Rebalancing power in Global Mental Health

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Abstract

Global Mental Health has become clearly defined as a distinct academic discipline and area of practice since the 1990s, and has gained increasing prominence. Its roots lie in international and cultural psychiatry, but it has taken a clear direction of focusing on effective real-world change through application of evidence-based health interventions in a scientific psychiatric paradigm, strongly influenced by social psychiatry. While culture is acknowledged as important, it is seen as an overlay, presuming a common scientific paradigm for mental health globally. One example of this is the use of local adaptation of international guidelines like the WHO's mhGAP.

While a growth in investment, prioritisation and application of knowledge has the potential to positively impact on lives of people affected by mental ill health, there is a risk of causing harm by inappropriate application of ideas not well suited to local needs. Global frameworks for mental health and human rights already advocate a human rights approach with participation of people affected, but it is only by rebalancing power towards local actors that national authorities can be held to account, and potential benefits of Global Mental Health be realised.

Key words

Global Mental Health, Human Rights, Service Users, Low and Middle Income Countries, Psychosocial Disability

The report of the Lancet Commission on Global Mental Health and Sustainable Development (Patel et al, 2018) is the latest in a series of key publications that have documented a maturing discipline, based on the established precepts of global health, and taking in the specificities and additional complexities that mental health brings in research and practice. Global Mental Health has been defined as 'the area of study, research and practice that places a priority on improving mental health and achieving equity in mental health for all people worldwide' (Patel & Prince, 2010). It has evolved as an academic discipline and set of development interventions, influenced by a number of disciplines and traditions, over the last 20 years. As with other fields of global health, the field is focused on equity and access to care, but concerns related to differing local cultural concepts of health and ill health are probably even more pertinent to mental health than other health sectors. As with other parts of global health, a central concern is the degree to which concepts are universally valid, and whether evidence generated predominantly in high income countries, can lead to effective interventions, that are appropriate and acceptable. This paper explores the structures on which global mental health was built, where power might lie in directing its course, and how this might be rebalanced towards a future where it is more likely to reflect the needs and aspirations of those impacted by it.

From international mental health and transcultural psychiatry to Global Mental Health

As far back as Emil Kraeplin's famous visit to Java to investigate the social, cultural and environmental factors associated with mental ill health in 1904, transcultural psychiatry and related

research has attempted to address the question of what is common, and what varies, across cultures in terms of expression of mental illness, and by extension, the degree to which treatment might or might not be appropriately utilised across cultures. The early 20th century saw the exporting of European psychiatry as a part of a wider colonial agenda, with treatment and attitudes reflecting prevailing scientific and social views (Sadowsky, 1999). Through the latter part of the 20th century, anthropology and social sciences predominated in this area, using mainly ethnographic methods to explore local traditional beliefs and practice, mainly emphasising differences between cultures. Such an emphasis is naturally sceptical of the value of common approaches to addressing diverse experiences, and the field of transcultural psychiatry has critiqued the foundational idea of a global mental health agenda, and the potential risks of exporting predominantly biomedical models of care (Littlewood and Lipsedge, 2014).

Lee and Collin (2005) describe the transition from International Health to Global Health as a shift from the study and practice of health in 'other' (usually tropical) countries, with an often charitable approach; to recognition of the common, trans-border nature of determinants and outcomes of many health concerns. Mental health can be traced as having undergone this transition, with a growing literature emphasising the need for urgent action on a global scale to respond to the suffering and disability caused by mental conditions, and disparities in access to mental health care in all countries (Patel et al, 2018).

It was the Global Burden of Disease (GBD) studies in the 1990s (Mathers et al, 2007) that first highlighted with robust epidemiological data the very high prevalence of mental conditions, which showed mental, neurological and substance-use conditions[i] to contribute more to the total burden of disease than many other traditional health priorities. The GBD study used the metric of Disability Adjusted Life Years (DALYs), which combined Years of Life Lost (YLL) and Years Lived with a Disability

[i] I have used 'conditions' directly in place of 'disorders' throughout this paper, but the terms can be read as synonymous

(YLD). Using this metric, extremely high levels of burden of disease were attributed to mental conditions because many conditions start early in life, last for a long time, and were assessed by people affected as being extremely disabling (so having a high disability weighting compared to other impairments). In fact, the DALYs for these conditions is the highest proportion of all Non-Communicable Diseases, and makes up around 13% of all health-related DALYs, though there is a good argument that even this is an underestimate (Vigo et al, 2016). This stands in contrast to the low prioritisation of mental health, as exemplified by the very low level of investment in research and service provision compared to other areas – often less than 1% of health budget in low income settings (Saxena et al, 2007).

