Towards a more nuanced Global Mental Health

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Summary: The World Health Organization has made concerted efforts to scale-up mental health services in low and middle-income countries through the mhGAP initiative. However, an over-reliance on scaling-up services based on those used in high-income countries may risk causing more harm than good.

Declaration of Interest: None

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 treatment (WHO, 2008). This has been referred to as the treatment gap; the difference between the level of mental health provision that is required, and the actual level of support that is available. In an effort to increase (or *scale-up*) mental health provision in LMIC, the WHO published two key documents: the *Mental Health Gap – Action Programme* (mhGAP-AP[1]) and the *Mental Health Gap – Intervention Guide* (mhGAP-IG[2]). The mhGAP-AP outlines key steps for scaling-up mental health services in LMIC, while the mhGAP-IG presents integrated management plans for priority conditions including: depression, psychosis, bipolar disorders, and epilepsy in LMIC. Whilst acknowledging that the WHO initiatives (along with the two *Lancet* series on Global Mental Health) have undoubtedly increased awareness about mental health difficulties in LMIC, there is a need to critically reflect on the strategic direction that the mhGAP initiative has taken and consider whether this is the most productive way to proceed. This reflection is particularly timely in light of the adoption of the *Mental Health Action Plan 2013-2020*[3] which has been based on global and regional consultations.

The ubiquitous use of medication

Contained within mhGAP-IG there are templates for 'evidence-based interventions' that can be adapted for use in different countries to address a range of psychiatric, substance abuse and neurological disorders that are identified as priority conditions. This is in spite of there being on-going debate about the cross-cultural validity of psychiatric diagnoses such as depression[4,5]. The first line of

treatment recommended in many of the mhGAP-IG templates for intervention is psychotropic medication. It is important to consider whether there is sufficient justification for this being the case. Unlike physical health problems (such as polio, influenza, and HIV), the evidence for biomedical *causes* of mental illnesses (such as depression and schizophrenia) remains fairly weak[6,7]. There is also growing evidence that aligning the treatment of mental health difficulties too closely to a biomedical model may have potentially detrimental effects. For example, a reliance on biomedical causal explanations of mental health difficulties has been associated with increased prejudice, fear, and desire for distance from individuals diagnosed with psychiatric disorders[8]. Although, psychotropic medication can be helpful in managing distress, there are also limitations to this approach that the mhGAP initiative fails to address. For example, long-term use of antipsychotic medications can contribute to increased morbidity (including metabolic disorders and cardiovascular conditions), and risk of premature mortality linked to sudden cardiac death[9]. Research indicates that reducing or discontinuing the doses of antipsychotic medication in the early stages of remission from first episode psychosis is actually associated with superior recovery compared to maintenance treatment with antipsychotics[10]. Important questions have also been raised about the methodologies employed by pharmaceutical companies to evidence the effectiveness of psychotropic medication[11].

There is a danger that biomedical explanations of mental health difficulties and an over-reliance on psychotropic medication may serve to inhibit the utilization of alternative forms of support. This is an important issue that merits careful consideration by those involved in scaling-up services for mental health in LMIC. It has been argued 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[12, 13]. 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 these interventions may inhibit pluralism and the use of other forms of healing and/or support.

Establishing evidence-based services…or not

The mhGAP initiatives highlight the importance of scaling-up 'evidenced-based' interventions. However, the financial, human and technical resources available for conducting research in LMIC to establish an evidence-base for mental health interventions are very limited[14]. Indeed, the challenges associated with establishing evidence-based approaches are highlighted in the following extract from the mhGAP-AP[1(P.13)]:

> "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".

On one hand, there is a tacit acknowledgement of the importance of doing pilot research to verify the acceptability and effectiveness of interventions, and on the other, there is an assertion that scaling-up needs to occur before this evaluation can take place. We propose that this reasoning is fundamentally flawed. A key question that needs to be addressed is whether this approach is ethical?

Whilst we acknowledge the pressing need to support the mental health needs of people across the globe, this should not happen at the risk of causing harm. Research conducted by the WHO has indicated that outcomes for serious mental disorders are not superior in high-income countries (HIC) relative to LMIC (where populations may not have access to medication-based treatments)[15]. An examination of the academic discourse that followed the dissemination of the findings concluded that strenuous efforts were made to 'preserve an image of Western superiority and Third World inferiority'[16]. If the psychiatric services that are generally offered in HIC are failing to deliver, then great caution should be exercised in using these as a benchmark for scaling-up similar services in LMIC. It has been suggested that better outcomes for complex mental health difficulties in LMIC may be a consequence of the multiplicity of treatment/healing options available in LMIC compared to HIC[17]. Unfortunately, the types of services advocated by the mhGAP initiatives largely mimic the approach to service design that is currently advocated in HIC and do not embrace medical pluralism.

Services that reflect the beliefs and practices of local people

One of the key limitations of the mhGAP initiatives is the lack of emphasis that is placed on the potential role that social and cultural factors play in mental health problems across the globe. The mhGAP-AP acknowledges that 'social and cultural factors' are examples of *demand-side barriers* that may limit individuals' willingness to engage with mental health interventions in LMIC[1], but it does not elaborate on how these factors should inform the development of services. We believe that the design, development and implementation of services to support the mental health needs of particular populations will need to be embedded in qualitative research that will directly inform this process and tailor it to the needs of local populations. This process will require the involvement of a wide range of stakeholders. We are concerned that the mhGAP initiatives did not involve sufficient consultation with individuals with a lived experience of mental health difficulties about what constitutes good services for mental health in LMIC. This lack of consultation is a criticism that has been made of mental health services in HIC.

In our view, the failure of the mhGAP initiatives to recognise the limitations of the biomedical and institutional models of health-care undermines the validity, relevance and appropriateness of the approach that it advocates. We appreciate that there are 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. The growing connectivity, integration, and interdependence between people across the world can create great opportunities for progress. But these networks of connectivity are only as good as the ideas that are shared. We 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).

Looking to the future

In June of 2013, the WHO adopted the *Mental Health Action Plan 2013-2020*[3]. This outlines 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'. It is hoped that this plan with its global focus; support for the involvement of people with lived experiences of mental health problems; and emphasis on mental health promotion (rather than a narrow focus on mental illness) will go some way to facilitating greater reciprocity between HIC and LMIC in efforts to produce innovation in mental health services. Only by engaging in critical reflection about how mental health services are designed and delivered in both HIC and LMIC can we foster a Global Mental Health that is truly global. Global Mental Health is a worthy quest, but it is a quest that needs to be receptive to the wealth of beliefs and practices espoused by the diverse populations that it seeks to serve. Moving forward there is a need to ensure that: a more balanced exchange of knowledge occurs between HIC and LMIC; greater credence is given to diverse explanatory models of distress, socio-cultural influences on mental health are better understood, and individuals are facilitated to find meaning in their experience irrespective of where they are on the globe.

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