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Editorial

Toward a new architecture for global mental health

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Abstract

Current efforts in global mental health (GMH) aim to address the inequities in mental health between low-income and high-income countries, as well as vulnerable populations within wealthy nations (e.g., indigenous peoples, refugees, urban poor). The main strategies promoted by the World Health Organization (WHO) and other allies have been focused on developing, implementing, and evaluating evidence-based practices that can be scaled up through task-shifting and other methods to improve access to services or interventions and reduce the global treatment gap for mental disorders. Recent debates on global mental health have raised questions about the goals and consequences of current approaches. Some of these critiques emphasize the difficulties and potential dangers of applying Western categories, concepts, and interventions given the ways that culture shapes illness experience. The concern is that in the urgency to address disparities in global health, interventions that are not locally relevant and culturally consonant will be exported with negative effects including inappropriate diagnoses and interventions, increased stigma, and poor health outcomes. More fundamentally, exclusive attention to mental disorders identified by psychiatric nosologies may shift attention from social structural determinants of health that are among the root causes of global health disparities. This paper addresses these critiques and suggests how the GMH movement can respond through appropriate modes of community-based practice and ongoing research, while continuing to work for greater equity and social justice in access to effective, socially relevant, culturally safe and appropriate mental health care on a global scale.

Keywords

community mental health, culture, globalization, global mental health, political economy, public health, social determinants of health

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Introduction

The emerging field of global mental health (GMH) aims to address the enormous disparities in mental health that beset populations around the globe. A growing body of epidemiological research has established mental health as a priority for global health research and intervention. Significant advances have been made in identifying targets and strategies for research (Collins et al., 2011; Patel, Boyce, Collins, Saxena, & Horton, 2011) and developing packages of interventions (Mari, Razzouk, Thara, Eaton, & Thornicroft, 2009; Patel, Simon, Chowdhary, Kaaya, & Araya, 2009; Patel & Thornicroft, 2009). Despite the efforts to build a solid scientific foundation for GMH, notably in the Lancet Global Mental Health Group series of articles published between 2007 and 2011 (Patel et al., 2008, 2011; Prince et al., 2007), there continues to be controversy and debate about the knowledge base (Summerfield, 2008, 2012), as well as the appropriate methods for establishing priorities, research themes and approaches, and modes of developing and/or adapting interventions in global mental health (Das & Rao, 2012; Fernando, 2012; S. Fernando, 2014; Mills, 2014). In particular, there are tensions between a public health approach, grounded mainly in biomedicine and current evidence-based practices (which are still largely produced in high-income countries), and a socially and culturally informed community-based approach that emphasizes the social determinants of mental health and the imperatives of listening to local priorities, strengthening community resources, and developing endogenous solutions (Bemme & D'Souza, 2014; Saraceno & Dua, 2009; Saraceno et al., 2007).

Global mental health is itself a product of international professional, economic, and political institutions. As such, it can be viewed through the lens of critical social sciences that seek to trace the tacit assumptions, influences, and tensions inherent in current practice. The cultural critique of global mental health has raised some basic issues: (a) the priorities of global mental health have been largely framed by mental health professionals and their institutional partners mostly located in wealthy countries, which therefore reflects the dominant interests of psychiatry and may give insufficient attention to locally defined priorities; (b) global mental health is based on rough estimates of the global prevalence of major "neuropsychiatric" disorders, which it assumes are biologically determined entities with stable features, course, and outcome; (c) in focusing on existing evidence-based treatments, global mental health assumes that standard treatments can be readily applied across cultures with minimal adaptation; and (d) global mental health tends to emphasize professional mental health interventions and may marginalize indigenous forms of helping, healing, and social integration that can contribute to positive outcomes and recovery (Kirmayer & Swartz, 2013; Sax, 2014).

To foster debate on these issues, the Division of Social and Transcultural Psychiatry at McGill University organized an Advanced Study Institute on Global Mental Health: Bridging the Perspectives of Cultural Psychiatry and Public Health, in Montreal, July 5–7, 2012.[1] The conference and workshop aimed to foster a dialogue between proponents and critics of global mental

health to identify areas of consensus, clarify concerns, and map relevant programs of research. Selected papers from the meeting appear in this issue of *Transcultural Psychiatry*, along with other articles received by the journal on related topics.

