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COMMENT

Global Mental Health Movement: Need for a cultural perspective

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Abstract

The present commentary reviews the goals and differing positions on the Movement for Global Mental Health (GMH), with a distinct emphasis on the cultural differences in the understanding of the aetiology of mental health issues. The proponents and advocates of GMH support its intentions and primary agenda of scaling up mental health services, especially in low-income and middle-income countries where the prevalence of mental health disorders is continually rising. However, many cultural psychologists and sociologists critique the movement for universalising psychiatric symptoms, as this universalisation could actually suppress local voices and might also undermine the significance of culture and political and psychosocial predictors which may contribute to mental health challenges. After discussing the pros and cons of the GMH movement, this commentary concludes with a conceptual analysis of the GMH position and offers predictions about its future discourse.

Keywords: *global mental health; GMH; mental illness; culture and mental health*

Introduction

Mental health issues make a substantial contribution to the global health burden, as indicated by World Health Organization (WHO) health statistics, 2017 [1]. According to the World Health Report of 2001, it is expected that one out of four individuals in the world are, at some point in their lives, susceptible to mental or neurological disorders [2]. Globally, there has been an increase in depression by 18.4% from 2005 to 2015 [1]. Worldwide, mental health comprises up to 13% of the total disease burden, and at least two-thirds of all the people with mental illness fail to receive any treatment, especially in low-resource countries [3]. Despite the availability of various effective treatment strategies and increased awareness of mental health problems, around 76-85% of people with severe mental illness receive no treatment in LMICs compared with 35–50% of those in high-income countries [4]. In fact, LMICs are said to account for less than 20% of total global mental health resources and these statistics are a clear indicator of the need to scale up resources to improve mental health around the globe [5]. The *Lancet* Movement for Global Mental Health launched a campaign to address this crisis, aiming to design different kinds of interventions across routine-care systems in an effort to scale up mental health services, and strengthen respect for the human rights of patients with mental illness, along with careful consideration of the well-being of their family members [5].

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Movement for Global Mental Health

With its "call to action" in 2007, through a series on the subject, *The Lancet* aimed to stimulate a Movement for Global Mental Health advocating for the human rights of people with mental health problems, more healthcare research in LMICs and universal mental healthcare policies, etc. Global Mental Health (GMH) groups advocated that any substantial advance in mental health services could only truly be achieved if governments, multilateral agencies, public health organisations, mental health experts and other stakeholders worked together towards that goal. This movement inspired various other fields to contribute to mental health research, in order to maximise healthcare delivery through existing resources to the affected individuals, and to design effective policies that respect the rights of this often-stigmatised population across race, colour, gender, creed, or location [6, 7].

Scientific evidence and human rights are the two fundamental principles that serve as this movement's strong foundational pillars. The GMH movement is built upon the foundation that mental disorders around the globe are mostly linked with poverty, marginalisation, social inequality, which result in scarce financial and human resources and inefficient allocation of such resources. Thus, this movement asserts that scaling up resources will help in increasing access to mental health facilities and diminishing the illness-based inequalities (either outcomes or discrimination) between or within countries. Synthesising the evidence on what treatments are effective for addressing a wide range of mental illnesses is one of the objectives of GMH. The proponents of GMH believe that building a common

platform for mental health experts and societies is essential to work towards their shared goals. To sum up, the four core foundations of GMH [5] can be traced to:

a. evidence supporting the claims of the inter-relationships between mental illness and social disadvantages;

b. associations between physical health issues and mental illness, as suggested by DALY (Disability-adjusted-life-year);

c. effectiveness and cost-efficacy of pharmacological and psychosocial treatments for mental illness in LMICs; and

d. lack of basic human rights of such populations. For instance, research among people with mental illness from poor societies has shown that patients are kept chained to the bed or caged in small cells, among other inhumane treatments [8].

GMH incorporates a comparative approach wherein each nations' status in terms of its own progress towards the set targets is compared with that of other nations. Just 3% of the published literature in high-impact psychiatric journals originates from LMICs [9]. This lack of sufficient research blocks us from gaining a fuller and more comprehensive representation of mental health conditions. Since the access to healthcare services for people with mental disorders, mainly in LMICs, is grossly lacking — accounting for less than 20% of total global mental health resources — GMH's primary aim is to strengthen such facilities. GMH believes that there should be cost-effective delivery of clinical guidelines on routine clinical practices [5]. For this, they have laid down various panels to describe them in the *Lancet* series. In short, the GMH movement hopes to fill treatment gaps and to preserve the basic human rights of individuals with mental disorders, among various other sub-goals.

