

Reciprocity in Global Mental Health Policy

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In an attempt to address inequalities and inequities in mental health provision in low and middle-income countries the WHO commenced the Mental Health Gap Action Programme (mhGAP) in 2008. Four years on from the commencement of this programme of work, the WHO has recently adopted the *Comprehensive Mental Health Action Plan 2013-2020*. This article will critically appraise the strategic direction that the WHO has adopted to address mental health difficulties across the globe. This will include a consideration of the role that the biomedical model of mental health difficulties has had on global strategy. Concerns will be raised that an over-reliance on scaling up medical resources has led to a strengthening of psychiatric hospital-based care, and insufficient emphasis being placed on social and cultural determinants of human distress. We also argue that consensus scientific opinion garnered from consortia of psychiatric ‘experts’ drawn mainly from Europe and North America may not have universal relevance or applicability, and may have served to silence and subjugate local experience and expertise across the globe. In light of the criticisms that have been made of the research that has been conducted into understanding mental health problems in the global south, the article also explores ways in which the evidence-base can be made more relevant and more valid. An important issue that will be highlighted is the apparent lack of reciprocity that exists in the impetus for change in how mental health problems are understood and addressed in low and middle-income countries compared to high-income countries. Whereas there is much focus on the need for change in low and middle-income countries, there is comparatively little critical reflection on practices in high-income countries in the global mental health discourse. We advocate for the development of mental health services that are sensitive to the socio-cultural context in which the services are applied. Despite the appeal of global strategies to promote mental health, it may be that very local solutions are required. The article concludes with some reflections on the strategic objectives identified in the *Comprehensive Mental Health Action Plan 2013-2020* and how this work can be progressed in the future.

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Background

Projections suggest that neurological and substance use disorders will become the second biggest cause of ‘disease burden’ by 2030 (Mathers & Loncar, 2005). The World Health Organization (WHO) has estimated that four out of five people in Low and Middle Income Countries (LMIC) who need services for mental, neurological and/or substance use disorders do not receive them (WHO, 2008). This has been referred to as the ‘treatment gap’; the difference between the levels of mental health need and the capacity within local systems to address these needs. In an effort to increase (or *scale-up*) mental health provision in LMIC, the WHO has published two key documents: the *Mental Health Gap – Action Programme* (mhGAP-AP; WHO, 2008) and the *Mental Health Gap – Intervention Guide* (mhGAP-IG; WHO, 2010a). The mhGAP-AP outlines key steps that the WHO regard as fundamental for scaling-up services in LMIC: secure political commitment, assess needs and resources, develop policy and legislative infrastructure, deliver intervention packages, strengthen human resources, mobilize financial resources, and monitor and evaluate services. The mhGAP-IG progresses this work by presenting integrated management plans for priority conditions including: depression, psychosis, bipolar disorders, and epilepsy in LMIC. While we acknowledge that the WHO initiatives, along with the *Lancet* series on Global Mental Health, have undoubtedly increased awareness about mental health difficulties globally, and within LMIC, we explore here whether there may have been some unintended negative consequences of this work for those living in LMIC.

The focus on biomedical models of illness

Our main concern is that the mhGAP initiative is focused on psychiatric diagnoses. This presupposes that mental health difficulties can be treated in similar ways to physical health problems. However, unlike physical health problems such as polio, influenza, and HIV, the evidence for biomedical *causes* for mental illnesses such as depression and schizophrenia remains fairly weak (Stahl, 2000; Nestler et al., 2002; Wyatt & Midkiff, 2006). It is important to determine the potential detrimental effects of aligning the treatment of mental health difficulties too closely to a biomedical model. The use of biogenetic causal explanations of mental health difficulties and diagnostic labeling by the general public has been associated with increased prejudice, fear, and desire for distance being directed at individuals labeled with the mental health difficulty (Read et al., 2006). More recently, Angermeyer et al. (2011) concluded that biogenetic causal models are an inappropriate means of reducing rejection of people with mental health disorders. This is of particular concern in light of claims that the negative effects of prejudice and stigma can actually outweigh the disabling impact of mental health difficulties (Hinshaw & Stier, 2008). For example, Thara et al. (2003) highlighted that the stigma associated with the label ‘schizophrenia’ was such that families of individuals with schizophrenia in India hid the condition because they were fearful about the implications that

this would have for the likelihood of the individual getting married and/or accepted by their local community. Similarly, research from China found that over half of the family members of people with schizophrenia who were surveyed indicated that they concealed the occurrence of schizophrenia within their family (Philips et al., 2002). *Social Labelling Theory* (Waxler, 1974) provides one potential explanation for how psychiatric labels such as schizophrenia can accentuate the impact on the individual. If the individual is given a psychiatric label, s/he 'receives many messages that something is seriously wrong with his (or her) self; his (or her) self-perception and behaviour may conform to these messages and his illness may have a long duration' (Waxler, 1974:379).

It seems that the introduction of biomedical explanations of mental health difficulties may also have potentially detrimental effects on the management of these difficulties. Ethnographic research with the families of people experiencing psychosis in Tanzania highlighted how the introduction of biomedical explanations of mental health difficulties led to the emergence of criticism, hostility and over-involvement within the family – characteristics that are associated with high *expressed-emotion* that had not previously been observed in this cultural context (McGruder, 1999). Reflecting on her work in Tanzania, McGruder described the role that the biomedical model might play in understanding mental health problems as follows: 'We might employ biomedicine as a partial frame, useful at times, but incomplete and inadequate for much of what we want to accomplish' (McGruder, 2001:77). It is important, however, to appreciate that McGruder's observations are laden with assumptions about the globalizability of psychological concepts developed in high-income countries such as the UK.

