Global Mental Health and its Discontents

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By

The field of Global Mental Health (GMH) is an emerging formation of knowledge and practice seeking to address mental illness on a global scale. A growing body of research has established mental illness as one of the most pressing "burdens of disease" (Lancet series, 2007). Recently, an article in *Nature* entitled "Grand Challenges in Global Mental Health" (2011) identified mental health priorities for research in the next 10 years, sparking controversy and debate about the appropriate methods for establishing priorities, research themes, and interventions in GMH. This year's annual Advanced Study Institute (ASI) and Conference, hosted by McGill's Division of Social & Transcultural Psychiatry (July 5-7 2012) in Montreal, Canada, sought to address these concerns and focused on ways to generate critique of the GMH movement to ensure that its goals and methods are responsive to diverse cultural contexts. The ASI workshop and conference entitled "Global Mental Health: Bridging the Perspectives of Cultural Psychiatry and Public Health.", was chaired by Laurence Kirmayer and Duncan Pedersen, and was animated with intense discussions about various themes related to the GMH endeavour. The three-day ASI series sought to address ongoing controversies and tensions between a public health approach to mental health (grounded in current evidence-based practices largely produced by high-income countries and exported and adapted to local situations) and a culturally-based approach (which emphasizes local priorities and community-based resources and solutions). The first two days took the form of a workshop bringing together experts in cultural psychiatry, public health and medical anthropology for a consideration of ways to bridge various perspectives on GMH.

In an attempt to convey the essence of the ASI meeting, we report on the proceedings of the workshop and conference in the form of a debate, giving voice to those in attendance.

Understanding Global Mental Health

> *"I am confused. From what I've learned over the last days of discussion, it is not 'global', not about 'mental', and not about*

> *'health'. So why don't we call it 'local political recovery'?"* Suman Fernando (closing statement to the ASI conference)

Discussion about the nature and vision of the GMH agenda oscillated between two antagonistic poles. One described it as a bottom-up, public health movement driven by local knowledge and priorities, with the aim of providing access to mental health care for everyone. On the other end of the spectrum, GMH was seen as a top-down, imperial project exporting Western illness categories and treatments that would ultimately replace diverse cultural environments for interpreting mental health.

Vikram Patel, a psychiatrist at the London School of Hygiene & Tropical Medicine, and a major proponent of the field of GMH, described current mental health treatment conditions as a fundamental human rights crisis. In contrast to other humanitarian crises, he argues**,** there has been no global outrage about the dramatic treatment gap in mental health care, partially because some people "perpetuate the myth that mental illness does not exist". He suggested that unlike its colonial predecessors "tropical medicine" and "international health", GMH was shaped by a postcolonial framework which asks "what can we do collaboratively**?**" rather than "what can we [the West] do for you?". According to Patel, the GMH movement was grounded in the belief that mental healthcare interventions should be driven by local knowledge and that such knowledge should flow in both directions between the global south and the global north. In this vision of GMH, he described a shifting of power from "places like Montreal to places like Delhi".

An alternative perspective on the GMH movement was voiced by Derek Summerfield and Suman Fernando, who both suggested that GMH is becoming a predominantly Western scientific endeavour driven by psychiatry and the pharmaceutical industry. Summerfield, an honorary senior lecturer at London's Institute of Psychiatry, pointed to the limited explanatory power and relevance of Western mental health concepts in many parts of the world and questioned the existence of a "hidden burden of mental illness" which only becomes conceivable when Western psychiatric categories and measures are assumed to be universal. It was purported that evidence of efficacy for many psychiatric treatments is still contested in the West and was thus not robust enough to be scaled up in the South. Similarly, Fernando argued that the Western notion of the individual has become the universal subject in mental health care and although the GMH's program is tweaked with culturally sensitive language, it does not include the voices of the service users and the poor. He further pointed out that economic interest and funding structures will always be a political issue as they create an unequal relationship between donors and recipients and determine what kind of system emerges in a

particular context.

