Why mental health matters to global health

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Article

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Abstract
Global health has been defined as an area of study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide. This article provides an overview of some central issues in global mental health in three parts. The first part demonstrates why mental health is relevant to global health by examining three key principles of global health: priority setting based on the burden of health problems, health inequalities and its global scope in particular in relation to the determinants and solutions for health problems. The second part considers and addresses the key critiques of global mental health: (a) that the "diagnoses" of mental disorders are not valid because there are no biological markers for these conditions; (b) that the strong association of social determinants undermines the use of biomedical interventions; (c) that the field is a proxy for the expansion of the pharmaceutical industry; and (d) that the actions of global mental health are equivalent to "medical imperialism" and it is a "psychiatric export." The final part discusses the opportunities for the field, piggybacking on the surge of interest in global health more broadly and on the growing acknowledgment of mental disorders as a key target for global health action.

Keywords
critique, global mental health

Introduction

Global health is the new incarnation of what we once called "international health" and, going back further in time, "tropical medicine." Global health has been recently defined as "an area for study, research and practice that places a priority on improving health and achieving equity in health for all people worldwide"

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(Koplan et al., 2009). Global health stands out from its predecessors in three key respects: first, its priorities are determined by the burden of disease; second, its driving philosophy is equity, that is, justice and fairness in the distribution of health within and between populations; and third, its scope is global, that is, it concerns knowledge and actions which can benefit the health of people globally. Global health emphasizes global learning; thus, while international health was built on the tradition of what the "developed world" could teach those in the "developing world," global health emphasizes what all countries can learn from each other and do together to address the health of all the peoples who must share our planet (K. S. Reddy, personal communication). The quotation marks I have used in the preceding sentence signify my caution with such simplistic characterizations of a globalizing world where resource levels are a better way to describe contexts—in this sense, the "developed world" reflects the contexts which are better endowed with resources and have held more power in global discourses, including medicine, than the "developing world." This paper considers evidence to make the case that mental health is not only relevant to global health in all these respects, but in fact lies at its very heart. The paper then addresses some of the critiques of global mental health which have been raised in other discourses, including in an earlier issue of *Transcultural Psychiatry* (Summerfield, 2012) and at the Advanced Study Institute on "Cultural Psychiatry and Global Mental Health: Bridging the Perspectives of Cultural Psychiatry and Public Health" held at McGill University in June 2012 (see www.mcgill.ca/tcpsych),[1] and ends with a consideration of the opportunities and way forward.

Why mental health matters to global health

To address this question, let us consider each of the principles of global health. First, consider the burden principle. Burden can be assessed in several ways. At its crudest is the estimation of numbers of people affected; by even the most conservative estimates of the most serious mental disorders such as the psychoses, intellectual disability, dementias, drug and alcohol dependence, and severe depression, at least 5% of any population is affected. Translated into absolute numbers, this would mean at least 300 to 400 million affected people globally, the vast majority of whom live in developing countries. A life lived with a mental disorder is, typically, a much reduced one—even in rich countries, life expectancies for people with mental disorders are as much as 20 years shorter than for those without them (Wahlbeck, Westman, Nordentoft, Gissler, & Laursen, 2011). In some countries, there are few adults in the community with intellectual disabilities—given that the childhood prevalence of this condition is relatively high, one is forced to conclude that these children died prematurely (Patel, Simbine, Soares, Weiss, & Wheeler, 2007). Mental disorders also kill people in more direct ways. Suicide is now amongst the leading causes of death in young adults in all countries (Patton et al., 2009); in a recent study from India, suicide was ranked the second leading cause of death, killing as many young women as maternal causes and twice as many people as HIV/AIDS

