

LONDON
SCHOOL of
HYGIENE
& TROPICAL
MEDICINE



Patel, V; Prince, M (2010) Global mental health: a new global health field comes of age. *JAMA*, 303 (19). pp. 1976-7. ISSN 0098-7484
DOI: <https://doi.org/10.1001/jama.2010.616>

Downloaded from: <http://researchonline.lshtm.ac.uk/3660/>

DOI: [10.1001/jama.2010.616](https://doi.org/10.1001/jama.2010.616)

Usage Guidelines

Please refer to usage guidelines at <http://researchonline.lshtm.ac.uk/policies.html> or alternatively contact researchonline@lshtm.ac.uk.

Available under license: <http://creativecommons.org/licenses/by-nc-nd/2.5/>

Global Mental Health: a new global health field comes of age

Vikram Patel & Martin Prince

Joint Directors, Centre for Global Mental Health, London School of Hygiene & Tropical Medicine & King's Health Partners, London, UK.

Address for correspondence: Dr Vikram Patel, Sangath Centre, Alto Porvorim, Goa 403521, India.

Email: vikram.patel@lshtm.ac.uk

Date of revision: 2 March 2010

Word count: 1200

Acknowledgements

VP is supported by a Wellcome Trust Senior Research Fellowship in Tropical Medicine. We are grateful to Pamela Y. Collins, MD, MPH (Office for Research on Disparities and Global Mental Health, National Institute of Mental Health, USA); Ritsuko Kakuma, MSc, PhD (Health Systems Research and Consulting Unit, Centre for Addiction and Mental Health; Dalla Lana School of Public Health, University of Toronto); and Alan John Flisher, MD, FCPsych (Sue Streungmann Professor of Child and Adolescent Psychiatry and Mental Health at the University of Cape Town) for comments on an earlier draft of this paper.

Disclosure statement

Both authors are Joint Directors of the Centre for Global Mental Health in the UK.

Both have received funding from the Wellcome Trust and are members of the WHO's mhGAP Guidelines Development Group and the Movement for Global Mental Health. Neither have received any personal emoluments, and have no financial interests in relation to any of these activities

VP has also received funding from the MacArthur Foundation, the Medical Research Council and Autism Speaks. He serves on the research advisory boards of the Institute for Health Metrics and Evaluation and the George Institute for International Health and has honorary professorships at the Public Health Foundation of India and Dalhousie University. He co-chairs the Scientific Advisory Board of the Grand Challenges in Global Mental Health.

Martin Prince leads a research group which has also received grant funding from the the US Alzheimer's Association, the Medical Research Council and the Psychiatry Research Trust.

Global health is “an area for study, research and practice that places a priority on improving health and achieving equity in health for all people worldwide”¹. Global mental health is the application of these principles to the domain of mental ill-health. The most striking inequity is that concerning the disparities in provision of care and respect for human rights of people living with mental disorders between rich and poor countries. Low and middle income countries (LMIC) are home to over 80% of the global population, but command less than 20% of the share of the mental health resources². The consequent ‘treatment gap’ is in itself a contravention of basic human rights –more than 75% of those identified with serious anxiety, mood, impulse control or substance use disorders in the World Mental Health surveys in LMICs received no care at all, despite substantial role disability³. In sub-Saharan Africa the treatment gap for schizophrenia and other psychoses can exceed 90%⁴. Even where treatment is provided, far too often this falls far below minimum acceptable standards. Failure to provide basic necessities such as adequate nourishment, clothing, shelter, comfort and privacy, unauthorised and unmonitored detention, shackling and chaining are all well documented abuses, described recently as a ‘failure of humanity’⁵.

Three critical foundations of evidence account for the emergence of the new field of global mental health. First, a large body of cross-cultural research and, equally important, the narratives of health workers and people living with mental disorders, have finally put to rest any notion that mental disorders were a figment of a “Western” imagination and that the imposition of such concepts on ‘traditional’ and ‘holistic’ models of understanding amounted to little more than an exercise in neo-colonialism. Second, a growing body of epidemiological research attested to the considerable burden of mental disorders in all world regions. The Global Burden of Disease report⁶ surprised the global health community with its finding that five of the top ten contributors to years lived with disability globally were mental disorders. The vicious cycle of disadvantage, social exclusion and mental disorder was a key message of the World Mental Health Report⁷ and the subsequent World Health Report of 2001⁸. Third, the evidence that there are efficacious drug and psychological treatments for a range of mental disorders and that non-specialist health care workers can deliver psychological treatments or multi-component stepped care interventions for mental disorders, with large treatment effect sizes that are sustained for extended periods of time⁹. In the face of the severe and persistent shortages of personnel and the spiralling costs of specialist mental health care, such evidence countered the nihilistic view that nothing could be done¹⁰.