The justification for addressing these common conditions was the huge gaps in access to treatment in many countries, and the appalling human rights abuses was framed in explicitly moral terms (Kleinman, 2009), with a clear position that while cultural context is important, this is an overlay to fundamental commonalities across humanity, and does not justify inaction. Despite ongoing concern about the risks of globalising particular models of care (Mills, 2014), this concern has been the impetus for the expansion of the field, providing a basis for the subsequent growth in investment, research, training opportunities, and political buy-in that has followed.

Where does power lie in GMH?

The clearly stated purpose of the field of global mental health has been one of real-world impact, for example, the *call to action* (Lancet Global Mental Health Group, 2007) arising from the key Lancet Global Mental Health Series of 2007, emphasises a drive towards the dual goals of a closure of the treatment gap, and improved human rights for people with mental illness. The call to action was linked directly to the launch of a Movement for Global Mental Health (Eaton and Patel, 2009) recognising the crucial impact of mass engagement in an issue (citing the example of the Treatment Action Campaign in raising the profile of HIV). However, despite these efforts to democratise Global

Mental Health, the impetus, theoretic underpinnings and leadership for this drive have undoubtedly to date come from the academic community.

In what way has power, then, been exercised beyond the confines of universities and research environments? More than in the fields of transcultural and international psychiatry, the main principles of Global Mental Health can be seen in the key formal recommendations and reports of global technical and governance bodies like the UN and WHO, for example the 1995 World Mental Health Report (Desjarlais et al, 1995), the 2001 WHO World Health Report; New Understanding, New Hope (WHO, 2001b) and the Mental Health Atlas (WHO, 2001a; WHO, 2018), and These publications, perhaps as might be expected from the World Health Organisation, argue for a major increase in attention for mental health, but also importantly, a transformation of the way that mental health care was provided. The WHO has continued to be closely aligned to the field of Global Mental Health, and the main characteristics of services espoused are almost indistinguishable from the current recommendations; deinstitutionalisation, task shifting, stepped collaborative care, and integration of care into general health and social care systems. These publications also promoted engagement with traditional systems of care and mobilisation of community resources for support of people with mental conditions, but this is not reflected in the volume of recommendations related to more orthodox western psychiatric services, even if this is based on reform of services, such as the use of task shifting models and other innovations that have formed the core of an growth in evidence generated about efficacy of interventions in low income settings, and how to deliver these changes (Eaton et al, 2011). In addition to being clearly aligned to the key principles of Global Mental Health, the WHO has clear formal influence on governments through the UN system, partly through its role in normative guidelines development and technical support to governments globally. Clear rules apply to potential conflicts of interest in contributing to these guidelines, but there are many ways in which evidence is distorted by private interests, for example the pharmaceutical industry (Goldacre, 2012). While WHO and national governments often set policy frameworks, it remains the case that the practicality on the ground is of most people using

traditional mental health care, or private providers, many of whom do not respond to policy of formal guidelines (WHO, 2018) .

It is worth noting the 'values-based agenda' of the United Nations, particularly the respect accorded to human rights approaches, providing a strong framework for advocacy by civil society groups, who are often formally consulted in decision-making processes. This has led in the case of mental health to rights being placed as guiding principles in key documents like the WHO Mental Health Action Plan (MHAP) (WHO, 2013), and the QualityRights Initiative (WHO, 2012).

Evidence generation; who creates the narrative?

A 10/90 split in research production has been described, where less than 10% of mental health research is carried out where 90% of the world's population lives (Patel, 2007). Compounding this is a dominance of research related to biomedical and psychiatric treatment-related research, rather than, for example, research related to social determinants of mental ill health or means of promoting wellbeing. The consequence is a historical bias in themes and quality of available evidence in the field, which affects priorities in interventions and investment. For example, the influential WHO Mental Health Gap Action Programme (mhGAP) Intervention Guide (WHO, 2008) demanded rigorous evidence as a part of the WHO's quality standards for guidelines development (Barbui et al, 2010), but the 'hierarchy of research methods' used in such exercises tends to reinforce existing orthodoxies, by favouring for example randomised controlled trials, which are more likely to be carried out for medicines, using clinical symptom outcomes, rather than psychological or social interventions. Publication biases also works against innovative solutions that fall outside of well-funded research, for example work done by many civil society organisations, that is not routinely evaluated for publication in peer reviewed journals.

