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Universal mental health: re-evaluating the call for global mental health

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EDITORIAL

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Introduction

We have recently seen the global community of mental health professionals (MHP) and researchers calling for action on global mental health (GMH) (Global Mental Health 2007, 2011, Manning and Patel 2008, Collins and Patel 2011), with a particular focus on low-and middle-income countries (LMIC).

This editorial critically evaluates the logic of this call, charts out its arguments, and proposes further refinements. It interweaves concepts from global health and social determinants of health (SDH) to attempt to build on existing critiques (Béhague 2008, Summerfield 2008, Brhlikova *et al*. 2011, Fernando 2011, Timimi 2011). While re-opening the call, Raviola and colleagues (2011) situated it within the discourse of global health and SDH. The accompanying papers, however, perhaps under-theorized 'global' in global health. As Bozorgmehr (2010) defined it, 'global' implies those 'supraterritorial processes and connections' (Bozorgmehr 2010, para. 30) that not only have a spatial (worldwide) character but also an irreducible global quality. Thus globalization needs to be recognized as the driver for initiatives in global health. Globalization has reconfigured social space with a supraterritorial dimension that houses the playing field of power. This is not to deny the territorial space that interacts with other similar spaces to differing degrees. Rather, such interactions converge with other global processes in this supraterritorial space. The consequent local implications are linked not by distances or levels, but directly through complex pathways. Understanding the SDH requires the study of *links* between the living conditions that determine health, social infrastructure, and how society decides to redistribute resources (Raphael 2006). Thus in inegalitarian societies the poor are more deprived than in comparatively egalitarian societies because fewer investments are made in infrastructure and social services (Navarro and Shi 2001). These investments affect the quality of SDH. Here the focus is on the political, economic, and social processes that shape the quality of SDH. This has been referred to as the *neo-materialistic* approach, which (in contrast to more conventional materialist approach, focusing narrowly on how material conditions link to health status) offers a nuanced, inclusive, and holistic framework for understanding causation, embracing both materialist and socio-cultural determinants, in the context of how economics and (above all) politics shapes these determinants. This approach is enhanced with a class-theoretical perspective in mind (adapted from Navarro 1999, 2009). Thus the focus is on political and policy processes, rather than health as understood in terms of diseases or disease burdens.

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The call for GMH

The call for GMH primarily focuses on the LMIC but recognizes that the call has global implications. Essentially it is a call for scaling up services for mental *disorders* (Eaton *et al*. 2011). This is to be supported on the principles of evidence-base and human rights (Patel and Eaton 2010). It derives its moral strength from calls to both equity and humane treatment. It recommends scaling up of clinical treatments (pharmacological and psychosocial) based on evidence in LMIC (Lancet Global Mental Health Group *et al*. 2007, Patel *et al*. 2007).

The call acknowledges the acute shortfall of resources (Saxena *et al*. 2007, Kakuma *et al*. 2011) for mental health services. It proposes to overcome this with increased government expenditure, primarily on community based services. It plans to tackle the human resource crunch by task-sharing/task-shifting to non-specialist health workforce with necessary training. In addition, it emphasizes advocacy, empowerment, and participatory planning. In keeping with the globalized agenda in health, policy also prescribes public–private partnerships and insurance as a mechanism for public funding of private care.

The arguments that have been put forward by the team are primarily: (i) the huge (economic) burden of mental disorders especially due to their chronic disabling nature, and co-occurrence with other health conditions which tend to complicate each other (Prince *et al*. 2007); and (ii) the economic efficiency of treating mental disorders by clinical means (Lancet Global Mental Health Group *et al*. 2007, Patel *et al*. 2007). The other subsidiary arguments include the promotion of human rights (Maj 2011, Patel *et al*. 2011) and justice (Patel *et al*. 2006, Raviola *et al*. 2011). It is also claimed to be a developmental priority (Lund *et al*. 2011).