Biomedical explanations for mental distress inevitably lead to an overreliance on biological 'cures'. Despite the lack of research evidence supporting biomedical causes of mental health difficulties, and the lack of efficacy of medication in dealing with many mental health problems, there has been an exponential increase in the sale of psychotropic medications in recent years (Whittaker, 2010). This increase has not been associated with an increase in understanding about the mechanisms by which these medications work. Within mhGAP-AP there is a template for 'evidence-based interventions' to address each of the priority mental, neurological and substance-use conditions that it identifies, adapted to the situation in different countries. The first line of treatment recommended in many of these templates is psychotropic medication. There is no convincing reason why this should be a universal approach to dealing with mental distress. Although, psychotropic medication may relieve the mental distress that some individuals experience, and should be made available to populations across the world, there is a need to fully understand their benefits, as well as the limitations and the long-term consequences of use of these medications, before they can be advocated as the first line treatment for varied mental health problems. There is a growing body of research that suggests the long-term use of these medications may contribute to the chronicity of morbidity and be harmful to individuals (Luhmann, 2007; Whittaker, 2010).

Antipsychotic medications can contribute to increases in morbidity (metabolic disorders and cardiovascular conditions) and risk of premature mortality linked to sudden cardiac death (Alvarez-Jiminez et al., 2008; Ray et al., 2009; Weinmann et al., 2009).

It is also likely that reliance on psychotropic medications may inhibit the development of other forms of support. For example, Read (2012) observed that in Ghana, psychotropic medications are often synonymous with 'modern' medical treatment, meaning that little consideration is therefore given to psychosocial interventions within psychiatric services. This is despite the fact that the emphasis placed on social functioning in concepts of health in Ghana suggests that treatment approaches which support the resumption of a social role, however limited, may be most valued (Read, 2012). Kitanaka (2011) has also observed a similar biological dominance of treatment options for depression in Japan. Although mhGAP-AP and mhGAP-IG both highlight the importance of integrated treatment packages that include both medication and psychosocial interventions, there is no acknowledgement of how the availability of different treatment options may create a dynamic that might serve to inhibit the development and use of other forms of intervention. Furthermore, a recent editorial in the *British Journal of Psychiatry* has highlighted the importance of introducing patient choice in the prescription of anti-psychotic medication. The editorial concludes that: 'It may be time to reappraise the assumption that antipsychotics must always be the first line of treatment for people with psychosis; rather, this should be a collaborative decision that is balanced with provision of informed choices and the offer of evidence-based alternatives' (Morrison et al., 2012). Unfortunately, the mhGAP initiative opted not to explore the issue of non-adherence or patient choice when discussing psychotropic medication.

Culture and diagnosis

The central weakness of global mental health programmes, such as mhGAP, is their assumption that mental health problems are the same the world over, and that these are diseases of the brain. At present, within these programmes, there is very limited focus on the potential role that social and cultural factors play in mental health problems across the globe. Culture has been defined as 'a set of institutional settings, formal and informal practices, explicit and tacit rules, ways of making sense and presenting one's experience in forms that will influence others' (Kirmayer, 2006:133). The discourse and programmes of global mental health follow from an implicit endorsement of the *Universalist Hypothesis* that suggests that biomedical processes cause mental health difficulties; that these processes are the same the world over; and that current diagnostic entities are equally valid across different cultural settings. However, it is important to consider the possibility that biomedical explanations of mental health difficulties may actually be a cultural construct in their own right, and that psychiatric diagnoses may not be valid to 'non-Western' cultures.

Arthur Kleinman used the phrase ‘category fallacy’ to describe ‘the reification of one culture’s diagnostic categories and their projection onto patients in another culture, where these categories lack coherence and their validity has not been established’ (Kleinman, 1988:14). If a particular diagnosis is not valid across cultural groups, there is a risk that measures and interventions will be inappropriately foisted on particular populations. This process of enforced homogenization of concepts and associated practices across cultures has been referred to as *imposed etic* (Berry, 1989; Tweed and DeLongis, 2006). For example, Lutz (1985) proposed that *depression* has no exact equivalent in ‘non-Western’ cultures, because many non-Western cultures do not define emotions as internal, mainly biological, unintended, distinct from thoughts, and characteristic of the person rather than situations. Similarly, Summerfield (2006:161) highlighted concerns about the cross-cultural validity of the diagnosis of depression and dismissed the apparent rise in prevalence of depression across the globe by referring to it as a ‘pseudo-epidemic’. However, other researchers have argued that the core symptoms of depression are evident in different populations (Patel, 2001), and that there is striking congruence in the symptoms of depression irrespective of where the disorder is measured (Simon et al., 2002). A compromise position permits local variations in mental health difficulties to be referred to as *psychiatric diagnostic equivalents*, which are in keeping with the major diagnostic systems’ (DSM-IV/ICD-10) descriptions of depression, schizophrenia, mania, and anxiety in Africa and South America (Ndeti et al., 2006; Incayawar, 2008). However, Summerfield (2012:5) has criticized the concept of psychiatric diagnostic equivalents ‘as being an attempt to relieve Western psychiatry of any obligation to examine the limits of its knowledge and epistemological traditions’.

