constraints, has had a significant, positive impact on mental health. On the other hand, much remains to be done in the areas of primary care, prevention, integration of psychiatric and medical services, evaluation of the quality of extramural services and the quality of life of the patients in these services.

References

Athens Mental Health Promotion Project (2003) *WPA Sections Newsletter*, issue 6, p. 4.

Bouras, N., Webb, Y., Clifford, P., *et al* (1992) A needs survey among patients in Leros asylum. *British Journal of Psychiatry,* **161**, 75–79.

Christodoulou, G. N. (1970) Psychiatry in Greece. *International Journal of Social Psychiatry*, **16**, 314–316.

Christodoulou, G. N., Kontaxakis, V. P., Havaki-Kontaxaki, B. J., *et al* (1994) Leros deinstitutionalization program: psychopathological parameters in sheltered care residents. In *Topics in Preventive Psychiatry* (eds G. N. Christodoulou & V. P. Kontaxakis), pp. 116–124. Karger.

Christodoulou, G. N., Kontaxakis, V. P., Havaki-Kontaxaki, B., *et al* (1999) From the Leros asylum to sheltered housing in the community. In *Issues in Preventive Psychiatry* (eds G. N. Christodoulou, D. Lecic-Tosevski & V. P. Kontaxakis), pp. 83–89. Karger.

Hall, P. & Brockington, I. F. (eds) (1991) *The Closure of Mental Hospitals*. Gaskell.

Hellenic Psychiatric Association (1989) Report on the issue of Leros. *Psychiatriki*, **1**, 183–189.

Madianos, M. (1983) Mental illness and mental health care in Greece. *Public Health Reviews*, **11**, 73–93.

Madianos, M. (2002) Deinstitutionalization and the closure of public mental hospitals. *International Journal of Mental Health*, **31**, 66–75.

Madianos, M., Madianou, D. & Stefanis, C. (1993) Help-seeking behavior of psychiatric disorders from physicians and psychiatrists in Greece. *Social Psychiatry and Psychiatric Epidemiology*, **28**, 285–291.

Madianos, M., Tsiantis, C. & Zacharakis, C. (1999*a*) Changing patterns of mental health care in Greece (1984–1996). *European Psychiatry*, **14**, 462.

Madianos, M., Zacharakis, C., Tsitsa, C., *et al* (1999*b*) Geographical variation in mental hospital discharges in Greece and socio-economic correlates: a nationwide study (1978–1993). *Social Psychiatry and Psychiatric Epidemiology*, **34**, 477–483.

Sarantidis, D., Kladouchos, V., Tripodianakis, J., *et al* (1992) The reform of psychiatric care in Greece. *European Psychiatry*, **7**, 251–257.

Stefanis, C., Madianos, M. & Gittelman, M. (1986) Recent developments in the care, treatment, and rehabilitation of the chronic mentally ill in Greece. *Hospital and Community Psychiatry*, **37**, 1041–1044.

Tansella, M., De Salvia, D. & Williams, P. (1987) The Italian psychiatric reform: some quantitative evidence. *Social Psychiatry and Psychiatric Epidemiology*, **22**, 37–48.

Thornicroft, G. & Bebbington, P. (1989) Deinstitutionalisation – from hospital closure to service development. *British Journal of Psychiatry*, **155**, 739–753.

Zissi, A. & Barry, M. (1997) From Leros asylum to community-based facilities: levels of functioning and quality of life among hostel residents in Greece. *International Journal of Social Psychiatry*, **43**, 104–108.

SPECIAL PAPER

Attitudes towards mental illness in Uganda: a survey in 18 districts

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Uganda, in common with many countries in sub-Saharan Africa, has many population risk factors predictive of high levels of mental disorder but poor coverage of mental healthcare (Kigozi, 2005). Recent population studies conducted in Uganda have shown rates of disorder in excess of 20% (Kasoro *et al*, 2002; Bolton *et al*, 2004; Ovuga *et al*, 2005) and the survey by Kasoro *et al* (2002) showed a high prevalence of patients with severe mental illness and poor access to services. There are 19 psychiatrists for 24.8 million people in Uganda, all but one of whom is based in the capital city, Kampala (Kigozi, 2005). The provision of mental health services relies on the use of psychiatric clinical officers (a cadre of trained mental health workers, similar to community psychiatric nurses, who currently cover 18 of the 56 districts in Uganda), primary care personnel, non-governmental organisations and members of the community. Liaison with traditional healers is encouraged (Ovuga *et al*, 1999).

