
Libya  
Sudan  
Iraq  
Iran (5 presentations)  
Lebanon (1 presentation)  
Turkey (2 presentations)  
Macedonia  
Georgia  
Czech Republic  
Poland  
Cambodia (2 presentations)  
Taiwan (2 presentations)  
Holland (2 presentations)  
UK (6 presentations)  
Australia (7 presentations)  
USA (5 presentations)  
Norway  
France

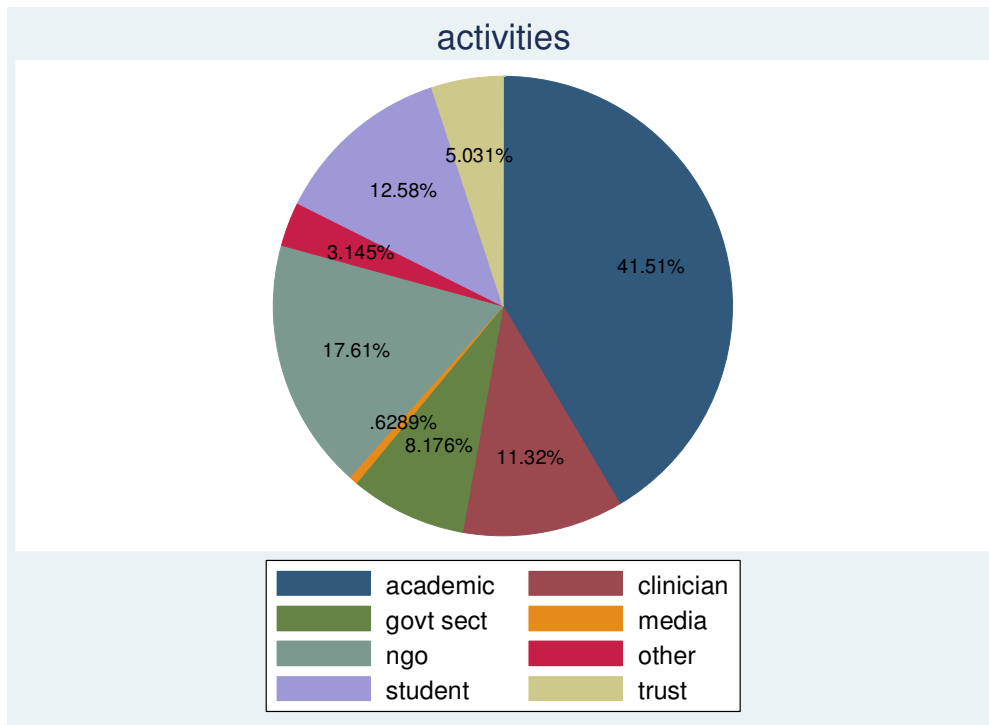
The parallel sessions were divided into 12 themed symposia; child and adolescent mental health, psychosis, depression, violence, stigma, Africa mental health (I - initiatives, II – research and policy), responses to war and natural disaster, cross-cultural research, epidemiology, mental health policy, eastern European mental health.

Details of presentations are available from our website at [www.iop.kcl.ac.uk/international](http://www.iop.kcl.ac.uk/international) there you will find the IMH 2005 conference brochure in PDF file.

## ATTENDANCE

One of the key aims of the conference was to ensure widespread participation, and encourage the presence of speaker and delegates from lower income countries. We had delegates coming from South America (7%), North America (10%), Africa (12%), Asia (24%), Europe (including Eastern Europe) (8%), Oceania (6%) and the UK (34%), representing a total of 36 countries, of those 56% were developed and 44% were developing. It is important to take into account that a high number of delegates who included their selves as residents in the United Kingdom were nationals of developing countries including Brazil, India, Ethiopia and Macedonia. All regions of the world were well represented

Figure 1 shows the variety of participants' backgrounds who attended the conference.



Academics were again the most prevalent category of attendees (42%), but in contrast to last year the second biggest presence in our conference in 2005 was from those of the NGO sector. This is understandable because this year the conference had as one of its major themes the role of mental health specific and mainstream NGOs. In addition to the plenary speakers from CAFOD and Basic Needs, we had important contributions from NGOs from India, Ghana, Nigeria and Pakistan. We also saw a rise in the numbers of student attendees and in delegates from government sectors.

## FEEDBACK

We are grateful to delegates for their helpful feedback. Overall, this was highly favourable. The medians and means come from a ranking of 0 to 10, where 0 means awful, 5 adequate and 10 excellent:

	Median	Mean
The conference was	8	7.97
Organisation	8	8.02
Stimulation	9	8.76
Enjoyment	9	8.76

97% said that they would definitely recommend the conference to someone in the future.

We also asked for the participants tell us if the some aims were achieved such as the conference's focus on international health, focus on policy relevance of such research and if we were able to enhance international

collaboration. 65 % said that we were focused in international research, and 56% said that we could enhance international collaboration.

Detailed comments highlighted some areas which either had not been covered or were not well covered. Some of the common requests included sessions that focus upon:

- specific aspects of mental health policy
- development and delivery of community mental health services
- mental health research and its development
- establishing international collaborations
  - practical workshops on establishing research collaboration between NGOs and research institutions
  - networking
- issues related to displacement and resettlement
  - mental health issues in conflict zones
  - conflicts in developing countries
  - mental health in refugee camps

We shall seek to incorporate as many of these helpful suggestions as possible into the programme for future conferences.

## THE FUTURE

The 3<sup>rd</sup> Annual International Mental Health at the IoP Conference will be held in August/September 2006.

Venue: Franklin Wilkins Building Conference Centre,  
London, UK

Pre-conference day: 29<sup>th</sup> August 2006

Conference days: 30/08- 01/09 2006

Short course: 4<sup>th</sup> Sept – 8<sup>th</sup> Sept 2006

In line with requests from participants, we are proposing as an overarching theme for the 2006 conference:

### **‘People on the Move’ Population shocks, displacement, reconstruction and resettlement**

We aim to finalise this in time for the first call for abstracts (23<sup>rd</sup> January 2006), and we will also need to specify secondary themes at that time.

The deadline for submission for abstracts for oral or poster communications will be 30<sup>th</sup> April 2006

Thank you on behalf of the IMH Executive Group for your continued support and interest. Please contact us for further comments and suggestions (particularly regarding themes for the 2006 conference) at [imh@iop.kcl.ac.uk](mailto:imh@iop.kcl.ac.uk).