The problem with the economic argument

The economic argument is based centrally on the calculation of the burden of mental disorders as measured by Disability Adjusted Life Years (DALY). This is problematic, as for measuring burden, crucial related information that can modify the experience of disease burden (such as support from public services, income, and family) and help seeking are not accounted for (Anand and Hanson 2004). Moreover, the burden as measured does not take into account differences in individual coping ability or burdens borne by family or society at large (Anand and Hanson 2004). Additionally, as Anand and Hanson (2004) argue, the use of standardized maximum life expectancies, much higher than those in LMIC, for calculating DALY implicitly assumes that these life expectancies can be achieved by health interventions alone, rather than non-health sector (developmental) interventions. Thus what is measured is the '*burden of disease and underdevelopment,* and not that of disease alone' (Anand and Hanson 2004, p. 187, authors' emphasis). Furthermore, the problem in measuring co-morbidity leads to an overestimation of the burden. This is especially important for mental disorders where co-morbidity is the rule rather than an exception. More significantly, some critiques have questioned the validity of global burden estimates due to the poor quality of the epidemiological evidence that is used. The problem is more acute for low-income countries (Mathers 2005). Brhlikova *et al*. (2011) reveal how profoundly misplaced this is for calculating the global burden of depression.

The argument of planning mental health services for developmental reasons appears just in order to break the cycle of poverty and mental illness (Lund *et al.* 2011). But the logic of economic gains (of poverty reduction) through provision of mental health services appears misplaced. This is because, firstly, developmental tasks and consequent social justice applies to gains outside the economic matrix. And, secondly, psychiatric interventions that have been shown to influence poverty reduction are practically difficult to instate in low resource settings. This latter problem is vital as the planning of mental health services for developmental purposes is being applied precisely to LMIC. Moreover, for the call, development implies individual poverty measures (cash transfer, loans, debt management), not redistributive policies that influence aggregate measures of poverty or other dimensions of development (equality, literacy).

Scaling up: questioning evidence

Patel and colleagues' (2007) review of treatment and prevention in LMIC, in aggregate, reveals that more than 80% of trials for depression were for psychopharmaceuticals alone. This suggests a bias in the research agenda, when evidence from high income countries (HIC) indicates that both pharmacological and psychological interventions are equally efficacious (Casacalenda *et al.* 2002). Importantly, the recommendation of Selective Serotonin-Reuptake-Inhibitors (Patel *et al.* 2007) among the antidepressants is questionable in the wake of a recent meta-analysis of randomized controlled trials (in HIC) showing their ineffectiveness (Kirsch *et al.* 2008). This has also been true in the case of other newer antidepressants (Turner *et al.* 2008).

For scaling up, a vital condition is the evidence of effectiveness of health interventions in pilot projects (Mangham and Hanson 2010). Here, the outreach and effectiveness of a service delivery system is necessary. For evidence, the call cites research on single disease specific service delivery models that are either stand alone programs (Dias *et al.* 2008), or programs having preexisting structural support (Araya *et al.* 2003, Chatterjee *et al.* 2003) or with a separate monitoring mechanism (Rahman *et al.* 2008). These are models that are appealing to donors and cost-benefit analyses, but are not sustainable for comprehensive health care. A health system that can deliver is rare in most LMIC. These models require clinical cum social measures for consideration of equity in service use and health outcomes. The latter are not taken into account in cost evaluation analysis for scaling up. The foregoing shortcomings bring forth an important barrier to improvement of mental health services in LMIC i.e. the state of functioning of the primary health care system. Though the group of international MHP (Saraceno *et al.* 2007) notes this, it is essential that the call recognizes this explicitly as a crucial roadblock. A worldwide analysis in 2008 of countries with Gross National Income per person of less than $ 4999 (and births more than 100,000 per year) shows that among 80 countries only 14 have constituted a comprehensive primary health care plan (Rohde *et al.* 2008). Recent research suggests strengthened health system as the key to the successful scale-up of services (Coker *et al.* 2004, Tkatchenko-Schmidt *et al.* 2010).