However, these proposals outlined by the *Lancet* series of GMH have their own pitfalls, which have been critiqued by many researchers working in the field of mental health. One such criticism revolves around the fact that universalising symptoms and treatments suppresses local voices and undermines the importance of culture and other psychosocial and political factors that contribute to the development, prognosis, and treatment of mental health challenges [10, 11, 12]. In addition, the GMH efforts to scale up mental healthcare have been confined to writing popular editorials rather than involving in actual on-ground research work [13, 14]. Making mental illness context-free or culture-independent serves as an important barrier in treatment efficacy. Moreover, the emphasis on physical health over mental health, inadequate training, and "over-reliance" on hard quantitative data over qualitative measurement obscures the reality of this underserved population. This is not to suggest that physical illnesses should take a backseat, or that quantitative studies on mental health are not important to enhance our understanding of such disorders. However, qualitative studies may serve as a better and more appropriate research tool, for those seeking to understand the reality of the existing burden and not merely the extent of it. Overlooking these ground realities about the policies, presentations, and approach of this movement would indeed be problematic unless addressed immediately.

Primary care, mental health services and stigma

The World Health Assembly (2013) initiated the Comprehensive Mental Health Action Plan (CMHAP) for 2013-20 [15], which aimed at integrating mental healthcare services in United Nations (UN) member states into primary care [16]. This initiative has resulted in much-needed changes in community-based primary healthcare systems. This transformation has been achieved by including better diagnosis and interventions for both severe and common mental health issues. CMHAP is also committed to enhancing the quality of mental healthcare promotion and prevention of such disorders among its member states. The UK government-funded "Programme for Improving Mental Health Care" (PRIME) shares similar goals of enhancing the design, evaluation, and cost-effective methodologies of integrating severe mental illness into common mental disorders [17]. While these various frameworks of GMH focus on advancing the prognosis, care and treatment of people suffering from mental illness, it has long been established that individuals with mental illness face serious prejudice and discrimination [18]. Therefore, a strong emphasis on reducing such stigma in their framework is as much needed as on the other goals. The Ministries of Health in India, among other LMICs in Asia and Africa, are in collaboration with PRIME, contributing towards quality improvement and applying collaborative care principles through rigorous studies, which include larger indigenous samples that address health-related stigma and discrimination among users of mental health services [19]. These studies will, hopefully, highlight the stigma and discrimination these groups face, and ensure that a proper counselling channel and awareness programme is designed to normalise mental health issues.

Universalisation of symptoms

GMH ensure a standard comprehension of mental health distress and how it can be treated across the globe, with a specific focus on LMICs. While the earlier focus of conceptualisation of mental illness was based on self, society, and politics, it has now been moved to a universal approach. This might lead to the basic error of objectivity and generalisability as cultures are highly diverse and what may apply to one culture might not apply to the other [20]. Some researchers argue that traditional psychiatry runs too much in a straight line, and is chained to a quantitative approach. However, a more realistic way to understand illness is to see psychology as outside the body of an individual. The critics of GMH proclaim that understanding

psychological pathology (and more precisely that of humans) is more a philosophy than a science. Since the approach itself wholly believes in science, the globalised outlook of mental healthcare and its whole pharmaceutical industry is erroneous.

The medicalisation of mental illness has resulted in an epidemic of false positive diagnoses [21]. Moreover, there has been an increased attribution of the aetiology of mental disorders to physiological causes. This has further escalated the prescription of psychotropic drugs among mental health practitioners. The critics of the GMH position believe that the more resources are made available, the more they are perceived to be needed, leading to an unending circular process [22]. The rise of the mental healthcare industry in the west has itself become problematic, rather than being a solution, as even the slightest signs of everyday distress are often labelled as one or the other mental illness [21]. In addition, there has been a long dispute among experts on the treatment efficacy of these drugs. This has all somehow resulted in the development of medical imperialism, wherein western psychiatry is given overdue emphasis. Moreover, psychiatric practitioners from the West often believe that individuals from other cultures should understand and accept their medical philosophy, and not the other way around [22].

The medicalisation has done nothing to lessen the stigmatisation faced by such a population. For instance, the two-generation usage of antipsychotics has still not improved the overall employment rate among people labelled as schizophrenics [23]. In another instance, Hengartner [24] concluded in his review that individuals on anti-depressants overall had a higher mortality rate than those who were not diagnosed and their matched non-drug controls. In other words, people who were diagnosed were at a higher likelihood of dying early as compared to those who demonstrated symptoms of a mental disorder but never received any clinical diagnoses. Moreover, Sinha and Ranganathan [25] have documented how individuals with experiences of hearing voices are often medically treated for these auditory hallucinations, despite the voices being harmless, friendly, or even motivating. This leads to a conclusion that the medicalisation of mental illness has discarded other factors that may contribute to or lead to the development of other concerns revolving around poor life outcomes. While one may argue that poor life outcomes among individuals on "pills" may largely be due to the wrong labelling of these individuals, this further strengthens the point that there exists a tendency among medical professionals to label what might be "social suffering" as some "mental illness" that needs medical attention [12, 25].