The recent rapid growth in the visibility of the field can be traced to a single event that drew together and built upon these three strands of evidence: the launch of a series of articles focusing on global mental health in September 2007 in the *Lancet* medical journal. A Google search for 'global mental health' on November 1st 2009 identified approximately 62300 sites of which over 85% of sites were registered after the publication of the series. The 'call to action' of the series, to scale up services for people with mental disorders on the twin principles of scientific evidence and human rights¹⁰, has now become widely adopted as a focus of action in global mental health. Two examples stand out amongst these: the WHO's mhGAP (Mental Health Global Action Program) and the Movement for Global Mental Health (<http://www.globalmentalhealth.org>). The WHO has declared mhGAP as its 'flagship' program in mental health. The program will publish evidence-based guidelines for non-specialist health workers to provide treatments for eight mental, neurological and substance use disorders, in routine health care settings. The Movement for Global Mental Health is a coalition of individuals and institutions committed to actions to close the treatment gap. It derives its inspiration from the success of the Treatment Action Campaign in transforming the lives of people living with HIV worldwide by campaigning to ensure access to antiretroviral medicines.

The field is now poised for rapid growth as donors pledge new or strengthened commitments to global mental health (such as DFID and the Wellcome Trust); the launch of new academic initiatives such as the Centre for Global Mental Health in London (www.centreforglobalmentalhealth.org); the growth in capacity building initiatives in global mental health, such as the Masters in International Mental Health Policy, Services & Research by the University of Lisbon; and the launch of a new Grand Challenge in Global Mental Health led by the National Institute for Mental Health and the Global Alliance for Chronic Diseases. Much, of course, remains to be done. Above all, the field must continue to advocate to donors that mental health is not a luxury item on the health agenda of less resourced countries. There is no health without mental health, and mental health is highly relevant to the management of existing health priorities as defined by the Millennium Development Goals¹¹. Scaling up services can take two distinct paths. Integrating mental health care into the programs already in place for other health conditions is a pragmatic and efficient approach which may require only marginally additional resources; HIV/AIDS, chronic diseases and maternal and child health serve as obvious examples. However, the most vulnerable people with mental disorders are those living with serious, enduring

and disabling conditions: intellectual disabilities, schizophrenia and dementia are hallmark examples of such conditions across the life course. For these individuals, there is an urgent need for deinstitutionalisation and provision of acute and continuing care services closer to the communities where those affected live.

There is a critical need for more research. While the essential ingredients of packages of care have already been identified⁹, there is some uncertainty as to how precisely these should be delivered. Hence, much attention needs to be directed to the implementation science. This needs to focus particularly on the most effective interaction between specialist and non-specialist care providers; for example, the extent to which tasks can be shifted, and the duration, type and frequency of training and supervision that is required. So far, the field of global mental health has been largely focused on the large treatment gaps in LMIC, a clear moral and ethical priority. However, the field will reach maturity only when it recognizes its potential to bring about improved care and outcomes, and reduced inequities in all world regions. There are many under-served sub-populations in HIC too and the provision and quality of mental healthcare has been shown to vary widely. In a globalising world, the field will increasingly need to address trans-national influences on mental health; migration, conflict, disasters, and the impact of global trade policies are notable examples. Knowledge can and must flow in both directions between HIC and LMIC. Researching mental disorders and treatments in diverse populations and translating advances in neuroscience to the benefits of patient care in the global mental health context are grand challenges for the field. Ultimately, the search for a better understanding of the causes of mental disorders and affordable and effective treatments is of importance to improving the lives of people living with these disorders in all countries; this is the ultimate goal of global mental health.

References

1. Koplan JP, Bond TC, Merson MH, et al. Towards a common definition of global health. *Lancet* 2009;373:1993-5.
2. Saxena S, Thornicroft G, Knapp M, Whiteford H. Resources for mental health: scarcity, inequity, and inefficiency. *Lancet* 2007;370:878-89.
3. Demyttenaere K, Bruffaerts R, Posada-Villa J, et al. Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *Jama* 2004;291:2581-90.
4. Kebede D, Alem A, Shibre T, et al. Onset and clinical course of schizophrenia in Butajira-Ethiopia--a community-based study. *Soc Psychiatry Psychiatr Epidemiol* 2003;38:625-31.
5. Kleinman A. Global mental health: a failure of humanity. *Lancet* 2009;374:603-4.
6. Murray C, Lopez A. *The Global Burden of Disease*. Boston: Harvard School of Public Health, WHO and World Bank; 1996.
7. Desjarlais R, Eisenberg L, Good B, Kleinman A. *World Mental Health: Problems and Priorities in Low-Income Countries*. Oxford: Oxford University Press; 1995.
8. World Health Organization. *The World Health Report 2001: Mental health: New Understanding, New Hope*. Geneva: WHO; 2001 2001.
9. Patel V, Thornicroft G. Packages of care for mental, neurological, and substance use disorders in low- and middle-income countries: PLoS Medicine Series. *PLoS Med* 2009;6:e1000160.
10. Lancet Global Mental Health Group. Scaling up services for mental disorders--a call for action. *Lancet* 2007;370:1241-52.
11. Prince M, Patel V, Saxena S, et al. No health without mental health. *Lancet* 2007;370:859-77.