'Global' (mental) health: globalization and its configuration

To set the context of the call, it is important to understand how certain global (supraterritorial) pressures within and outside the health sector influence health and equity. Economic globalization has undergone a qualitative transformation (Woodward *et al*. 2001), with the expansion (and sometime the imposition) of neo-liberal economic ideas across the globe. A class-theoretical analysis shows how, for the establishment of neo-liberalism, the power of organized labor is weakened, bypassed, or violently repressed by the cohesion of the businesses and corporations and their capacity as a class to suborn state power (Harvey 2005). Thus the terms of global (economic) exchange are controlled and overseen by the following mix of multilateral economic organizations, namely the International Monitory Fund, the World Trade Organization, and the World Bank (Wade 2003). To understand how globalization contours health, a holistic model (Labonte and Torgerson 2005) within the SDH framework allows us to focus on local and global links. One vital context is Structural Adjustment Policies and the 'evidence-free' implementation of Health Sector Reforms (Whitehead *et al*. 2007). These policies, aimed at opening markets globally to international capital, have assisted in the privatization of public assets (Pollock and Price 2000), and had profound effects on health and equity (Labonté and Schrecker 2007a). Thus health systems that consider not only access to health care but also macroeconomic, domestic, and local political economic environments can best engage with the SDH (Labonté and Schrecker 2007b). Increasingly neo-materialist work on the SDH has been able to gather evidence on the linkages between politics, policies, and population health (Davey Smith *et al*. 2000, Navarro *et al*. 2006, Muntaner *et al*. 2011). For mental health, although there is a scarcity of evidence (and the call provides the opportunity to vocalize such research agendas), trends in living and working conditions across nations have shown adverse effects on mental health (Quinlan *et al*. 2001, Stuckler *et al*. 2009). The call for *global* mental health (and not just mental disorders) therefore needs to take into consideration the power dynamics that shape the quality of the SHD. This may have implications for 'mental health' in a broader sense.

The pathways to link such macrofactors to individual and community mental health are complex. These involve more than just the cultural influences of globalization, associated identity shifts, and proposed 'acculturative stress' (Bhavsar and Bhugra 2008). Rather, any attempt at understanding culture and mental health requires engagement with the 'material realities of people's lives' (Swartz 2008, p. 305). These interactive forces, set within the global dynamics of power, can also help us understand research biases and the call's Eurocentric nature (Béhague 2008, Fernando 2011).

Enhancing the call

A call for GMH needs, then, to properly encompass the global (meaning supraterritorial) context of mental health, and accordingly set the research agenda. Global and local (class, gender, and, in many cases, caste) power structures and their alliances across this domain influence the patterning of policies that have deep influences on health service and program orientation. This may also help to include service users' voices (starting from agenda setting) (Timimi 2011) and strengthen the rights-based argument of the call. Power dynamics also have influence on how

diagnostic categories are defined. GMH research should call for inclusion of local forms of knowledge and philosophy in defining mental dysfunction and in generating solutions (Summerfield 2008). Pertinent social science research at this juncture may look into the discursive proceedings that 'critically examine the interaction of both local and global systems of knowledge and power' (Kirmayer 2006).

Economic arguments, as articulated in the call, can undermine arguments for health equity and justice. Any optimism toward community movement in mental health should not be based on the argument of economic efficiency, but the right to social participation in the community. And this is to be reinforced by a network of supportive provisioning.

A renewed call for a focus on mental health in LMIC is timely. However, this editorial has argued for our understanding of 'GMH' to go beyond conceptualizing mental health as a universal, worldwide challenge, or to focus on the transnational flows of mental health workforces, financial resources, and pharmaceuticals (Patel and Prince 2010). More fundamentally, meeting the challenges of GMH requires an understanding of *globalized* mental health, informed by research on how global economic and political forces structure the mental health and well-being of those in LMIC.

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References

Anand, S. and Hanson, K., 2004. Disability-adjusted life years: a critical review. *In*: S. Anand, F. Peter and A. Sen, eds. *Public health, ethics, and equity*. Oxford: Oxford University Press, 183–199.

Araya, R., *et al*., 2003. Treating depression in primary care in low-income women in Santiago, Chile: a randomised controlled trial. *Lancet*, 361, 995–1000.

Béhague, D.P., 2008. The domains of psychiatric practice: from centre to periphery. *Culture, Medicine and Psychiatry*, 32, 140–151.

Bhavsar, V and Bhugra, D., 2008. Globalization: mental health and social economic factors. *Global Social Policy*, 8, 378–396.

Bozorgmehr, K., 2010. Rethinking the 'global' in global health: a dialectic approach. *Globalization and Health* [online], 6, 19. Available from: http://www.globalizationandhealth.com/content/6/1/19 [Accessed 3 Nov 2011].