Deliberate efforts have been made to rationally set a research agenda in Global Mental Health, the most widely cited of which is the Grand Challenges in Global Mental Health Delphi exercise led by the US National Institutes of Health and published in Nature (Collins et al, 2011). In the Delphi

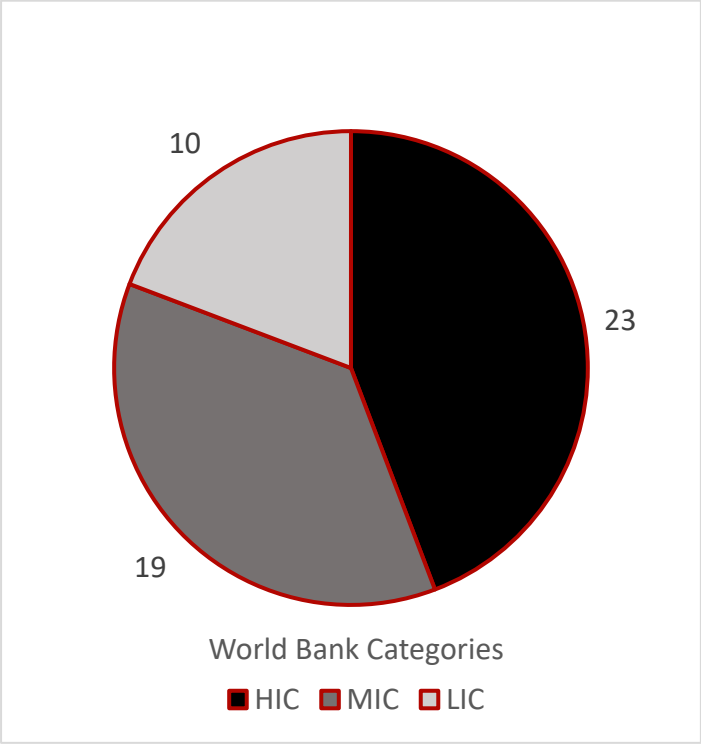
process, efforts are made to systematically sample opinion of identified experts in a field, often where there is a recognised lack of evidence available. This affords the possibility of reframing the definition of 'expert', recognising other forms of knowledge, and exploring the agendas of different actors in the field.

Another means of broadening the range of voices in translation of research into practice is to use participatory approaches to guidelines development, which allows consensus to be reached that is able to highlight areas of neglected research, for example psychological interventions tailored for low income settings were recognised as important in the first mhGAP Intervention Guide development process, but it was only after significant investment in this area in subsequent years that the specific high quality evidence exists for the interventions proposed (Purgato et al, 2018). Such 'expert groups' are widely used, for example in the mhGAP Intervention Guidelines development, and the Lancet Commission on Global Mental Health and Sustainable Development. This reflects an acknowledgement of a need to incorporate broader perspectives, and significant progress has been made in this regard. A rapid assessment of these two landmark publications with publically available authorship, looking at the countries where expert group members work demonstrates a fair global geographic spread, though not reflecting global population distribution (see box 1). The Grand Challenges in Global Mental Health Delphi group also had over half of respondents from low and middle income countries.

Importantly, despite the fair global balance by country of work, the great majority of participants were clinicians in the northern psychiatric or psychological tradition, even if from the global south, and this is the very clearly defined paradigm within which this work is carried out. So while traditional perspectives are acknowledged as important for the practice of implementing reform, there is a very unequal value placed on local world-views and northern scientific paradigms in the field of Global Mental Health, when it comes to reform in countries.