In this introductory essay, we discuss the rationale for current programs in global mental health and outline the critique from social and cultural perspectives. In particular, we consider some potential negative effects of global mental health interventions that do not sufficiently address local and global contexts and structural issues. Finally, we identify key topics for a socially and culturally oriented research agenda for global mental health.

From tropical medicine to global health

Global health represented a major shift from the earlier perspectives of tropical medicine and international health. The older approaches had roots in colonial medicine. As such, they did not emphasize building local capacity or addressing the basic inequities that were part and parcel of colonial order. Towards the end of the 19th century, the discovery of microbes and the emergence of the germ theory resulted in the adoption of the "doctrine of uni-causality" (one germ = one disease). Under this doctrine, all intervention efforts were to be based on developing antimicrobial agents, later followed by DDT to attack disease vectors, and other pharmacologically active substances. Early successes with this approach led many to believe that the human body and the natural environment could be purged of micro-organisms and vectors, leading to the conquest and eventual eradication of all tropical and microbial-related diseases (Pedersen, 1996). The emerging field of public health introduced population-level measures, campaigns, and interventions focused on the control or elimination of specific diseases in specific populations but, here again, the overall strategy was generally to import Western models of primary and secondary prevention, as well as introduce the use of new drugs and pharmaceuticals. With the postcolonial emergence of new nation states, tropical medicine was progressively transformed into international health with the mandate to control epidemics across the boundaries between nations (Brown, Cueto, & Fee, 2006). International health was largely framed in terms of the delivery of biomedical services modeled on urbanized Western medical practices, disease prevention, and therapeutics.

At the turn of this century, authors moved away from international health and tried to redefine global health as either "health problems, issues and concerns that transcend national boundaries" (Institute of Medicine [IOM], 1997) or inequities caused by unfair patterns of international trade and investment, including the marketing of harmful products by transnational corporations, as well as the effects of climate change and the transmission of diseases resulting from travel between countries (Smith, Tang, & Nutbeam, 2006). In turn, others have looked at the historical and political dimensions of global health and the influence exerted by WHO in deploying this term as an organizational strategy for their own survival (Brown et al., 2006).

More recently, Koplan et al. (2009) presented a comparative framework for public health, international health, and global health domains in which different levels are compared in terms of geographical reach (from scope of location to scope of problems), level of cooperation (from binational cooperation to global partnership), focus on individuals and/or populations, health equity (from within a nation or community to across nations and for all peoples), and range of disciplines (from multiprofessionalism to transdisciplinarity). This comparative framework provides a useful way to move beyond understanding global health in terms of a simple mapping of the worldwide distribution of problems or disease categories and resources (Saxena, Sharan, Garrido-Cumbrera, & Saraceno, 2006), toward more structural distinctions that work across similar fields of enquiry. It is now clear that we need to redefine global health in its own right as distinct from conventional public health or international health (Pedersen, 2012).

The logic of global mental health

Redefining the field as "global" rather than "international" or "public" has implications for how problems are framed and where solutions are sought. These changes in terminology are not arbitrary, but respond to changing contexts across time as well as the interests of disciplinary fields which sometimes remain circumscribed and focussed on specific roles and tasks. For example, public health usually focuses on health issues affecting specific populations in any given country, while international health efforts target people from undeveloped countries. In contrast, global health aims to include the needs of all populations, rich and poor, across the globe, irrespective of their location, nationality, or income.

The essential issues that have led to a redefined global mental health are first, the global nature and scope of the problem. Global health strives to recognize the interdependence of health in high, low and middle-income countries through global networks of influence and exchange. These networks include trade, electronic communications, and international flows of knowledge. Popular media and the Internet serve to create new channels of influence and health-related values, behaviours, and exposures that demand both local and global coordinated responses.

The second set of issues is partly related to this new level of networking and stems from the need to address the profound changes in the scale of societal crises: in particular, the great concentration of wealth and income in certain sectors, including financial and political power, as a key consequence of globalization (Harvey, 2005; Tabb, 2002). Understanding the impact of these new forms of inequity requires analysis of the nature of global economic institutions and political dynamics not only in relation to health but across all sectors of the economy. Contemporary global governance involves the distribution of economic resources and political power; tracing the effects of this governance on health therefore requires an analysis of power disparities and their consequences (Ottersen et al., 2014).