Brhlikova, P., Pollock, A.P., and Manners, R., 2011. Global burden of disease estimates of depression – how reliable is the epidemiological evidence? *Journal of the Royal Society of Medicine*, 104, 25–35.

Casacalenda, N., Perry, C.J., and Looper, K., 2002. Remission in major depressive disorder: a comparison of pharmacotherapy, psychotherapy, and control conditions. *American Journal of Psychiatry*, 159, 1354–1360.

Chatterjee, S., *et al*., 2003. Evaluation of a community based rehabilitation model for chronic schizophrenia in a rural region of India. *British Journal of Psychiatry*, 182, 57–62.

Coker, R., Atun, R., and McKee, M., 2004. Health care system frailties and public health control of communicable disease on the European Union's new Eastern border. *Lancet*, 363, 1389–1392.

Collins, P. and Patel, V, 2011. Grand challenges in global mental health. *Nature*, 475, 27–30.

Davey Smith, G., Gunnell, D., and Shlomo, Y.B., 2000. Life course approaches to socio-economic differentials in cause- specific adult mortality. *In*: D. Leon and G. Walt, eds. *Poverty, inequality and health: an international perspective*. London: Oxford University Press, 242–273.

Dias, A., *et al*., 2008. The effectiveness of a home care program for supporting caregivers of persons with dementia in developing countries: a randomised controlled trial from Goa, India. *PloS One*, 3, e2333.

Eaton, J., *et al*., 2011. Scale up of services for mental health in low-income and middle-income countries. *Lancet*, 378, 1592–1603.

Fernando, S., 2011. A 'global' mental health program or markets for big pharma? *OpenMind* [online], 168, 22. Available from: http://www.sumanfernando.com/Global%20Program%20&%20Big%20Pharma.pdf [Accessed 17 Mar 2012].

Global Mental Health. Launched in London [online], 2007. Available from: http://www.thelancet.com/series/global-mental-health [Accessed 15 May 2011].

Global Mental Health [online], 2011. Available from: http://www.thelancet.com/series/global-mental-health-2011 [Accessed 3 November 2011].

Harvey, D., 2005. *A brief history of neoliberalism*. Oxford: Oxford University Press.

Kakuma, R., *et al*., 2011. Human resources for mental health care: current situation and strategies for action. *Lancet*, 78, 1654–1663.

Kirmayer, L.J., 2006. Beyond the 'New cross-cultural psychiatry': cultural biology, discursive psychology and the ironies of globalization. *Transcultural Psychiatry*, 43, 126–144.

Kirsch, I, *et al*., 2008. Initial severity and antidepressant benefits: a meta-analysis of data submitted to the food and drug administration. *PLoS Medicine*, 5, e45.

Labonté, R. and Schrecker, T., 2007a. Globalization and social determinants of health: the role of the global marketplace (part 2 of 3). *Globalization and Health* [online], 3, 6. Available from: http://www.globalizationandhealth.com/content/3/1/6 [Accessed 15 May 2011].

Labonté, R. and Schrecker, T., 2007b. Globalization and social determinants of health: introduction and methodological background (part 1 of 3). *Globalization and Health* [online], 3, 5. Available from: http://www.globalizationandhealth.com/content/3/1/5 [Accessed 15 May 2011].

Labonte, R. and Torgerson, R., 2005. Interrogating globalization, health and development: towards a comprehensive framework for research, policy and political action. *Critical Public Health*, 15, 157–179.

Lancet Global Mental Health Group, *et al*., 2007. Scale up services for mental disorders: a call for action. *Lancet*, 370, 1241–1252.

Lund, C., *et al*., 2011. Poverty and mental disorders: breaking the cycle in low-income and middle-income countries. *Lancet*, 378, 1502–1514.

Maj, M., 2011. The rights of people with mental disorders: WPA perspective. *Lancet*, 378, 1534–1535.

Mangham, L.J. and Hanson, K., 2010. Scaling up in international health: what are the key issues? *Health Policy and Planning*, 25, 85–96.

Manning, N., and Patel, V., eds, 2008. Globalization and mental health: a special issue of global social policy. Global Social Policy, 8, 299–396.

Mathers, C.D., 2005. *Uncertainty and data availability for the global burden of disease estimates 2000–2002*. Geneva: WHO.