(Patel, Ramasundarahettige, et al., 2012). Some argue that suicide is primarily related to social determinants, but choose to ignore the fact that this is equally true of most health outcomes and that this in itself does not imply that mental illness does not play a role (which, many studies from developing countries, have shown it does; [Vijayakumar, John, Pirkis, & Whiteford, 2005]). Irrespective of its distal determinant, suicide is itself a preventable mental health outcome as it involves the psychological characteristic of an intention to harm oneself. The premature mortality experienced by persons with other mental disorders, such as schizophrenia and substance misuse, is mediated through a range of other pathways including unhealthy lifestyles, poor physical health, and lack of access to avenues for health promotion. But beyond mortality, we also have to consider the impact of a health condition on the quality of the life we have saved; the strong association of mental disorder with disability is well recognized. When the combined effect of mental disorders on life expectancy and the quality of life lived is estimated using the DALY (disability adjusted life years; Murray et al., 2013) metric, we find that about 7% of the global burden of disease is attributable to these disorders (Lopez, Mathers, Ezzati, Jamison, & Murray, 2006; Murray et al., 2012). And this figure does not even take into account the impact of mental disorders on other health problems (e.g., the contribution of depression in mothers to child undernutrition [Surkan, Kennedy, Hurley, & Black, 2011]) or the economic consequences or consequences on caregivers. No doubt there have been critiques of the use of the DALY metric but it is worth noting that this is the only metric currently available to describe and compare the burden of health conditions around the world.

Second, consider the principle of equity or fairness. The central issue, from a global perspective, is not just the enormous burden and staggering numbers of people affected by mental disorders, but the fact that the vast majority of these persons do not receive the care we know can greatly improve their lives. In no country in the world is the proportion of expenditure of the health budget on mental health reflective of the overall burden of mental disorders (World Health Organization, 2011). Even in the best resourced countries of the world, up to half of affected families suffer alone (Wittchen & Jacobi, 2005). In the least resourced countries, this figure reaches an astonishing 90% even for the most severe mental disorders such as schizophrenia (Lora et al., 2012). This, despite the robust knowledge of the effectiveness of specific treatments and of packages of care—from medicines to psychological treatments to social interventions—that we possess (Patel, Araya, et al., 2007; Patel & Thornicroft, 2009; World Health Organization, 2010). The consequences are tragic. Speak to anyone who has been affected by a mental disorder, either directly or as a caregiver, and the chances are that you will hear stories of hidden suffering, shame, and frank discrimination in schools, in the community, at work, and even in health care settings. The most heart-breaking stories of all are those of the countless thousands who are abused, chained, and imprisoned in mental hospitals, the very institutions built to care for them (Patel, Kleinman, & Saraceno, 2012). The denial of quality medical care to people with mental disorders is one of the reasons for the substantial life

expectancy gap described earlier. The problem of the human rights violations of people with mental disorders represents nothing less than a "failure of humanity" (Kleinman, 2009).

Third, the principle of global knowledge and actions to promote global health. Much of the evidence to guide the understanding and treatment of mental disorders in biomedical systems of knowledge emanates from a relatively small fraction of the global population (i.e., the developed world; [Patel, 2007]). However, there is an equally rich tradition of knowledge and innovation which exists in the rest of the world, and which can inform and transform global mental health practice. The incorporation of psychological strategies from "Eastern" traditions into "Western" psychological treatments has led to the emergence of hybrid approaches such as mindfulness-based cognitive therapy. The innovative use of lay and community health workers to deliver mental health interventions, evaluated in clinical trials for a range of mental disorders, is an example of the creativity borne out of the grave scarcity of specialized health professionals in developing countries (Patel, 2012). Several lessons emerge from these experiments for which I have coined the acronym "SUNDAR" (which means "attractive" in the Hindi language). First, that we should ***S***implify the messages we use to convey mental health issues, for example avoiding using psychiatric labels which can cause shame or misunderstanding. Second, that we should simplify our interventions by ***UN***packing them into components which are easier to deliver. Third, that care should be ***D***elivered as close as possible to people's homes. Fourth, that we should recruit and train ***A***vailable manpower from the local communities to deliver these interventions. And finally, that we should judiciously ***R***eallocate the skills of specialized manpower to supervise and support these community health agents. What is truly *sundar* about this innovation of task-sharing is its potential significance for developed countries where the costs of mental health care are spiraling out of control and mental health care has become heavily professionalized and remote from communities. It is this collective evidence of knowledge and experience, from diverse societies around the world, which offers the greatest promise for reducing the global burden of mental disorders. Recently, a number of global initiatives (briefly summarized later in the article) have further blurred the boundaries between developed and developing countries and present new opportunities for local and global action in this field.

Critiques of global mental health

There are, of course, several critiques of the objectives, assumptions, and strategies which underlie the principles of global mental health. At the heart of the critiques is the idea that mental disorders are not "real" causes of human suffering and the use of a biomedical paradigm is inherently flawed. Four specific critiques are frequently invoked: (a) that in the absence of a biological marker, psychiatric diagnostic

categories lack validity; (b) that as social determinants play a key role, therefore there is, at best, only a minimal role for individual health care; (c) that the discipline is a front for the interests of the pharmaceutical industry; and (d) that applying knowledge generated in developed contexts to developing ones is tantamount to "medical imperialism." I will address each of these in turn.