Finally, the third and crucial element is the ethical argument for social action on the global level in order to address social inequalities arising from the unfair or

unbalanced distribution of resources and the need to advance toward global health equity and social justice (Venkatapuram, 2010). This argument may invoke human rights, appeals to human dignity and fairness, and other moral frameworks that make sense across diverse countries, cultures, and contexts (Kleinman, 2009).

To advance these issues, advocates for GMH have made four key moves:

1. Documenting the enormous disparities in mental health in low and middle-income countries. This has been done with increasing sophistication lending credence to figures that identify mental health or neuropsychiatric disorders as among the most prevalent and disabling health problems worldwide;
2. arguing that given their high prevalence and economic burden, mental health problems should be given a high priority in development goals and the allocation of resources at all levels of government and economic institutions;
3. framing the disparity in terms of a treatment gap, that is, the relative lack of adequate mental health services. The assumption is that mental health services and interventions can ameliorate the observed inequalities in mental health;
4. responding to the treatment gap with a research and action program focused on identifying, testing, and scaling up evidence-based interventions to meet the treatment gap.

Although still in its early stages, the success of this argument has resulted in the mobilization of significant resources toward research on interventions that can improve mental health in low and middle-income countries.

Critiques of the GMH agenda

Recent debates on global mental health have raised questions about the goals, methods, and consequences of current approaches. These critiques emphasize the difficulties and potential dangers of applying Western categories, concepts, and interventions given the many different ways that society and culture shape illness experience. The concern is that in the urgency to address disparities in global health, ways of framing problems and intervening that are not socially relevant and culturally consonant will be exported to local populations with likely negative effects. Some of the tensions may be between those who are armchair critics—lacking the direct experience of working with people with mental disorders or else feeling no pressure or mandate to respond with action—and those at the opposite pole who uncritically apply a framework that serves to promote professional power and authority and respond in ways that are not sensitive to context. Notwithstanding these biases, the debate raises basic theoretical and conceptual issues about the logic of global mental health that must be considered.

Critics of the GMH movement have challenged each of its core assumptions:

1. Estimates of the prevalence and burden of mental health problems in low and middle-income countries and regions of the world are based on limited data and

uncertain or questionable extrapolations that may lead to inflated or misleading figures (Summerfield, 2008; for an overview of current methods, see: Murray & Lopez, 2013);
2. social inequalities, poverty and unemployment, structural violence, war and conflict on both local and global scales are far more important determinants of mental health outcomes than the types of problems recognized in conventional epidemiological studies (Geneva Declaration Secretariat, 2008; Lund, et al., 2010; Wilkinson & Pickett, 2006);
3. framing the disparities in terms of a treatment gap privileges mental health services and interventions by mental health professionals and ignores or downplays community-based and grassroots approaches (Fernando, 2012; Sax, 2014); and
4. evidence-based practices developed in Western countries may not be culturally appropriate, feasible, or effective in other contexts (Kirmayer, 2012). Moreover, the demand to scale up evidence-based practices may predetermine the types of intervention available since it may be much easier to provide medication or simple, standardized behavioural interventions, than to conduct more complex psychosocial interventions (Jain & Jadhav, 2009; Kirmayer & Swartz, 2013; Swartz, 2012).

Cultural considerations contribute to all four arguments. The ways that problems are categorized and counted depends on culturally rooted systems of psychiatric nosology.

The social determinants of health are dependent on culturally mediated distinctions between groups that vary across societies. The local response to suffering is embedded in cultural systems of meaning and healing that are part of the religious, spiritual, and moral fabric of communities and societies. The production of evidence is shaped by social expectations and cultural assumptions, and the fit (or adaptability) of interventions across societies and cultures depends crucially on the generalizability of these concepts, values, and practices (Kirmayer, 2012).