Understanding mechanisms contributing to the globalization of mental illness

The current trend of globalization of mental illness must be understood in relation to the underlying dynamics and power and its linkages with related larger movements of globalization. Edquist (2008), for example, has identified practices that prioritize technical knowledge over political process in what has been termed the ‘globalization of mental illness’. She highlights the *International Consortium on Mental Health Policy and Services* (Gulbinat et al., 2004), as an example of an *assemblage* which has been defined as ‘conglomerations of scientific expertise, state policy, international institutions, and practices employed with a will to improve the lives of perceived sufferers of mental disorder’ (Edquist, 2008:375). Assemblages of this type create circumstances where technical advice from experts circumvents political checks and balances that would normally facilitate a broader consideration of different viewpoints. The repercussions of these assemblages are far reaching. Through the implementation of uniform, technically driven, national health plans, societal attitudes towards mental health difficulties can change, resulting in the marketing of one kind of technical knowledge (i.e the biomedical model of mental illness), and thus encouraging self-diagnosis, self-surveillance, and even self-treatment. As Edquist (2008:389)

puts it, ‘mental health assemblages not only reinforce medical experts’ and institutions’ influence, but in fact encourage non-experts to apply the knowledge concepts developed by expert’. Examples of the way in which understandings about mental health difficulties can be systematically shifted through the influence of professional assemblages can be seen in relation to eating disorders in Hong Kong and China (Edquist, 2008); depression in Latvia (Skultans, 2003); and the marketing of depression in Japan (Kitanaka, 2011). Large and powerful organisations (such as the WHO), sharing knowledge at an international level, increases the risk of populations being indoctrinated by the seductive allure of technical expertise. The key to offsetting this risk will be to encourage the involvement of non-experts, politically minded individuals and social activists in the adoption of scientific knowledge and discourse to influence, and potentially participate in, assemblages in constructive ways (Edquist, 2008).

The use of the term ‘non-expert’ is however problematic here, it could be argued that individuals with a lived experience of mental health problems are ‘experts’ about this experience. What constitutes ‘scientific’ is also an increasingly contested category. Kleinman (2012) has argued that academic psychiatry is faltering due to an over-emphasis on an *Evidence-based Medicine* paradigm. This paradigm suggests that preferential weight should be given to randomized controlled trials and meta-analyses, and comparably less credibility attached to case studies and qualitative research methods. It is widely recognized that there has been a dearth of research conducted into mental health in LMIC (Sharan et al., 2009), so scientific knowledge about mental health is assumed to be universally applicable to the global population, when there is actually insufficient evidence to support this claim.

Sociologists claim that societal views about mental health difficulties can feed into a dynamic process that influences how mental health difficulties may present in the future. Hacking’s notion of *Looping Effects* (Hacking, 1995; 1999) proposes that: ‘what was known about people of a ‘kind’ may become false because people of that kind have changed in virtue of how they have been classified, what they believe about themselves, or because of how they have been treated as so classified’ (Hacking, 1999:114). Hacking (1995) raises the prospect that defining a behavioural pattern in terms of biological processes can create circumstances in which the behavioural pattern then changes in response to how ‘science’ dictates people should be treated. Di Nicola (2012) raises the possibility that the *looping effects* may create a situation where mental health professionals around the world look to high-income countries for leadership and, in doing so, potentially suppress local traditions and professional innovation. As Summerfield (2012) points out, the more that people think that they are not expected to cope through their own recourses and networks, then the greater the risk that time honoured ways of enduring and coping may be lost. As such, the WHO need to reflect on the risk of culturally appropriate, effective interventions being *scaled-down* to be replaced by imported interventions that lack any evidence of efficacy in that particular setting.

Global Burden of disease – an epidemiological artefact?

Much of the impetus for global mental health is derived from the notion that there is a global burden of mental health problems, largely unrecognised and therefore untreated. There is an analogy with physical medicine here that is debatable. There is no reason to accept that conditions like depression (and many other psychiatric diagnoses) are the same as, say, polio or heart disease. The cross-cultural validity of such psychiatric diseases is highly questionable. Nonetheless, the WHO have projected that depression will be the second biggest cause of global disease burden in 2030 (Mathers & Loncur, 2005). Disease burden is measured using the Disability Adjusted Life Year (DALY) statistic, which is a combination of number of years of life lost prematurely and number of years living at less than full health. WHO figures indicated that in 2000, Major Depressive Disorder (MDD) was the third leading cause of burden accounting for 4.3% of global DALYs (Ustun et al. 2004). Notwithstanding questions concerning the cross-national and cross-cultural validity of depression, there are discrepancies in the estimated prevalence rates for MDD between and within different regions of the world (Paykel et al. 2005; Weich & Araya, 2004). An inherent difficulty with reviewing and synthesising different studies that have investigated the prevalence of psychiatric disorders, such as MDD, relates to the differences in the methodology used by the different studies (Weich & Araya, 2004). An analytical review of the Global Burden of Disease figures obtained in 2000 concluded that there was significant heterogeneity across epidemiological estimates for depression and that the global burden of depression estimates were ‘epidemiologically flawed in terms of representativeness and quality’ (Brhlikova et al. 2011: 32). The estimates are based on narrow samples which make any kind of generalisation difficult (the EURO region had studies relating to 15 out of 52 countries compared to the AFRO region which had studies relating to 3 out of 52 countries). Generalisability is also hampered by the small sample size of studies; the lack of information about methodology and sample frame; the lack of available data relating to incidence (as opposed to prevalence) data; and the limited number of studies that assessed duration of MDD.