Muntaner, C., *et al*., 2011. Politics, welfare regimes, and population health: controversies and evidence. *Sociology of Health and Illness*, 33, 946–964.

Navarro, V, 1999. Health and equity in the world in the era of "globalization." *International Journal of Health Services*, 29, 215–226.
Navarro, V, 2009. What we mean by social determinants of health. *International Journal of Health Services*, 39, 423–441.
Navarro, V. and Shi, L., 2001. The political context of social inequalities and health. *Social Science and Medicine*, 52, 481–491.
Navarro, V., *et al*., 2006. Politics and health outcomes. *Lancet*, 367, 1033–1037.
Patel, V. and Eaton, J., 2010. Principles to guide mental health policies in low- and middle-income countries (editorial). *Revista Brasileira de Psiquiatria*, 32, 343–344.
Patel, V. and Prince, M., 2010. Global mental health: a new global health field comes of age. *JAMA*, 303, 1976–1977.
Patel, V., Saraceno, B., and Kleinman, A., 2006. Beyond evidence: the moral case for international mental health. *American Journal of Psychiatry*, 163, 1312–1315.
Patel, V, *et al*., 2007. Treatment and prevention of mental disorders in low-income and middle-income countries. *Lancet*, 370, 991–1005.
Patel, V, *et al*., 2011. A renewed agenda for global mental health. *Lancet*, 378, 1441–1442.
Pollock, A. and Price, D., 2000. Rewriting the regulations: how the World Trade Organisation could accelerate privatisation in health-care systems. *Lancet*, 356, 1995–2000.
Prince, M., *et al*., 2007. No health without mental health. *Lancet*, 370, 859–877.
Quinlan, M., Mayhew, C., and Bohle, P., 2001. The global expansion of precarious employment, work disorganization, and consequences for occupational health: a review of recent research. *International Journal of Health Services*, 31, 335–414.
Rahman, A., *et al*., 2008. Cognitive behaviour therapy-based intervention by community health workers for mothers with depression and their infants in rural Pakistan: a cluster-randomised controlled trial. *Lancet*, 372, 902–909.
Raphael, D., 2006. Social Determinants of health: present status, unanswered questions, and future directions. *International Journal of Health Services*, 36, 651–677.
Raviola, G., Becker, A.E., and Farmer, P., 2011. A global scope for global health-including mental health. *Lancet*, 378, 1613–1615.
Rohde, J., *et al*., 2008. 30 years after Alma-Ata: has primary health care worked in countries? *Lancet*, 372, 950–961.
Saraceno, B., *et al*., 2007. Barriers to improvement of mental health services in low-income and middle-income countries. *Lancet*, 370, 1164–1174.
Saxena, S., *et al*., 2007. Resources for mental health: scarcity, inequity, and inefficiency. *Lancet*, 370, 878–889.
Stuckler, D., *et al*., 2009. The public health effect of economic crises and alternative policy responses in Europe: an empirical analysis. *Lancet*, 374, 315–323.
Summerfield, D., 2008. How scientifically valid is the knowledge base of global mental health? *British Medical Journal*, 336, 992–994.
Swartz, L., 2008. Globalization and mental health: changing views of culture and society. *Global Social Policy*, 8, 304–308.
Timimi, S., 2011. A reply to "Grand challenges in mental health". *Somatosphere* [online]. Available from: http://somatosphere.net/?p=2033 [Accessed 17 Mar 2012].
Tkatchenko-Schmidt, E., 2010. Why do health systems matter? Exploring links between health systems and HIV response: a case study from Russia. *Health Policy and Planning*, 25, 1–9.
Turner, E.H., *et al*., 2008. Selective publication of antidepressant trials and its influence on apparent efficacy. *New England Journal of Medicine*, 358, 252–260.
Wade, R., 2003. The invisible hand of the American empire. *Ethics in International Affairs*, 17 (2), 77–88.
Whitehead, M., Dahlgren, G., and McIntyre, D., 2007. Putting equity center stage: challenging evidence-free reforms. *International Journal of Health Services*, 37, 353–361.
Woodward, D., *et al*., 2001. Globalization and health: a framework for analysis and action. *Bulletin of World Health Organization*, 79, 875–881.