Neglecting culture and social context in GMH therefore may have negative effects at the level of individual health care as well as the design of mental health policy, systems, and services. At the level of *individuals and families* in clinical care, negative effects may occur in several ways: through assessment that uses diagnostic systems that are not appropriate for local cultural contexts, resulting in misdiagnosis; by failing to recognize relevant personal and social problems that demand solutions other than mental health treatment; by applying treatments of uncertain value; by undermining local modes of understanding, explaining, and effectively coping with affliction; and by stigmatizing individuals through associations with psychiatric illness. At the level of *health systems*, *institutions*, *communities*, *and populations*, negative effects may occur in additional ways, including: by displacing attention from social structural and political economic determinants of mental health to the immediate and proximal biological causes of poor mental health outcomes in individuals; by adopting the economic agendas of multinational pharmaceutical corporations or other vested interests that may ultimately conflict with public health goals; by ignoring, invalidating, or displacing indigenous systems of mental health promotion and

healing that are part of the social fabric and resilience of local communities; and by undermining community autonomy and self-direction in favour of professional, technocratic, expert-driven approaches associated with mental health services.

Social determinants of health

The inequalities that are the central concern of global mental health are directly related to social structural and economic determinants. The growing literature on social determinants of health has provided compelling examples of how social inequalities lead to a wide range of health problems, not only among those who are disadvantaged but for all who participate in regimes marked by inequity and social injustice (Marmot, 2005, 2007; Marmot & Wilkinson, 2006; Wilkinson & Pickett, 2006).

Although global mental health has drawn from efforts to uncover and address social structural issues, the focus on discrete neuropsychiatric disorders and specific treatments may work against more structural, intersectoral, political, and economic solutions. Indeed, since structural solutions are usually difficult to implement, transforming complex social problems into issues of delivering mental health services more effectively may suit certain economic and political interests and actually help stabilize—at least temporarily—situations of inequality and health disparities.

The focus on cultural adaptation of interventions also has been critiqued for diverting attention from these basic determinants (Metzl & Hansen, 2014). However, analyzing the cultural context of health and illness remains important even when trying to address structural inequalities. Culture is an important contributor to social determinants of health in several ways: (a) it produces categories of identity and social practices that disadvantage specific groups; (b) it influences the social determinants of health by providing interpretive systems that may aggravate or mitigate particular forms of adversity (e.g., providing relationships, spiritual practices, or notions of meaningful activity that change the meanings of poverty and social exclusion); (c) it mediates the effectiveness of interventions both at population and individual levels; and (d) it shapes the definitions, values, and priorities of well-being and other positive health outcomes (Adeponle, Whitley, & Kirmayer, 2012; Myers, 2010; Ruiz-Casares, Guzder, Rousseau, & Kirmayer, 2014).

The report of the WHO Commission on the Social Determinants of Health (CSDH, 2008) moved away from conventional epidemiological models which focus on individual-level determinants, such as individual characteristics (age, sex, education, etc.), exposure to harmful agents, individual behaviours or genetic factors, or even appeals to subindividual levels (i.e., molecular epidemiology), as explanations of disease occurrence. In contrast, the CSDH report adopted a social epidemiological approach, focusing on the contextual, supraindividual factors. However, this shift in focus inevitably highlights two politically sensitive issues: first, the extraordinarily unequal social distribution of disease-related morbidity and mortality and second, the social causation of disease and disability. In making these links, the CSDH report has contributed most significantly to a paradigm

shift, laying the ground for the development of global health and global mental health as emerging and dynamic areas of enquiry and practice (Pedersen, 2012).

For instance, inequalities in life expectancy cannot be explained by biological endowment, but rather are most likely to be determined by differences in the daily conditions of life, that is, the conditions in which people are born, grow, live, work, and age, as well as the fundamental drivers of these conditions: the (unfair) distribution of power, money, and resources (CSDH, 2008).

The main pathways linking social inequities with health outcomes and longevity remain to a large extent unknown. Nevertheless, it seems clear that poverty, racism, and social exclusion, can exert powerful influences in mental and physical health, both in terms of morbidity and mortality (Patel & Kleinman, 2003). Material insecurity, which comes along with poverty, is itself a source of distress, worry, and constant threat, which should not be underestimated. People exposed to stressful life events (i.e., marriage dissolution, job loss or insecurity, death of family members, legal prosecution, eviction, serious financial trouble, etc.) have higher mortality rates. There are several possible psychosocial pathways linking stressful life events with higher morbidity and mortality, some involve biological factors such as immune and neuroendocrine systems, while others are related to the psychosocial and cultural dimensions (Marmot & Wilkinson, 2006).