The World Mental Health Survey (WMHS) Consortium attempted to address some of these methodological concerns by conducting population surveys in 28 countries using standardised protocols for collecting data (Bromet et al. 2011). The WHO’s Composite International Diagnostic Interview (CIDI) was used to diagnose cases of Major Depressive Episode (MDE). The results revealed marked regional variation in the 12-month prevalence of a MDE, ranging from 2.2% in Japan, to 10.4% in Brazil (Bromet et al. 2011). This may be indicative of true differences in prevalence rates, but the cross-cultural reliability and validity of the CIDI are not well established (Simon et al. 2002; Wang et al. 2007; Bromet et al. 2011). It is, therefore, important to adopt a critical perspective on the Global Burden of Disease data, for, as Brhlikova et al. (2011:25) concluded, ‘the uncritical application of these [GBDepression] estimates to international healthcare policy-making could divert scarce resources from other public healthcare priorities’. This is particularly pertinent for LMIC

where basic healthcare needs may not be met.

The WHO claim that the mhGAP ‘programme is grounded on the best available scientific and epidemiological evidence on priority condition’ (WHO, 2008:10). Yet this does not mean that the evidence is sound enough as to apply across the world, especially if the purpose of such an exercise is to determine healthcare priorities. A major weakness of global initiatives in mental health, such as mhGAP, is their failure to provide a critical perspective on the epidemiological research in LMIC. This has potential ramifications for the allocation of resources. Commenting on the burden of disease estimates for sub-Saharan Africa, Cooper et al. (1998:210) pointed out that ‘if these data are wrong the consequences are likely to be most damaging for the very populations under-represented in the fact-gathering process’. Despite such concerns, the *mhGap-Action Programme* suggests that the monitoring and evaluation of interventions for mental health in LMIC could be indexed to epidemiological research and the global burden of disease. This would facilitate the generation of *output* (e.g. the number of trained mental health practitioners), *outcome* (the number of people treated for depression as a proportion of the overall prevalence) and *impact* (the prevalence or global burden of a disorder) indicators (WHO, 2008).

The skewed notion of culture-specific disorders

It is true that international panels have been used to reach consensus opinions about which diagnostic criteria should be included in the editions of the International Classification of Diseases (ICD) which are often cited in Global Mental Health related research and policy. However, these panels of international experts have been criticised for being unrepresentative of the global population. For example, of the 47 psychiatrists who contributed to the initial draft of the most recent World Health Organisation diagnostic system (ICD-10; WHO, 1992), only two were from Africa, and none of the 14 field trial centres were located in sub-Saharan Africa. Inevitably this led to the omission of local experiences (e.g. *brain fag syndrome* that had been described for many years in Africa) (Patel and Winston, 1994). A further source of concern about the composition of expert panels who influence the classification of mental health difficulties and policies designed to address these difficulties, relates to the fact that ‘expert’ tends to mean an expert in Western psychiatry. Unfortunately, much of the experience that these individuals have may be drawn from hospital-based work. Other influential stakeholders that work with ‘madness’ or distress, who could make important contributions to the classification and treatment of these difficulties, are largely absent. These stakeholders include individuals who have experienced distress, their families, traditional healers, faith healers etc. Representation by these individuals on WHO policy panels would better reflect the pluralistic approach to mental health that many people across the globe adopt.

The ICD-10 (WHO, 2000) does at least acknowledge that there are exceptions to the apparent

universality of psychiatric diagnoses by including what are called *Culture-specific Disorders*. One such example of a Culture-specific disorder is *Koro*; a form of genital retraction anxiety which presents in parts of Asia. Prior to ICD-10, symptom presentations such as Koro, tended to be subsumed into existing diagnoses, such as delusional disorder (Crozier, 2011). Yet the inclusion of culture-specific disorders only serves to perpetuate a skewed view of the impact of culture on mental health, in that ‘cultural’ explanations seem to be reserved for non-Western patients/populations that show koro(-like) syndromes, and not for diagnoses that are more prevalent in high income countries (HIC) (e.g. Anorexia Nervosa). Indeed it has been suggested that many psychiatric conditions described in these diagnostic manuals (such as Anorexia Nervosa, or Chronic Fatigue Syndrome) might actually be largely culture-bound to Euro-American populations (Kleinman, 2000; Lopez & Guernaccia, 2000). Because people living in ‘western’ countries tend to see the world through a cultural lens that has been tinted by psychiatric conceptualisations of mental illness, they are blind to how specific to ‘western’ countries these conceptualisations actually are.