In addition to poor access to services, it is possible that ignorance and stigma prevent people with mental illness from seeking appropriate help, and that community attitudes and beliefs play a role in determining help-seeking behaviour, as well as the success of treatment (Hugo *et al*, 2003). A strong element in the culture of Uganda is the collective nature of the people and this can be utilised in enhancing services. In order to develop mental health policy and services in Uganda, there is a need to establish a series of estimates of the extent of psychiatric disorder and knowledge of local idioms, beliefs and management (Boardman & Ovuga, 1997). The aim of this study was to examine community attitudes toward mental illness in urban and rural Uganda.

Methods

The study was carried out in 2002–03, when one of the authors (V.W.) was working as a visiting psychology lecturer at Mbarara University of Science and Technology. The study was a cross-sectional survey exploring attitudes towards

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mental illness in 18 districts of Uganda: Kabale, Ntungamo, Bushenyi, Mbarara, Kasese, Kabarole, Masaka, Mpigi, Mubende, Wakiso, Kampala, Jinja, Tororo, Bugiri, Soroti, Masindi, Lira and Gulu.

Interviews were undertaken with 60 rural and 60 urban participants. The sample was collected by first-year medical students, who conducted a survey in their home districts during their half-term holiday. Each student interviewed four people using a structured interview schedule that gave opportunity for open-ended answers. Participants were allowed to give more than one answer to each question and there were no prompts in the interviews. The questions and answers were translated by the interviewing students, who all spoke fluent English and the local language in question.

The interview protocol included demographic questions such as age and educational level. The other questions explored people's attitude to mental illness, using five main questions (see Results, below). The interview schedule had good face validity but content validity and reliability were not established.

From an initial content analysis of the 120 transcribed interviews, recurring themes were identified and coded. The data were analysed using descriptive statistics and cross-tabulation. The five items describing participants' attitudes to mental illness were compared on the basis of location (rural *v*. urban), age-group (20–39 *v*. 40–60 years) and educational level (no formal or only primary education *v*. senior or higher-level education).

Results

Can you get better from mental illness?

Most participants believed that mental illness is treatable (73.3%) or sometimes treatable (23.3%). Only a small number of participants (3.3%) thought that it was not treatable. Although most people therefore had positive attitudes regarding the treatability of mental illness, this was significantly more common among people with higher levels of education (77.3%) than among those who had obtained no or little education (66.7%; $P<0.001$). Similarly, those with less education were more likely to endorse negative attitudes than their more educated counterparts (9% *v*. 0%; $P=0.009$).

What people can you go to see in case of mental illness?

Most participants expressed a clear preference for one form of treatment, although 26 participants mentioned both traditional and Western forms of treatments. Less than half of all participants (45%) believed that mental illness can be treated by traditional medicine, whereas over two-thirds (67.5%) believed that mental illness is treatable by Western medicine. A few participants (9.2%) believed that mental illness is treatable by other means, such as counselling by a priest or a church leader. People from an urban setting and those who had obtained a higher level of education more often regarded Western medicine as the most appropriate treatment for mental illness than did their rural counterparts and those with less education, who more commonly mentioned traditional medicine as a treatment choice for mental illness (Table 1). Younger people were more likely to believe that mental illness was treatable by Western medicine than were older people (Table 1).

Table 1 Percentages of people from different demographic groups who mentioned Western and/or traditional medicine as a possible treatment choice for mental illness

Variables	Western medicine %	Traditional medicine %
Rural location	43.3	70.0
Urban location	91.7***	20.0***
Lower education	35.6	71.1
Higher education	86.7***	29.3***
Younger age (<40 years)	73.5	43.4
Older age (>40 years)	54.1*	48.6

Totals add to greater that 100% as multiple preferences were allowed.

*$P=0.036$; ***$P<0.001$, *v*. comparison demographic group

Table 2 Participants' views on how people who are mentally ill should be dealt with and actual practices mentioned by participants

	Percentage of sample ($n=120$)
Participants' views (with statements beginning 'People who are mentally ill should be…':)	
Helped and looked after like any other person	42.5
Taken to hospital	37.5
Treated or given medication	25.8
Isolated from the society	25.0
Given advice or counselling	16.7
Taken to traditional healers	6.7
Actual practices reported ('People who are mentally ill have been…')	
Ignored, isolated, neglected, left to move freely	45.8
Beaten up, tied up, locked up, chased away or stoned	38.3
Taken to hospital	32.5
Helped by giving food, clothes	11.7
Taken to traditional healers	7.5
Looked after by relatives	5.0
Other	1.7

Totals add to greater that 100% as multiple preferences were allowed.

What do you think and feel about people with mental illness?

Most of the participants (82.5%) expressed a sympathetic attitude to or concern for people with a mental illness. Although 15.8% feared such people, only 5% expressed a negative attitude.

How do you think people with mental illness should be dealt with?