A research domain based on social inequity, disease, and poor health outcomes offers an opportunity to explore pressing mental health and social issues while forging links among different disciplines and research topics. Societies with greater social inequality tend to have higher rates of death from most causes including alcohol-related morbidity, drug abuse, self-inflicted injuries and suicide, crime, homicide as well as elevated rates of both interpersonal and collective violence (Wilkinson & Pickett, 2006).

In every society, health and disease are unequally distributed with some segments or groups experiencing better health outcomes across multiple measures (Evans, Barer, & Marmor, 1994). From the perspective of social sciences, health may be seen as a product or a commodity and illness as the result of inequity in the distribution of resources and unequal access to wealth and power. Power in society relies not only on domination, control, repression, and submission of others, but also is expressed in the ability to define what is acceptable, appropriate, and considered normal (Lock & Lindenbaum, 1993). The critical public health approach borrows from social science perspectives to argue that distress, disease, and human suffering are social productions modeled by the structural power relations at work in the larger society (Pedersen, 2012). Hence, dominant groups can normalize health inequalities by defining them as an expectable or inevitable state of affairs, or as deplorable but attributable to characteristics of the affected individuals rather than structural violence (Farmer, 2004).

In sum, the study of social determinants of health makes it clear that there is a continuous loop from the molecular biology of cells and physiology to the health of populations, and back again, in which the past and present social environment of individuals (and their perceptions of those environments) constitute key links and

pathways (Evans et al., 1994). In the coming decades, one of the main challenges will be advancing a global mental health research agenda that can elucidate these linkages and pathways to identify sites and modes of effective intervention.

Poverty, structural violence, and structural competence in GMH research

An important cross-cutting area of global mental health research involves the systematic exploration of the ways in which health inequalities are historically and socially produced. This should not be limited to the analysis of how illness, including mental illness, is socially distributed, but—as proposed by Byron Good—must examine how political and economic structures are embodied in illness experience every bit as much as are early family experience and biology (Good, 1994). While most social scientists recognize the interplay of historical, social, and economic contexts in the production of health and illness, this recognition is seen as marginal among many biomedical researchers and health practitioners. Moreover, the significance of the social determinants is often underestimated, and generally there has been inadequate articulation of the macrosocial dimensions with the microsocial—the community, family, and individual experiences—and the biological, in attempting to explain the construction of illness and health.

While diseases resulting from poverty and poor environmental conditions, such as diarrhoea or tuberculosis, have often been "medicalized" (transforming largely social and political problems into narrow biomedical concerns) and subject to massive technological interventions, mental disorders and the newly emerging behaviour-related problems challenge conventional biomedical solutions and demand a different approach. As shown in carefully conducted studies, the course and outcome of severe mental disorders depend not solely on access to services, medication, skills, and the availability of professional care, but also on the reactions, care, and support provided by family members and the immediate social network of community resources (Adeponle, Whitley, & Kirmayer, 2012; Campbell & Burgess, 2012; Myers, 2010). Likewise, many behaviour-related disorders have no simple, effective, and readily available bio-technological solution, but require changes in individual *and* collective behaviours as well as interventions directed to both "microsocial processes" and the broader social context (Pedersen, 2012).

A first step in moving toward a new architecture for global mental health would be to acknowledge the fact that unless the cultural, social, political, and economic realities are incorporated into our research and action programs and we begin to address existing social inequalities on the global scale and find ways of improving global governance, the gap between the rich and the poor will continue widening, with consecutive impoverishment of large segments of the population, successive devastation of the natural environment, and consistently poor health outcomes, including mental health (Pedersen, 2013).

Economy and ecology are inseparable, and if distributed fairly across the globe there will be enough for all to lead decent lives in dignity. However, modern capitalism

tends to generate an unequal society, and there is evidence to suggest inequalities will continue to grow (Piketty, 2014). The concentration and accumulation of resources by an elite few will result not only in reinforcing further social inequalities, but also in increasing insecurity and instability, increasing conflicts and violence, and ultimately more suffering, disease, and death (Katz, 2010; Mooney, 2012).

Political economy of psychiatry and evidence-based practice

Research on the nature of mental health problems and the search for interventions to address global health inequities do not occur from a neutral scientific stance. There are a variety of interests that strongly shape research agendas, priorities, and practices. In particular, there are specific political and economic issues relevant to psychiatry as a global institution, often closely allied with the interests of the pharmaceutical industry (Applbaum, 2006; Kirmayer & Raikhel, 2009). This alliance plays out in both explicit and more subtle ways that shape how the profession defines itself and identifies best practices. While claiming to ground practice in scientific evidence, close examination of the production of scientific evidence in psychiatry reveals complex biases that influence how problems are framed and where solutions are sought (Lexchin, 2012).