Even within countries with highly developed mental health systems, the validity of psychiatric diagnosis has been questioned. Kendell & Jablensky (2003:11) concluded that, ‘at present there is little evidence that most contemporary psychiatric diagnoses are valid, because they are still defined by syndromes that have not been demonstrated to have natural boundaries’. In other words, psychiatric diagnoses do not constitute discrete entities with symptoms failing to have specificity to particular diagnoses. Kendell and Jablensky (2003) suggest that the potential benefit of diagnosis lies in its *utility*; diagnoses contribute to a shared language that can help facilitate discussion between professionals regarding treatments and outcome for particular constellations of symptoms. The advantages of diagnosis for service users and/or people experiencing distress may however be less clear. Whereas some service users may welcome the sense of clarity that diagnosis can bring, as previously discussed, diagnostic labeling by the public has been positively related to prejudice, fear, and desire for distance (Read et al., 2006). In apparent acknowledgement of the limitations of psychiatric diagnosis, *The National Institute of Mental Health* [NIMH] in the USA, identified the following goal in their strategic plan: ‘Develop, for research purposes, new ways of classifying mental disorders on dimensions of observable behaviour and neurobiological measures’ (NIHR, 2008:9). This has served to initiate the *Research Domain Criteria* [RDoC] project that will aim to identify basic domains of functioning that cut across disorders, and explore genetic and neural activity profiles that are characteristic of these domains. NIHR suggest that this will help in the development of new interventions for mental health difficulties. The extent to which these interventions are inclusive of social determinants of mental health difficulties remains to be seen.

Taking account of the socio-cultural context

Timimi (2010) has warned that a lack of academic and political engagement with alternative non-Western perspectives about mental health problems means that ‘western’ narratives about ‘mental illness’ dominate over local understanding. It is becoming clear that in this era of rapid globalisation, mental health practitioners, social scientists, anthropologists, politicians and community leaders need to come together and engage in constructive dialogue aimed at developing culturally appropriate ways of understanding and supporting mental health needs. Collaboration between these different parties may help with the development and use of what could be termed *contextual formulations*. These contextual formulations would be: narrative and/or diagrammatic accounts of individuals’ difficulties and strengths as seen and understood within their local setting; a values-based approach to understanding the individual’s life and what is important to them; and an examination of local resources that are available to provide support. The models of mental health care that evolve in this *bottom-up* approach to understand distress may vary from place to place, because one size will not fit all. For example, in some regions efforts may focus on community development and strengthening social support networks; in others, greater attention may be paid to helping individuals to develop coping strategies for managing difficult thoughts and emotions. The bottom line for mental health development is that services should reflect the needs and priorities of local communities, and cultural values and practices should be integrated into what services are delivered and how. The solutions may seem parochial, but the process for identifying appropriate solutions will be shared. The integrated management protocols that are detailed in the mhGAP-Intervention Guide could have been potentially more useful if they had detailed steps for acquiring information that might be important for understanding distress in particular contexts and utilizing what resources might be available to manage the difficulties.

Models of managing mental health difficulties

The mhGAP-AP is based on the expectation that treating people experiencing mental, neurological and substance use (MNS) disorders in primary care will enable the largest number of people to get easier and faster access to services in LMIC. Whilst the rationale for this might be overwhelmingly clear for conditions such as neurological disorders, or emotional adaptation to physical health problems, there are also limitations to this approach when applied to dealing with mental health problems. Where, for example, will more complex mental health difficulties be addressed? What about countries where primary care mental health services are not well developed? Or countries where primary care systems are struggling to cope with the demand for physical health services? In addition, there is a danger that narrowly focusing the provision of support via primary care diverts resources away from population-based interventions that may serve to promote health and well-being; for example,

educating children about emotional well-being in schools, combating stigma, and tackling poverty. By opting to inextricably link the provision of support for MNS disorders to physical health services, mhGAP-AP will perpetuate the dominance of the ‘illness’ model. This is compounded by the fact that mhGAP-AP also calls for resources for delivery of services to be made available from national health budgets.

Rather than focusing on psychiatric diagnoses, an alternative approach could focus on specific types of difficulties that people experience that might have an impact on their mental wellbeing (e.g. sexual and gender-based violence, poverty, social exclusion, migration, and physical health problems, such as HIV/AIDS) and target local resources in culturally appropriate ways to moderate or modify the impact of structural inequality and social injuries. This would allow particular populations to be actively involved in the development of a bottom-up understanding of how difficulties that they are facing may be impacting on their mental health and well-being. This could include a focus on the impact of particular difficulties on individuals and also more collectively the impact on communities. This alternative approach may lead to what seem like parochial solutions for responding to difficulties, but the systematic approach of identifying difficulties, mobilising stakeholders, assessing resources and implementing support may be transferable. The overall aim will be for individuals and communities to develop effective, sustainable and locally appropriate ways to support their needs. This may generate novel solutions that do not correspond that closely to systems and services used in high-income countries. After all, replicating the bureaucratic model of community mental health care of high-income countries (which draws on a pool of highly trained professionals) may not be feasible, or necessarily desirable, in many African settings (Alem, 2000; 2002). Unfortunately, the idea that countries in Africa might develop their own models of health care, rather than imitating those used in the West, appears to have been forgotten in ‘the drive for standardisation’ (Read, 2012:15). Consultation with local service users about the appropriateness of mental health services seemed to be largely ignored in the mhGap initiative. For example, the *mhGAP-Intervention Guide* (WHO, 2010a) makes mention of the fact that the *WHO Guideline Development Group of International Experts* collaborated closely with the *WHO Secretariat* in constructing recommendations about interventions for priority conditions, and that ‘the resulting, clearly presented, stepwise interventions...(were) then circulated among a wider range of reviewers’ (WHO, 2010a:1). However, it is unclear to what extent service users from across the world were consulted in this process.