The "diagnoses" of mental disorders are not valid

Critics argue that there is no validity to the diagnoses of mental disorders because there is no biological marker to verify the diagnosis. In this worldview, a person is sick only if one can demonstrate a biomarker for their sickness. By this yardstick, tuberculosis could not be considered a disorder till Koch discovered the bacillus responsible for it, and dementia was not a disorder (indeed, it was often seen as simply growing old badly) until its defining neuropathological features were identified. This critique ignores the crucial differentiation of illness and disease (Helman, 1981) and the central role of both concepts in the process of understanding the nature and causes of human sickness. Put simply, in order to identify the biological basis of a sickness (the "disease"), one has to first define the phenotype (the "illness"). Without the latter, the former will always be elusive. So, in rejecting the phenomenological approach adopted in psychiatric diagnosis because there is no biological correlate, the critics in effect reject any possibility of ever identifying one! Curiously, despite the absence of a biomarker, the concerns about validity do not extend to mental disorders like intellectual disability, drug dependence, and psychoses. In effect, we discover that the critique is primarily focused on depression, anxiety, and other "common mental disorders" (Summerfield, 2012). Of course, these critiques are absolutely on the mark when they emphasize how difficult it is to distinguish the miseries of daily life from "clinical" depression. Trying to define this distinction is precisely what decades of psychiatric research has attempted to address and while the current solution (an algorithmic system which takes into account the number, type, duration, and impact of illness experiences) is not perfect, it is the best we have at present and there is work afoot to refine its validity. Notwithstanding the absence of a gold standard for the diagnosis of depression, there are a number of other types of validity which one can also lean on: historical validity (e.g., that conditions which bear a remarkable similarity to depression have been described in a wide range of systems of medicine, and well before biomedical psychiatry came into existence); face validity (e.g., when presented with vignettes of persons with symptoms of depression, traditional healers and primary care practitioners recognize these as health conditions they encounter); predictive validity (e.g., that people with a diagnosis of depression are more likely to kill themselves); and concurrent validity (e.g., that people with a diagnosis of depression are more likely to seek health care or that maternal depression is associated with child development and growth problems).

Social determinants invalidate the use of biomedical interventions

This critique concerns the use of biomedical treatments in light of the robust evidence about the social determinants of mental disorders. Of course, the recognition of the social determinants of mental disorders is one of the foundations of global mental health (Patel, 2012), but to dismiss the role of health care because of this association would be tantamount to telling a woman whose arm has been broken by her violent husband that she should approach political leaders to sort out gender inequalities rather than fixing her arm! The dichotomy of social determinants and biological mechanisms is an inherently naive and flawed view of human health. In reality, virtually all health conditions are influenced by social determinants but are ultimately mediated through biological pathways. There is need for action at both levels, that is, at the level of social determinants to prevent illness, and at the level of health care to address the illness which is already established. In all countries, social disadvantage is a common accompaniment of mental disorder. Poverty, unemployment, and impoverished social relationships both increase the risk for mental disorders, and are also the outcomes of these conditions (Patel et al., 2009). But importantly, as has been shown in a recent review, some of these adverse socioeconomic outcomes can be reversed with effective mental health care interventions (Lund et al., 2011), breaking the vicious cycle of poverty and mental disorders. Furthermore, all of the psychosocial approaches to address mental disorders in developing countries explicitly acknowledge the role of social determinants as targets for action, for example, through addressing livelihood skills or interpersonal skills and mobilizing community resources (Balaji et al., 2012; Raja et al., 2012; Verdeli et al., 2004). Indeed, the hallmark of global mental health is to emphasize the simultaneous need for social interventions alongside biomedical interventions as appropriate for the individual. In the MANAS (Manashanti Sudhar Shodh; Patel et al., 2010) trial in primary care in India, for example, providing advice about women's shelters and legal rights was as critical an element of the intervention for severely depressed women as the use of antidepressants (Chatterjee et al., 2008).