The call for evidence-based practice (EBP) has been one important strategy for mitigating some of the biases in psychiatric theory and practice. EBP aims to improve the quality, effectiveness, and efficiency of mental health practice by grounding clinical care in interventions for which we have good empirical evidence of effectiveness. However, EBP makes many assumptions about the nature of evidence, its means of production and application in practice. These include commitments at several levels: an epistemological commitment to scientific research as a set of methods for generating evidence; a professional commitment to base clinical practice on scientific research and rational decision-making; and a political commitment to use science to guide health policy and services and arbitrate conflicts and legal disputes (Kirmayer, 2012).

Unfortunately, evidence is not produced on a level-playing field: economic and political forces shape the production, interpretation, and impact of evidence. When the pharmaceutical industry has set the agenda for research on psychiatric medications it has sought to provide evidence to bolster the marketing and positioning of specific medications of dubious worth. As a result, the samples enrolled in studies are often unrepresentative of real-life populations, favoring patients with single diagnoses in tertiary care settings. Positive effects from trials may be exaggerated and negative results may remain undisclosed; hence we lack evidence to accurately assess their utility. A case in point is the recent history of "atypical neuroleptics" which were touted as more effective and better tolerated but which, in fact, are no more therapeutically efficacious and result in increased morbidity and mortality due to metabolic syndrome. Interventions that are not associated

with economic or professional interests tend to get little study. A systematic review of randomized controlled trials (RCTs), therefore, will identify the best-supported interventions from only a very limited pool of potential alternatives. Evidence-based practice can adopt rigorous evaluation standards but is limited by the available evidence.

GMH research is actively working to expand the body of relevant evidence by organizing clinical trials of psychosocial interventions. Much more work is needed, however, to provide a more balanced picture of effective interventions and this needs to include community-based interventions that do not emphasize the toolkit of the medical professions, but rather the mobilization of indigenous resources and strengthening of resilience and coping strategies. Moreover, the outcomes assessed need to reflect local contexts and priorities and to follow patients over a long enough span of time to capture stable trajectories.

A balanced global mental health research agenda for the future must focus not only on the biological (i.e., molecular) bases and global burden of mental disorders, but also on the social, environmental, and economic (i.e., molar) determinants within which these diseases occur. To maximize the research capacity for innovation in low- and middle-income countries (LMICs) and knowledge transfer for global health, we need to travel in at least two distinct directions of the innovation process: *downstream*, searching for biotechnological and psychosocial solutions exemplified by global public–private product development partnerships (i.e., new drugs, devices, diagnostic and therapeutic procedures) to build more efficacious interventions in the secondary prevention and clinical domains; and *mid and upstream*, in exploring more actively the more distant causes: the social and environmental origins of health and disease or the "causes of the causes," in search of systemic social solutions and collective interventions, exemplified by health policy and health systems research from a multisectoral, cross-cultural, and transdisciplinary perspective. It seems clear from the discussion above that in the future, a unifying new paradigm for global mental health needs to be driven by both biotechnological and social innovations (Gardner, Acharya, & Yach, 2007).

Knowledge translation in global mental health

GMH tends to be framed in the conceptual language of psychiatry but there are local ways of understanding mental health and social problems that are important to understand, not only because they govern help-seeking and coping but also because they may provide novel strategies for intervention. At present, public health approaches to mental health promotion have emphasized mental health literacy, aiming to give lay people a better understanding of the nature of common mental health problems and improve access and referral to mental health services when appropriate. However, current approaches to mental health literacy do not sufficiently engage with local or folk understandings of mental health problems.