The lack of availability of human resources to contribute to the delivery of mental health services is a key issue that has been identified in LMIC. The *mhGap-Action Programme* states that ‘where doctors and nurses are in short supply, some of the priority interventions can be delivered by community health workers – after specific training and with the necessary supervision’ (WHO, 2008:18). This is referred to as *task-shifting*; the transfer of tasks that have traditionally been allocated to psychiatrists or clinical psychologists (who are

expensive and comparatively slow to train) to other lower skilled occupational groups. However, there is a risk that in being pre-occupied with shifting existing tasks, we may miss an opportunity to think creatively about new tasks that may help to promote mental health and well-being. In all likelihood, the huge diversity in where and why people present with mental health difficulties in different parts of the world will necessitate a process more akin to *task-innovation*. For example, it is possible that less emphasis needs to be placed on therapeutic interventions (i.e. psychotropic medication and/or psychotherapy), and more emphasis will need to be placed on development approaches. Poverty and oppression are major structural determinants of mental illness. However, there would appear to be insufficient attention paid to prevention and tackling socioeconomic determinants of mental ill health within mhGAP. The large treatment gap for mental health problems in LMIC is often accompanied by profound gaps between the rich and the poor and in huge national variations in the social determinants of health. Research has indicated that poverty can be both a determinant and a consequence of poor mental health (Murali & Oyeboode, 2004), and an inverse relationship has consistently been noted between socio-economic status and mental health difficulties (Dalgard, 2008; Patel & Kleinmen, 2003; Kessler et al., 1994). In a recent review of relevant literature, Lund et al. (2011) found that the mental health impact of poverty alleviation programmes is currently inconclusive, whilst mental health interventions tend to consistently lead to improvements in economic outputs.

The non-governmental organisation BasicNeeds has claimed some success in providing microcredit and work placements to enable people with mental health difficulties to engage in 'sustainable livelihoods' (BasicNeeds, 2010). BasicNeeds utilises what the organisation terms 'a community-based integrated Mental Health and Development (MHD) model' (Raja, 2012:1). The MHD model draws on development theory, emphasizes user empowerment and community development, and highlights the need to strengthen local health systems and influence policy. In apparent recognition of the importance of development for mental health, the WHO (2010b) published a document entitled '*Mental health and development: targeting people with mental health conditions as a vulnerable group*'. Thompson and Doherty (2006) provide an interesting examination of how social enterprise schemes can be used in different parts of the world to empower socially disadvantaged groups. Social enterprises are business ventures that serve to engage service users in meaningful activity that potentially provide a sense of purpose and/or some income. Approaches such as this could be extremely helpful in providing people with meaningful activity and a way to generate income that could serve to reduce the burden of mental health difficulties.

Conducting valid research to support the development of mental health services

The *mhGAP* initiative aims to scale up pharmacological and psychosocial interventions for mental health difficulties. The mhGAP Action Programme makes mention of the importance

of establishing ‘evidence about the effectiveness and feasibility of scaling up these interventions’ (WHO, 2008:11). However, concerns have been expressed about the validity and representativeness of the research that has contributed to the evidence-base, and there are inherent difficulties with making broad-ranging consensus statements on mental health related research. Barbui et al. (2010) highlight several limitations associated with the approach that the WHO have used to develop evidence-based recommendations for mental, neurological, and substance use disorders. For example, there is a lack of explicit criteria to guide the selection of measures for particular outcome measures can lead to potential bias (Barbui et al., 2010). The authors point out that in mental health-related research several rating scales purporting to measure the same concept are included in trials, systematic reviews and meta-analyses. Barbui et al. (2010) also point out that publication bias (where studies that do not evidence an effect of an intervention tend to be less likely to be published) is an important threat to the integrity of the research evidence base. The authors concede that currently only weak methods exist for managing the jeopardy caused by publication bias. There are three ways in which the evidence-base for mental health interventions can be improved.

First, there is a need for more mental health-related research to be conducted in LMIC. Patel & Sumathipala (2001) found that over 90% of papers published in a three year period in six leading psychiatric journals came from Euro-American countries. Fifty-seven percent of LMIC contributed less than five articles to mental health indexed journals over a ten-year period (WHO, 2007). Considering that the mhGAP-AP states that nearly three quarters of the global burden of neuropsychiatric disorders occurs in LMIC these are alarming statistics. The WHO has been instrumental in attempting to increase the amount of research being conducted. For example, the *Research Capacity for Mental Health in LMIC* (WHO, 2007) document outlines a number of challenges that need to be overcome to boost the research output, including: building political willingness to support mental health related research; creating systems to support research; identifying research priorities; increasing funding; and providing training. However, there is little critical reflection within the document about the relevance or appropriateness of methodologies that are favored in the West. It may be that research methodologies other than those prioritized by the Evidence-based Medicine paradigm (which tend to be dominated by randomized controlled trials) could lead to improved understanding about mental health difficulties (see: Thomas et al., 2012). For example, *action* or *participatory* research may prove fruitful ways of using research as a transformative tool in LMIC. It is important to embed future quantitative research in broader, narrative-based qualitative research. To date clinicians and researchers from a mental health background have not worked sufficiently closely with anthropologists. There has been inadequate attention given to ethnographic research investigating how and why distress presents in people in different parts of the world. This bottom-up approach to understanding distress has been inhibited by a top-down pre-occupation with assimilating presentations of distress into pre-existing frames of reference. Unfortunately this might be serving to limit our

understanding rather than advance it.