Who is setting the GMH agenda? Whose knowledge counts?

Many of those attending the ASI meeting questioned the selection of the Delphi panel[1] in strategizing the agenda of the GMH movement that informed the formulation of the "Grand Challenges in Global Mental Health" (*Nature*, 2011). In response, Patel described the Delphi process as one of the most transparent attempts of agenda setting since it included researchers from low-and-middle-income countries (LMICs) and because a third of the respondents were women. He also stressed that Western psychiatric nosologies, such as the DSM or the ICD were not the driving force behind the agenda, but that the basis was the World Health Organization's (WHO) mental health intervention guide mhGAP (WHO 2008), which aims at scaling up services for a small selection of mental, neurological and substance use disorders in LMICs.

In response to this, many panellists questioned the ways in which access to the process of agenda setting is distributed. One of the central dichotomies dominating the discussion on agenda setting was the divide between a powerful global North and a receiving global South. William Sax drew attention to the fact that although this division reflected a political argument, it did not capture the epistemological dimensions as to whose knowledge actually counts in the GMH discourse. He pointed out that Western psychiatry and traditional healing practices engage in an asymmetrical relationship in which traditional local practices have "less resources, social capital, and power because they are the traditions of poor people". Furthermore, he highlighted the failure of the North-South divide in addressing the implicit hierarchy of scientific knowledge which is negotiated within different, not locally specific networks and their practices of validation (peer review, evidence, RCT's). This argument was taken up and exemplified by Frederick Hickling, a Jamaican psychiatrist, who, over many decades created an immensely successful community-based mental healthcare system in Jamaica. However, he recounted that his attempts to publish his work in scientific journals was continually met with rejection based on the requirements of an imperial knowledge production:

> *"When we try now to get to the Western world to say 'this is what we have done, this is what we have achieved' we have to go through journals. They then tell us about equipoise… with the journal saying, 'we can't take your naturalistic perspective; we need to get an ethical randomized controlled trial'. So they still put us into this conundrum of the enslaved and marginalized people"*

Laurence Kirmayer added to this that not all interventions lend themselves to RCTs – especially psychosocial interventions may be difficult to standardize, randomize, and blind. According to him, the challenge of integrating evidence-based medicine and cultural psychiatry raises the question of methodological, epistemological and political pluralism. He identified the need to recognize different types of knowledge, e.g. outcome should be measured not only in terms of symptom reduction, behavioural change, or level of instrumental functioning, but in terms of individuals' ability to pursue culturally relevant goals, including the impact on the family and community.

Political dimensions of the Global Mental Health Agenda

The GMH discourse was also addressed as a political instrument creating legitimacy and avenues to care, particularly in the context of refugee health. Charles Watters, professor of childhood studies at Rutgers University, analyzed such "epistemologies of care" in the context of European asylum practices. Using his work on European asylum practices as an example, he showed how the medical model (i.e. the emphasis on one's sick body and mind) provided refugees with access to care, while also denying them other avenues of legitimacy. In other words, mental health was described as a parameter of legitimacy that people employed strategically in order to navigate the legal system while other factors, such as aspiring a new life and future were excluded since they undercut the Western concept of asylum, in which refugees are conceptualized as merely fleeing to the first available safe country. Laurence Kirmayer added that if refugees' life aspirations invalidate their medical claims, an important source of resilience is denied to them, which could be critical to the individual's mental health. Pierre Bastin, a psychiatrist working for Médecins Sans Frontières (MSF), noted that in this context, practitioners on the ground are very aware of the strategic and political power of diagnosis (i.e., PTSD) to aid in claims. Yet, speaking from his own experience in refugee camps in Somalia, Bastin described that diagnostic labels did not always provide access to care and/or asylum, and they could also, in many cases, become a barrier. He gave the example of refugees with the double label of being Muslim and having a mental health diagnosis, who were systematically denied access to certain countries.

What are we treating in Global Mental Health?