Over 40% of participants believed that people with a mental illness should be helped and looked after 'like any other person' (Table 2). Almost as many believed that they should be taken to hospital, whereas just over a quarter believed that they should be treated or given medication. Whereas 16.7% believed that people who are mentally ill should be given advice or counselling, only 6.7% advocated a traditional healer. A quarter of all participants believed that they should be isolated from society (Table 2). There were no significant correlations between these attitudes to treatment and socio-demographic factors.

How are people with mental illness dealt with in this community?

Participants' attitudes did not correspond well with how people who are mentally ill are managed in the community (Table 2). Regardless of most participants' sympathetic attitude, only 11.7% reported that people with a mental illness are helped in their communities by giving them food and clothes and so on. Almost half of all participants reported that people with a mental illness are isolated, ignored or neglected, and over 38% reported violent behaviour towards such people (violence included being beaten up, tied up, locked up, chased away or stoned). However, almost a third reported that people with a mental illness are taken to a hospital and 7.5% reported that they are taken to traditional healers (Table 2).

Discussion

The study utilised a cost-effective means of carrying out valuable data collection in a setting where research grants are in short supply. We acknowledge that using medical students as research workers may compromise the reliability of the study but believe that the benefits of this approach may override the limitations. Student research workers from different parts of Uganda with relevant language fluency, in a country with over 50 languages, offered a great opportunity for accessing areas that otherwise would have not been accessed in a research project without funding.

Attitudes of the population towards mental illness were mainly positive, but did not always match the community practices reported, which included unsympathetic acts and which corresponded with those reported by Kasoro *et al* (2002). The differences between urban and rural populations indicate that social change and greater education have an impact on beliefs and attitudes. Education about mental illness and people who are suffering from it can lead to change, and one area where this is urgently required is in the continuing dehumanising management practices described in this study.

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References

Boardman, J. & Ovuga, E. (1997) Rebuilding psychiatry in Uganda. *Psychiatric Bulletin*, **21**, 649–655.

Bolton, P., Wilk, C. M. & Ndogoni, L. (2004) Assessment of depression prevalence in rural Uganda using symptom and function criteria. *Social Psychiatry and Psychiatric Epidemiology*, **39**, 442–447.

Hugo, C., Boshoff, D., Traut, A., *et al* (2003) Community attitudes toward and knowledge of mental illness in South Africa. *Social Psychiatry and Psychiatric Epidemiology*, **38**, 715–719

Kasoro, S., Sebudde, S., Kabagambe-Rugamba, G., *et al* (2002) Mental illness in one district of Uganda. *International Journal of Social Psychiatry*, **48**, 29–37.

Kigozi, F. (2005) Mental health services in Uganda. *International Psychiatry*, issue 7, 15–18.

Ovuga, E., Oluka, G. A. O. & Boardman, J. (1999) Traditional healers and mental illness in Uganda. *Psychiatric Bulletin*, **23**, 276–279.

Ovuga, E., Boardman, J. & Wassermann, D. (2005) Prevalence of suicide ideation in two districts of Uganda. *Archives of Suicide Research*, **9**, 321–332.

POINT OF VIEW

Doctors' values, resilience and professionalism

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In 2001, Richard Smith, then editor of the *BMJ*, asked why doctors were so unhappy. He provoked a huge international response. The suggested reasons included: changes in the social structures of work; the demographic shift and difficulties in the recruitment and retention of staff; the replacement of trust with accountability; changes in relationships with people and bodies that are responsible for policy and practice; and negative media reporting.

Edwards *et al* (2002) concluded that 'this is an international and widespread problem' and ascribed the cause to 'a breakdown in the implicit compact between doctors and society'. At much the same time, Salter (2001) presented his analysis of the tensions in the triangle of relationships between the medical profession, society and the state in the UK.

In her Reith lectures, O'Neill (2002) provided a commentary on the impact on trust of interacting societal changes and governments' policies in the Western world. In my opinion, the latter have responded to, but also amplified, the real change in the nature of the public's trust of professionals. Salter (2001) pointed to the very rapid growth of a regulatory industry in the UK, such that all aspects of knowledge creation (research), knowledge and skill transmission (education) and application (practice) are now covered by organisations that set standards and monitor and/or evaluate their implementation. This has led to beliefs that, although there are similar developments across the world, healthcare is now more regulated in the UK than it is anywhere else.

Openness, *transparency* and *accountability* have been developed in place of reduced trust. Openness relates to processes for decision-making being open to scrutiny. Transparency refers to the basis of decision-making being overt. Accountability concerns the allocation of responsibility for decision-making, so that everyone is clear about their role and the scope of their capacity to make decisions. Although