Global mental health is a front for the expansion of the pharmaceutical industry

I am conscious that there are raging debates about the medicalization of seemingly everyday miseries by a psychiatry increasingly dominated and, in some instances, corrupted by the pharmaceutical industry (Frances, 2013). Global mental health shares these concerns totally. Yet, it has been claimed that global mental health is a front for the pharmaceutical industry. This is an allegation without any substance. Virtually every major initiative which has defined this field has been funded by governments or charities with no association with the pharmaceutical industry, for example, the Department for International Development (DFID), the Wellcome Trust, the National Institute for Mental Health (NIMH), and Grand

Challenges Canada. The vast majority of clinical trials and intervention programs in global mental health have principally involved psychosocial interventions. Still, it is equally important to recognize that medicines do play a role in mental health care, as has been shown very ably in the WHO's mhGAP guidelines (Dua et al., 2011). These guidelines list only generic medicines with a strong evidence base and such treatments are typically "packaged" with psychosocial interventions (Patel & Thornicroft, 2009). Multinational drug companies have little to profit from these recommendations, with manufacturers in developing countries playing a bigger role in the generics marketplace. One critic writes that "the Western cultural backdrop to these trends is of a relentless rise in the medicalisation and professionalisation of everyday life" (Summerfield, 2012: 520). Certainly, most global mental health practitioners would agree with this critique! But such critiques should focus on the overuse of psychiatric diagnoses and drugs in the developed world when, in reality, the majority of people with even severe mental disorders in the rest of the world do not ever receive a diagnosis, let alone any evidence-based medications (Plos Medicine Editors, 2013).

Global mental health is equivalent to "medical imperialism" and is a "psychiatric export"

As explained earlier, global mental health is firmly rooted within the discipline of global health, not psychiatry, and espouses its values of multidisciplinary approaches to understanding and addressing mental health inequalities. A substantial proportion of evidence is grounded in qualitative methods and led by social scientists and diverse mental health professionals, working with community-based organizations with a strong social justice imperative. The full range of tools which are transferred between cultures undergo systematic adaptation to ensure they are contextually appropriate; for example, an intervention may take years of mixed-methods research to develop before it is evaluated in a trial. Research instruments undergo thorough contextual adaptations, including modifications of content and language. The voices of persons with mental disorders are often central to these concerns. In fact, it would be fair to say that the defining characteristic of global mental health research is that it is carried out with great attention to context and culture and by investigators with a profound understanding of the setting of their research and compassion for their "subjects." One of the unique aspects of global mental health is the extent of engagement with communities and acknowledgment of context in the design, implementation, evaluation, and uptake of research.

In summary, the critiques of global mental health fail to recognize how deeply the social sciences and cultural psychiatry have influenced its principles and methods. Many of the critiques remind one of a most virulent brand of cultural relativism which smacks not only of ignorance of a vast body of scientific evidence but, more disturbingly, of the racist ideologies that led one-time colonial administrators to deny mental health care to the "natives" because they were either perceived to be

psychologically immature or had supernatural treatments to deal with their conditions (Le Roux, 1973).

Opportunities and the way forward

Global mental health is concerned with promoting the quality of life of people with mental disorders worldwide, most of whom live in low- and middle-income countries which enjoy only a tiny fraction of global mental health resources. Reassuringly, there is a growing recognition of the unmet needs of people affected by mental disorders and concrete actions are being taken to invest in global mental health. Today, global mental health has captured the imagination of a wide range of stakeholders, from consumer and civil society groups, to national policy makers to international donors and development agencies. The Movement for Global Mental Health (www.globalmentalhealth.org) has provided a virtual platform for professionals and civil society to stand together to call for action on improving access to care and promoting the human rights of people with mental disorders globally. A substantial proportion of its members are from civil society and include significant numbers of people affected by mental disorders. The Grand Challenges in Mental Health (Collins et al., 2011), supported by leading national research agencies from countries around the world, sought to identify the key research investments necessary to reduce the global burden of mental disorders and, not surprisingly, reported that initiatives aimed at improving access to care were the leading priorities. The leading five challenges were: integrating the screening and packages of services in routine primary health care; reducing the cost and improving the supply of effective medications; improving children's access to evidence-based care; providing effective and affordable community-based care and rehabilitation; and strengthening the mental health education of all health care personnel. Several government and charitable funders have responded to these challenges with commitments exceeding 50 million dollars in the past couple of years. Apart from the growing body of experimental evaluations of task-sharing for mental health interventions, there is also a growing body of well-documented programs in low-resource settings which demonstrate how contextually appropriate and affordable care can be delivered which addresses a diverse set of needs of people affected by mental disorders (Cohen et al., 2011). Several countries (including Chile, Brazil, India, South Africa, and China) have taken major steps to increase public resource allocation for mental health care, with a strong emphasis on primary care delivery systems (Eaton et al., 2011). The growing global concern about mental health reached a high point in May 2013 when the World Health Assembly unanimously passed the WHO's comprehensive mental health care plan (Saxena, Funk & Chisholm, 2013). Notably, much of the driving force in global mental health is being led by investigators and policy makers based in developing countries. The growing acknowledgement of and increasing resources allocated to global mental health present a golden opportunity to facilitate a better life for people with mental disorders. This opportunity is the result of decades of research, innovation, and