The voices of patients and the general population are often found to be missing and disqualified from the "mental health" discourse [3]. Before medicalisation and the psychopharmacological industry came into the picture, the focus was more on the "self". However, the scenario has been completely reversed now, and the individuals' dependency on self has moved on to biological factors, leading to diminished control over their symptomatology and disease mongering/psychiatric abuses [26]. Drugs have migrated from the realms of serious mental disorders into the area of everyday emotional problems [21]. For instance, what was seen before as an early childhood behavioural problem that fades away as the child enters adulthood is now called "paediatric bipolar disorder" [11]. GMH's use of an invalid approach and lack of appropriate cross-cultural research has made us largely understand symptoms globally. The universality of symptoms has been forced onto the local voices, which does no justice to the cultural, political and economic influences on an individuals' makeup. Trying to explain the aetiology of any particular mental illness through the lens of another culture could result in a serious misunderstanding of such illnesses. For example, the large-scale suicides of Indian farmers are largely more a result of poor economic conditions than disruptions in their actual physiological or psychological makeups [27]. GMH often questions various culturally designed strategies of healing in non-Western countries as psychologically non-effective [28]. Therefore, it is not surprising to note that various traditional modalities of healing, such as spirituality or local healers, are largely missing from the GMH literature.

Similarly, another initiative that advocates GMH also seems to carry similar issues in its guidelines to those the primary GMH movement carries. The guidelines issued by the WHO Mental Health Gap Action Programme (mhGAP), a WHO flagship programme on mental health, similarly advocates a top-down expensive healthcare system, which is not affordable or practical for most of the populations residing in LMICs. The small set of countries that they selected for review might not provide a full picture of other LMICs and, therefore, might not be a representative sample [29]. This scaling up ignores the mental disorders affecting children as most of the policies are centred on mental disabilities affecting the adult population and how these disabilities affect the activities of the daily lives of adults.

Conceptualising the GMH Framework

Even though the purpose behind the scaling up appears out to be optimistic, the primary research challenge requires addressing "how this scaling up should be done." The GMH movement has been truly instrumental in initiating research centred on task shifting. Such studies have unravelled various accounts where the need for therapies such as Cognitive Behavioural Therapy or family therapy have been realised and thus training mental health experts in such therapies may result in desirable health outcomes [30]. Therefore, it cannot be denied that these "task-shifting" researches could be classified as among the major achievements of the GMH movement.

While the question of the "how" of the scaling up has been widely discussed, this is also one of the major questions, which the supporters of GMH usually fail to answer. Another

setback that GMH itself notes is that there remains an inevitable uncertainty about the estimates concerning epidemiological demands and treatment coverage, utilisation, and costs, regardless of the availability of the best data. Moreover, though the target is set, it is essential to constantly monitor and revise needs based on the changing scenario, and, sadly, there is no significant mention of such strategies in their plan.

Despite the presence of a hierarchical framework addressing global mental health improvement, the targeted goals lack enough transparency and adaptability across different cultures. GMH turns out to be more an advocate for the pharmaceutical industry than an actual endorser of mental illnesses [12]. As Clark pointed out [3], medicalisation of illness produces a restricted view. It is, therefore, necessary to fund more research to fill the missing voids in context with the individually tailored objectives for LMICs and for high-income nations. Anthropologists also appeal the current approach to challenge the imperfections and inadequacies in current mental healthcare systems and approaches. Their approach of medicalising mental disorders is faulty, in that even though a medical diagnosis validates an individuals' suffering, the medicalisation of their mental disorder tends to cripple them from within [25]. Individuals seeking treatment then tend to believe in medicines more than in their own abilities to fight life challenges or their disabilities, and thus view mental disorders as similar to physical illnesses like diabetes, which require long-term pills management [31].

A large array of challenges needs to be addressed to improve the concept of GMH, which include developing innovative treatment plans and primary healthcare services, strengthening individual access to such services, and quality improvement in addition to developing national health policies and legislation for proper dissemination of such services. A clear, consistent, and holistic approach that covers all the factors (viz physiological, social, psychological, spiritual, cultural, economic, and political) is the only way to scale up mental health services and their better utilisation. For instance, a study on Indian mental patients indicated that the inclusion of psychosocial interventions in pharmacological treatments could actually increase their overall efficacy [32]. Moreover, allowing family members to become an active part of the treatment process can provide on-going monitoring and a better standard of care for patients outside hospital settings [20].

Conclusion

The GMH movement has indeed provided a productive dialogue between the mental health experts and users of mental health services — an overdue initiative missing so far. The scaling up and task-shifting strategies outlined by GMH policies are a fruitful avenue that allows both users and providers to enter a common ground where internal and external forces that result in mental illness are acknowledged. The GMH movement, however, has inevitable roadblocks to struggle with in the coming days due to its overarching goals. However, such critical analysis, in its actuality, is essential for a productive judgment over an issue. Both the critics and supporters of the GMH position, fortunately, intersect on the ground that mental health facilities need to be scaled up. Undoubtedly, if a stronger emphasis is placed on all these factors, the goals related to a mentally healthy society can be achieved.

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