An integral part of the struggle to define the GMH agenda was the disagreement over the targets and objectives of the GMH field. This

discussion was characterized by shifting frameworks, terms and concepts, the main argument of which concerned whether mental illnesses have a universal, biological foundation or whether they must be understood as culturally contingent expressions (with the DSM understood as a Euro-American cultural framework). Vikram Patel acknowledged that with the lack of biomarkers for mental illness, we must rely on currently existing knowledge as well as patients' accounts. However, he also believes that a shared biology underlies culturally diverse descriptions of mental illness. He gave the example of Alzheimer's Disease, which in the 1960s was simply described as "growing old badly" until it was confirmed as a disease entity through advances in biology and neuroscience. In terms of cultural variation and meaning of mental illness, Patel claimed that mental health, regardless of name or classification system (i.e., Chinese medicine, Ayurveda, the DSM) was experienced worldwide, stating that "a rose remains a rose, no matter how you call it".

Gilles Bibeau, a medical anthropologist from the University of Montréal responded to this phenomenological perspective by stating that every illness experience must be framed in its own context, as "each of those terms is a prisoner to their own history". Derek Summerfield took this critique further by challenging his colleagues to explain the difference between depression and sadness. He argued that validity remains a key issue in psychiatry, and if all we have are ways of validating illness categories which we ourselves constructed [in the West], "most of it can be thrown out because it fails validity; it fails the reality of these people". Using the example of depression**,** Summerfield stated that illness classifications should not be brought to places where there has been no such thing. Teaching concepts such as "mental health literacy" represents a unidirectional transfer of knowledge with unclear gains for the people who (are at the receiving end of this knowledge):

> *"We cannot gather all distressed people in the world and put them into the category 'depression'. I don't think there is such a thing as depression, as a universal category. I think that's a myth. At the end of the day it's like saying peoples' worlds are like colourful garments that you can strip away."*

While he acknowledged that the more severe spectrum of mental illness, like psychosis, would stand on firmer grounds of evidence than common mental illnesses, Summerfield insisted that even in these cases the question of cross-cultural validity must still be asked.

Debates as to what could be regarded as a mental illness erupted frequently throughout the ASI discussion, particularly in regards to suicide. Summerfield asked: "Does an Indian farmer commit suicide because of a

mental illness, or because farming broke down and left him with no income?" Fred Hickling also spoke to the issue of suicide stating that Jamaica has the lowest suicide rates worldwide, but that its homicide rates are amongst the highest. If suicide is considered a mental illness, is homicide a mental illness category as well?

Interestingly, the role of social determinants of mental health was relatively underrepresented in this debate. Duncan Pedersen pointed out that the questions of social determinants transcend the nature-culture divide dominating the current debate over definitions of mental illness. According to Pedersen, the GMH agenda should be driven by questions of social inequity. Reflecting on his work with the Trauma and Global Health program at McGill, he stated that war and trauma, and ongoing forms of structural violence are extreme contributors to mental health which could not be ignored, and "are not going to be solved in the biological-cultural dilemma."

How do we treat mental health problems?

Since there was little consensus on what constituted the objects of Global Mental Health, perspectives on how to implement GMH interventions were similarly diverse. There were a few central themes which revolved around practical strategies: Is it possible to scale up mental health treatments and is it the right approach? And if yes, what is it that we are scaling up? What constitutes evidence, valid instruments and measures? How much standardization does GMH bring about?

Patel pointed out that GMH is about universal healthcare, equity and scaling up public healthcare systems. Thus, the integration of mental healthcare into the primary healthcare system is a major goal of the GMH movement. In this context, it is inevitable that GMH strives to remove variability to ensure that everyone gets the same outcome. Patel stressed that although Global Health advocates a certain *function* (i.e. healthcare has to be affordable and follow a set of values and aspirations), the *form* can take many different shapes. Joop de Jong's concern was that the *function* of GMH remains unclear since it is lacking a (meta-) theory to guide its action. Without such theory, there is an impediment to developing testable models related to cooperation, and to solving major preoccupations related to access to care or stigma.