Although there is recognition in GMH of local cultural variability, scaling up interventions depends on having tools and interventions that are widely applicable. This fits with the WHO mandate and with the core commitment in biomedicine and psychiatry to translating scientific evidence into practice. From this perspective, a reasonable first step involves educating community workers and laypeople in general notions of mental health. However, in practice this may mean offering explanations of problems that do not fit well with local understandings or that actually undermine interpretive systems that are associated with coping strategies, healing practices, social support, and integration. While there is evidence that people with severe mental disorders face stigmatization and social exclusion in most societies, there is also some indication that people whose behaviour is not threatening or disruptive may be better integrated in smaller communities, nonurban settings, and cultural contexts where unusual experiences are not necessarily labeled as shameful and discriminated against, but may be given positive meaning. The hope that offering biological explanations for psychiatric disorders would reduce stigma has turned out to be naïve, in that biological explanations may convey less sense of personal agency but greater implication of chronicity and pessimism for recovery (Kvaale, Gottdiener, & Haslam, 2013; Kvaale, Haslam, & Gottdiener, 2013). Hence, efforts at mental health literacy must be rethought. Rather than a one-way transmission of knowledge from scientific experts to an ill-informed public, education is better conceived of as a symmetrical and bidirectional exchange of knowledge, values, and perspectives. This sort of dialogue and exchange requires knowledge of the other and indicates the need for continued research on lay concepts of mental disorders (Kirmayer & Ban, 2013).

Conclusion

Some of the disagreements and divergence of opinion in the debate on global mental health occur because opponents have in mind very different types of problems. For example, many proponents of GMH focus on the most severely mentally ill in low-income countries who currently receive little or no effective treatment and who may endure harsh conditions including long-term physical restraints, confinement, and noxious interventions that cause injury. On the opposite end, some critics of GMH focus on examples of people with milder cases of common mental health problems that overlap with everyday problems in living. Clearly, the appropriate responses to these opposite ends of the spectrum of severity need to be quite different and there may be some consensus when focusing on a specific type of problem or scenario. For example, most would agree that there are effective alternatives for people with chronic psychotic disorders who are chronically restrained and that medication may play an important role in reducing the use of physical restraints. Similarly, many would agree that people with milder cases of depression or anxiety should not be treated with medication and are likely to be best helped by interventions that include lifestyle changes, social support, and coping methods that build on their own skills and local resources.

Despite areas of agreement, however, there are persistent controversies. In particular, there is uncertainty about the universal applicability of existing diagnostic categories and treatments, the quality of available interventions, and the evidence as to what works. Even with interventions that have established efficacy, there may be questions about the relevance to different social and cultural contexts of the outcomes measured in clinical trials. Finally, there is concern about the need to protect and promote local, indigenous methods of helping, healing, and recovery, which may have multiple personal and social functions in addition to their therapeutic efficacy, serving to strengthen and maintain identity and community.

GMH and the evidence-based practice of psychiatry are at a crossroads facing major challenges that must be addressed. GMH cannot disregard the growing body of empirical evidence pointing to the primary importance of the nontechnical aspects of mental healthcare. Psychiatry should no longer be conceived as applied neuroscience (Kirmayer & Gold, 2012). Only by moving beyond the dominant technical paradigm can GMH achieve real collaboration with local communities and service users. We concur with Bracken and collaborators, that substantive progress in the field of psychiatry

> will not come from neuroscience and pharmaceuticals (important as these might be), but from a fundamental re-examination of what mental healthcare is all about and a rethinking of how genuine knowledge and expertise can be developed in the field of mental health. (Bracken et al., 2012, p. 431)

These challenges and persistent areas of controversy point to the need for a broader research agenda in global mental health (Kirmayer & Crafa, 2014). In psychiatry, this broader research program would include work on the relevance of existing nosological systems and their impact on help-seeking, illness course, and treatment response. In addition to refining international classification systems, there is a need to develop assessment approaches that are sensitive to local idioms of distress. Understanding local modes of coping, resilience, and recovery can guide both public health efforts at mental health promotion and clinical interventions. While current studies are evaluating the impact of mental health interventions in social and cultural context, this work must include attention to broader outcomes that reflect local concerns. Moreover, rather than simply testing conventional (usually Western) treatments, efforts are needed to examine the costs and benefits of indigenous healing systems. Comparative mental health policy and mental health systems research, using multisectoral, cross-cultural, and transdisciplinary approaches can provide the basis for a renewed global mental health agenda that is more inclusive, participatory, and responsive to local realities and perspectives.

Note

1. Videos of the Advanced Study Institute (ASI) presentations are available online at http://www.mcgill.ca/tcpsych/videos/asi-videos/2012.

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