advocacy by countless thousands of foot soldiers from diverse disciplines and countries who have devoted their lives to this goal. The ideological heart of global mental health lies in the central position of global health which calls for universal health care, and which allocates equitable resources for mental health.

We need to reject, once and for all, archaic dichotomies which have for too long bedevilled the discourse on unmet needs for care and delayed action on the ground. The first such dichotomy is between universality and relativism. We need to accept that in attempting to achieve universal health care, particularly in low-resource settings, there will be a natural tension between approaches which are exquisitely sensitive to local contexts and the demands of patients, policy makers, and practitioners for pragmatic solutions for health problems which can be implemented at scale in routine health care settings. In every setting, a balance between these poles will need to be struck based on contextual factors. The second dichotomy we need to set aside is that of social determinants versus biological determinants since all health conditions involve a profound and complex interaction between genetic, environmental, and social factors. The often cited biopsychosocial framework is an absolutely appropriate approach to understand mental disorders. The third dichotomy to reject is that between diagnosis and distress. There is no doubt that many health conditions, exemplified by diabetes, hypertension, and depression, are best described in the population as dimensions of illness or suffering. However, binary categories are often needed for health care and policy purposes, for example to define who should receive an intervention or how resources are allocated. A key scientific goal for global mental health is to constantly refine our understanding of where to draw the line between "case" and "normal" so as to ensure that scarce health care resources are used efficiently and normal forms of human suffering are not medicalized.

Conclusion

There is a robust body of evidence, generated by diverse disciplinary approaches, which testify to the burden of a range of mental disorders in countries around the world. These investigations vividly illustrate the daily tragedies played out in the lives of countless millions as a direct consequence of the lack of access to evidence-based mental health care. Global mental health is not, as one commentator has suggested, "the Americanization of mental illness" (Watters, 2010) for the simple reason that these disorders represent universal forms of human suffering which have been described in every society from times immemorial, well before the emergence of a biomedical psychiatry, or the pharmaceutical industry, or even the existence of America as a nation. Cultural and contextual factors profoundly influence all aspects of the mental illness experience, from its aetiology, to its expression, to the kind of help sought and the outcomes achieved. However, while we must explicitly recognize the crucial roles played by cultural and contextual factors, it is equally important not to romanticize the status quo, for example by overvalorizing indigenous medical practices (which in some instances can include flogging,

branding, and being labelled a witch). It is simply unethical to withhold what biomedicine has to offer, simply because it was "invented" somewhere else.

There is no doubt, of course, that the practice of global mental health is imperfect, but then this is the nature of any form of social engagement with the real world, which is necessarily complex and messy—the only "pure" position is that of the armchair. The hard grind of trying to make a difference on the ground, warts and all, may make the discipline more vulnerable to attack from lofty critiques delivered from ivory towers, and will lead to mistakes but also to demonstrated successes. Self-reflection is essential to the improvement of the practice of global mental health. While there must always be space for discourse and conflicting ideas, these must be based firmly on an equal commitment to science and to the right of people who are demonstrably unwell to receive care. Thousands of people with mental disorders turn up each day in health centres around the world only to receive inappropriate treatments, or die prematurely, or face discrimination and human rights abuses—we must not allow the false prophets, hiding behind the duplicitous cloak of protecting the "natives" from a profiteering and self-serving "Western biomedical imperialism," distract global mental health practitioners from their duty and responsibility to reduce this suffering. Ultimately, the goal of both cultural psychiatry and global mental health is to work together, as siblings perhaps, with the shared mission of the establishment of mental health as a global public good.

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Note

1. A summary of the debate can be found at http://somatosphere.net/2012/07/global-mental-health-and-its-discontents.html.

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