On the topic of standardization and scaling up services, William Sax highlighted the importance of preserving medical pluralism, especially traditional healing. He reflected on the possibility of integrating healers into the mental health care system and concluded that it would be impossible

for the following reasons: 1) the individualistic notion of the person used in psychiatry is incompatible with most forms of traditional healing; 2) there is a considerable social distance between health workers and healers, who are often perceived as backward, uneducated quacks by medically trained health workers; 3) ritual healing defines the boundary of the scientific episteme and can hence not be easily integrated into it; 4) the strength of locally contingent forms of healing is in fact their diversity. Health care systems on the other hand regulate, monitor and normalize traditional healing services– and would hence destroy the very characteristics that make traditional healing work: their local particularity. Patel responded to this by stating that traditional healers always have and will continue to co-exist with the medical standard to health care. Yet, Joop de Jong cautioned that although this may be a reality, there are always hierarchies of health seeking, since people "want to belong to the dominant class" of treatment, which is often associated with Western biomedicine or NGOs.

Marc Laporta, the director of the WHO Collaboration Center in Montreal, urged practitioners to focus on the variables that are "meaningful on the ground". From his perspective, outcomes are not just about what works best, but that increasing the participation of mental health patients in society might be more important than saving a government money. Drawing on a project which aimed at integrating mental health services into primary care settings in South East Asia, he outlined the problems they experienced on the ground. For example, one of the major limitations of mhGAP is the difficulty to match the goals with the average 15 minute time frame allotted for patient visits in primary care settings.

Hilary Robertson-Hickling, a behavioural scientist at the University of the West Indies in Jamaica, questioned whether mental health work should actually be taken out of a medical framework, pointing out that "psychiatry does not do humanity work due to its obsession with pathologies" – a focus which distracts from social processes and the question of "what can we do together?" Frederick Hickling emphasized that over the past 50 years, mental health institutions in Jamaica have been dramatically transformed into community-based programs and integrated into primary health facilities. With a 500-year history of enslavement and imperial oppression, he emphasized that today, in countries like Jamaica, medical imperialism must be avoided by all means, and that philosophies and instruments of Western psychiatry that have been "forced upon" their local ways of dealing with mental health are no longer valuable in local practice.

So, again, what *is* Global Mental Health?

Joop de Jong described GMH as a fashion trend, comparing it to new pop music: “it is nothing entirely new, but there are a lot of new components, a lot of new evidence”. It also comes with the aura of the new and the kind of energy and verve urgently needed to move things forward. On the other hand, Gilles Bibeau suggested that the construction of GMH could have real structural effects and should thus be used and deconstructed with critical distance. He explained that individuals live today in a “fluid, uncertain and floating space that gives birth to more pluralistic societies… and to multiple identities in the construction of self”. He emphasized the point that in interrogating mental health in the context of a globalized world, one must search for a ground of articulation between modern psychiatric systems and the knowledge of people. This means that the only possible ethics for a “dia-logue of cultures” is through *translation*. He stated that societies must be understood in their own terms using the language/ customs of those societies. He cautioned that the term “Global Mental Health” could invite new – and often inappropriate – interpretations of what sort of identity we produce. Thus, one has to be careful as to how this language will map our minds and shape our thinking. As an example, Bibeau described how the GMH grant proposals he has reviewed already suggest the problematic ways in which these labels will be used and appropriated in the future.