Secondly, there is a need to maximise the validity of the research being conducted because there is no point in increasing the research capacity of LMIC if the research remains of dubious quality and has no relevance. Summerfield (2008) claims that the predominance of 'Western' frames of reference for categorising and measuring mental health difficulties mean that the evidence-base for mental health interventions is not universally valid for the global population. These claims are contentious and have invited strong rebuttal from other researchers (see Fekadu & Cleare, 2009). More recently Summerfield (2012:523) has highlighted how the key issue with cross-cultural research is the lack of accurate 'translation between worlds'. Kirmayer (2012) has also claimed that the mental health evidence-base is seriously limited in its capacity to take into account cultural diversity. For example, in a review of 183 published studies on the mental health of refugees, four fifths of the studies relied exclusively on measures of psychopathology developed with Western populations (Hollifield et al., 2002).

The mhGAP-AP emphasises the importance of developing contextually appropriate ways of assessing outcome for mental health difficulties by stating that 'each country will need to decide which indicators to measure and for what purpose; when and where to measure them; how to measure them; and which data sources to use. Countries will also need to plan for analysis and use of the data' (WHO, 2008:21). There are some studies that have utilised qualitative methods to generate novel forms of assessment. For example, in a two-year ethnographic study in Zimbabwe, Patel et al., (2007) developed a 14-item local screening instrument for mental health problems. The authors pointed out that the symptoms incorporated into this measure generally cohered closely around symptoms of common mental disorders (e.g. anxiety and depression). In an attempt to be reflexive to the local context, Betancourt and colleagues successfully used qualitative methods, in their work in Northern Uganda and Rwanda, to determine the validity of existing measures of psychological syndromes, modifying the measures as needed and developing and statistically validating culturally relevant scales when the existing scales left a gap in knowledge (Betancourt et al., 2009; Betancourt et al., 2011). However, in both of these examples it could be argued that psychiatric concepts were serving as yardsticks for the new measures to a greater or lesser extent. New research ideally needs to engage with participants in a way that carries no preformed notions about what is 'mental' or 'health' in their world: local concepts must be the starting point for the creation of valid instruments for screening or diagnosis (Summerfield, 2008). Ungar (2012) raises the possibility that indigenous concepts that are not being measured by 'Western' measures of psychopathology may account for the apparent variability between ethno-cultural groups. This is an important point and emphasises the importance of reciprocity in knowledge exchange between individuals across the world, with the aim of improving mental health and well-being in low, middle and high income countries.

Thirdly, it will be important to consult with a broad range of stakeholders, including local communities and individuals with a lived experience of mental health difficulties. Tol et al. (2012) highlighted what they termed the ‘excellence vs. relevance’ debate in Global Mental Health research. This revolves around the apparent disconnect between different stakeholders regarding the research that is conducted into mental health in humanitarian settings. The article concludes that researchers need to be more reflexive and responsive to issues and concerns arising in humanitarian settings, and practitioner designed interventions need to better reflect research findings (Tol et al., 2012). Fernando (2012) picks up on the importance of consulting with individuals with a lived experience of mental health difficulties when identifying research priorities. She considers this to be pivotal to conducting what she termed ‘ecologically sound’ research. Whereas researchers might view the gathering of new information or the validation of a new measure as the main ‘benefit’ to the community, this may not translate to what the local community would readily identify as benefits (Fernando, 2012). Essentially communities could be mobilised to generate research questions that might provide an opportunity to shine light on the issues that they are struggling with. Individuals with a lived experience of mental health difficulties represent a particularly important resource for local communities when it comes to getting involved in research. Where possible, they should be actively involved in the development and delivery of research ideas. Their insights and advice regarding research procedures can prove invaluable in helping researchers to adopt a participant-centred approach that can serve to minimise potential adversity, and indeed irrelevancy, in the research process. Gupta and Roberts (2014) recently published some preliminary findings relating to the EMPOWER initiative that seeks to enhance collaboration between researchers and individuals with a lived experience of mental health difficulties in LMIC. This however was a comparatively small explorative study and further research is required.

Overall, there is a need to ensure that the findings that are derived from conducting research translate into changes in practice that will improve the lives of individuals experiencing mental health difficulties. In the absence of sufficient relevant and valid mental health related research conducted in LMIC, great caution should be exercised in investing scarce resources in what is referred to as ‘evidence-based’ interventions which may actually be anything but evidenced-based.

Scaling-up

There is an inherent contradiction in the rationale that the WHO provide in justifying the emphasis it has placed on *scaling-up* mental health services in LMIC. The folly of the approach is captured in the following extract from the mhGAP Action Programme; ‘Scaling up is defined as a deliberate effort to increase the impact of health-service interventions that have been successfully tested in pilot projects, so that they will benefit more

people... However, pilot or experimental projects are of little value until they are scaled up to generate a larger policy and programme impact' (WHO, 2008:13). On one hand there is a tacit acknowledgement of the importance of doing pilot work to verify the potential benefit of interventions. Yet, on the other hand, the WHO is stating that interventions need to be scaled-up to allow a proper evaluation to be conducted. This circular logic is breathtakingly inadequate. We have highlighted concerns about the long-term use of psychotropic medication, problems with the quality of epidemiological research, doubts about the cross-cultural validity of diagnostic categories, and a paucity of research evaluating mental health interventions in LMIC. This article has also highlighted how *assemblage*-driven attempts to scale up interventions for mental health difficulties in LMIC can inadvertently change existing frames of references which may have been functional for individuals living there.

There are key questions that need to be posed: Is there a risk that attempts to scale-up services might be harmful? Is this approach ethical? These questions are as important as they are contentious. There is clearly a need to embed the design, development and implementation of interventions for mental health difficulties in mixed (quantitative and qualitative) methods research that will directly inform this process and tailor it to the needs of local populations. The mhGAP-AP acknowledges that 'social and cultural factors' may be potential 'demand-side barriers' (WHO, 2008:14), which serve to limit individuals' willingness to engage with mental health interventions in LMIC. No consideration is given to the possibility that the biggest 'barrier' to engagement may actually stem from a complete lack of fit between the needs of particular populations and the types of services outlined in the mhGAP documentation. It may be instead that local ways of knowing and responding to distress are preferred. Rather than being an after-thought, cultural beliefs and practices should be central to the design and delivery of efforts to support individuals experiencing distress.

Lack of reciprocity

A key theme in the mhGAP-AP and the mhGAP-IG has been the lack of reciprocity between HIC and LMIC. The assumption is that LMIC will adopt strategies generally used in Western HIC to manage mental health problems. The transfer of knowledge tends to be unidirectional, and there is an associated lack of critical reflection from the West on the appropriateness and effectiveness of these strategies in culturally diverse settings. This has been likened to medical imperialism (Summerfield, 2008). Research has failed to conclusively show that outcomes for complex mental illnesses (such as psychosis) in high-income countries are superior to outcomes in LMIC (where populations may not have had access to medication-based treatments) (Hopper et al., 2007; Cohen et al., 2008; Alem et al., 2009). So the assumption that the effectiveness of care delivered in HIC is better than in LMIC is questionable. Greater attention needs to be paid to what have been termed *counter-flows* - the innovations that run contrary to the prevailing flow of information. A rare example of this

kind of counter-flow might be *Mindfulness*; a form of meditative practice that has its origins in Buddhism and is now integrated into psychological treatment of recurrent depression in the UK (NICE, 2009). However, some have claimed that mindfulness is actually a reified notion extracted from Eastern philosophy and made fashionable through Western life style management techniques (Grossman & Van Dam, 2011). The authors suggest that to truly enrich western mental health a greater appreciation of the complex Buddhist phenomenology of the mind is required. Other potential counter-flows include the move to have a greater involvement of families in mental health care in Western societies over the last 30 years (Diop & Dores, 1976; Nunley, 1998; Osei, 1993).

Conclusions

Global mental health initiatives, such as the mhGAP-AP and mhGAP-IG, fail to recognise the general failure of the biomedical and institutional models of mental health care. In our view, this fundamentally undermines the validity, relevance and appropriateness of scaling up services in LMIC - the central tenet of GMH. There are also inherent risks associated with managing the tensions between the urgency with which services need to be scaled up, and on the other hand ensuring that this is done in an ecologically valid, ethical and sustainable way. Large international organizations, such as the WHO, are in a very powerful position, where the policies that the WHO advocate can shape and influence how local populations interpret and understand mental health difficulties. The WHO must critically reflect on the merits of biomedical conceptualizations of mental health and weigh these with local perspectives and local resources (including indigenous healing, social support networks, rights-based organizations and family support). The growing connectivity, integration, and interdependence between people across the world that is the defining feature of the process of globalisation can create great opportunities for progress. But this process of connection is only as good as the ideas that are shared. By collating and exchanging knowledge from across the world, the WHO can help LMIC to benefit from hard lessons learned in HIC countries, and HIC countries can look afresh at how mental health difficulties are understood and treated in LMIC. Improved research capacity in LMIC, and the combination of ethnographic and quantitative research in a bottom-up approach to understanding, measuring and treating mental health difficulties will help facilitate progress. It may be that less emphasis is placed on the process of psychiatric diagnosis. Importantly, concerted efforts will need to be made to critically reflect on what is done in HIC to bring reciprocity to Global Mental Health policy. Practitioners in HIC will have to question major assumptions that they hold about mental health difficulties, and be open to alternative approaches.

The *Mental Health Action Plan 2013-2020* (WHO, 2013) aims to improve mental health services in countries across the globe. The plan has four key objectives including:

strengthening effective leadership and governance for mental health; providing comprehensive, integrated and responsive mental health and social care services in community-based settings; implementing strategies for promotion and prevention in mental health, and; strengthening information systems, evidence and research for mental health (WHO, 2013:10)

There are indications here of positive changes in policy direction, including a greater focus on the social determinants of mental health and greater emphasis on involving service users and carers. Perhaps this plan, with its global focus, will stimulate opportunities for critical reflection in how services are designed and will go some way to facilitate reciprocity in efforts to globalise mental health. However, this will only happen if there is a more balanced exchange of knowledge between LMIC and HIC, if greater credence is given to diverse explanatory models for mental health difficulties, and if individuals are facilitated to find meaning in their experiences, irrespective of where they are on the globe.

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