Going back to his initial perspective of the state of mental health care as a fundamental humanitarian crisis, Vikram Patel defended the often strong language of the GMH movement, as a means of getting policy makers’ attention and convincing people to take action: “These are the kind of figures we have to use to *shock* policy makers. Shock the world into action.” He stressed that GMH’s main audience **is** not academics, but policy makers and health ministers. Hence, in this context the language of standardization, feasibility, and affordability become the main contenders for scaling up services. He acknowledged that GMH is a public health endeavour supported by the academic community, but vital differences exist on how to address the problem in academia and which strategies should be used on the ground. Kwame McKenzie, a psychiatrist based at the Centre of Addiction and Mental Health in Toronto, agreed with this point suggesting that in order to move forward and make progress in advancing the GMH endeavour, one should focus on agreements within the field and move past the controversies. In response, a number of panel members took the position that critical insight and controversy are in fact at the core of scientific progress and should be valued over consensus. In the words of Gilles Bibeau: “I am not afraid of controversies, I am more afraid of consensus”. Controversy gives a chance to correct and eventually to improve things. This perspective of needing a system of checks and balances was shared by Jamaican psychiatrist Geoffrey Walcott who remembered the “dark times in history” in which disagreement was not possible.

What is *still* missing in the GMH discourse?

One of the major omissions from the GMH discourse in the three day ASI series was the topic of ethics. Research ethics were briefly mentioned by a few of the discussants in regard to carrying out studies in LMICs. For example, Mónica Ruiz-Casares, an assistant professor in McGill's Division of Social and Transcultural Psychiatry, was mainly concerned with research ethics that would avoid moral imperialism. She said it would be necessary to advance culturally-responsive mental health research designs and consent policies (e.g., visual consent forms). Yet, the overall ethical standards of the GMH movement were widely ignored for the major portion of the discussion. Duncan Pedersen acknowledged this "deficit" in the GMH discourse saying that "there is a need for more research- more robust and scientific base of GMH and a need to make explicit the ethical foundations of GMH". According to Pedersen, a balanced global health research agenda for the future in GMH should focus not only on the global burden of illness as outlined in the *Lancet* (2007) series, but also on the social, political, environmental and economic determinants within which these illnesses and diseases occur. He expressed his concern that issues of global equity and social justice were missing from the conversation and were essential to the GMH agenda

To this end, medical anthropologist Hanna Kienzler, from the Department of Social Science, Health and Medicine at King's College London, asked for more curiosity about the emergent social forms in the context of GMH. She said, "it might be helpful to learn more about how cultural and social differences play out as worldly encounters in a global arena instead of reiterating static dichotomies (north, south, west, HIC, LMIC, global, local). If we would look at these social encounters we would start to see interesting frictions – a term taken from anthropologist Anna Tsing – which produce new realities that can be instructive for our work. Such phenomena might be new and truly surprising, and not unfold along the same divisions and terms we have at the moment".

This desire to move the discussion beyond the impasse of culture versus biology and medicine versus politics by paying closer attention to how GHM actually plays out in concrete terms was shared by many younger scholars and interventionists. A number of younger conference participant**s** took the opportunity and stimulation provided by the ASI meetings to form a new group that is currently formulating a position paper aiming to add vital perspectives from the ground to the more conceptual discussion of the senior scholars. This call for new lenses to interpret the hopes or dangers of a newly emerging endeavour like GMH was also supported by Jaswant Guzder, a child psychiatrist at the Department of

Psychiatry at McGill, and Rachel Tribe, a counselling psychologist from the University of East London, both of whom highlighted the need to engage the younger generation of researchers and practitioners into this discussion.

Further reading and resources:

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Grand Challenges in Global Mental Health website

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community care settings. Building on this work, her doctoral research focuses on the recovery model as a product of Western epistemic cultures, which, when taken into different contexts through GMH interventions becomes a technology with its own social life and global trajectory. Contact: doerte.bemme@mail.mcgill.ca

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[1] The **Delphi method** is a structured communication technique, which relies on a panel of experts. In Delphi decision groups, a series of questionnaires, surveys, etc. are sent to selected respondents (the Delphi group) through a facilitator who oversees responses of their panel of experts. The group does not meet face-to-face. All communication is normally in writing (letters or email). Members of the groups are selected because they are experts or they have relevant information. (source: http://en.wikipedia.org/wiki/Delphi_method)