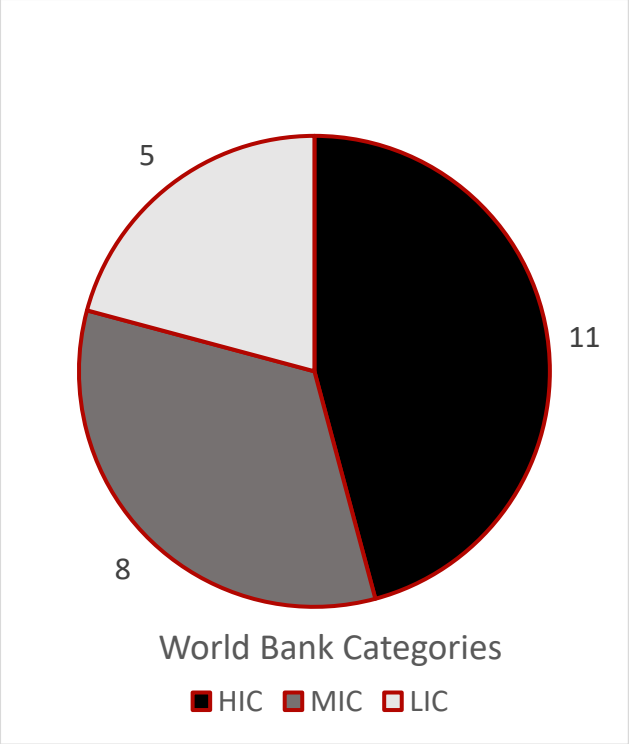
BOX 1: Make-up of mhGAP and Lancet Commission expert groups by country of work (numbers of people from High-, Medium-, and Low-Income countries in group).

a) WHO mhGAP Intervention Guide. 'Guidelines Development Group', 2010



Australia (2)
Austria
Belgium
Cambodia
Canada (3)
Chile
China (2)
Ethiopia
Ghana (2)
India (8)
Iran
Italy (3)
Kenya (2)
Lebanon
Liberia
Myanmar
Netherlands
Nigeria (2)
Pakistan
Sierra Leone (2)
South Africa
Spain
Sri Lanka (2)
Sweden
Switzerland (3)
Togo (2)
UK (6)
USA (7)
Zimbabwe

b) Lancet Commission on Global Mental Health and Sustainable Development 'Commissioners', 2018



Australia (2)
China
India (3) (secretariat)
Italy
Liberia
Mexico
Netherlands
Nigeria
Pakistan (2)
Palestine
South Africa (3)
Uganda
UK (4)
USA (3)

It is worth noting that in the Lancet Commission, inclusion of a Commissioner who was a person identifying as living with a mental illness was considered essential.

END OF BOX 1

There has been a substantial increase in publications on global mental health over the past 15 years (Patel & Kim, 2007). Although this has continued to be predominantly originating in high income countries, a number of key research grants have been deliberately targeted at researchers from the global south, or collaborations between the north and south, for example Grand Challenges Canada, the Hubs of the National Institute for Mental Health, the Global Challenges Research Fund, Tropical Health Education Trust, and others. A number have also specifically focused on building research

capacity in the global south, like the Wellcome-funded African Mental Health Research Initiative, AMARI (www.amari-africa.org/research/). This is likely to increase suitability and practical applicability of interventions in countries where researchers work, and may go some way to making it more likely that the research agenda is better aligned to national priorities, and facilitate meaningful influence of researchers from the global south on the global research agenda. Researchers and professionals/clinicians are often the same people, and have been identified as 'barriers' to reform, with vested interests in the status quo and dominance of established hierarchies slowing efforts to reform health systems (Saraceno et al, 2007). A wider rights-based approach being incorporated into knowledge generation and clinical training, as well as normative guidelines, offers the possibility of reducing resistance to change sometimes felt by civil society organisations.

Rebalancing power

While there are clear imbalances in power in setting the agenda of Global Mental Health, and a predominance of a medical paradigm, human rights approaches offer a bridge to bring together the perspectives of many civil society organisations, especially disability groups, and health-focused traditions (PANUSP, 2014). A human rights have been increasingly clearly articulated as the preferred approach in major guidelines, including the WHO Comprehensive Mental Health Action Plan 2013-2020 (WHO, 2013). The Lancet Commission on Global Mental Health has taken this further, reframing mental health as an essential contributor to human well-being as part of global development. Similarly, participation of people affected by mental illness and psychosocial disabilities has been held as a principle in most key documents and guidelines, but organisations of users have been critical of the reality of this participation (National Service User Network, 2018). Much of the tension has been specifically around the topic of the United Nations Convention on the Rights of Persons with Disabilities, UNCRPD (UN, 2007), which clearly encompassed psychosocial disabilities, and in doing so, challenged many of the common practices around mental capacity and enforced treatment and detention around the world. There is a clear variance with the clear

interpretation of the UNCRPD Committee from nation states (including those who have signed and ratified the convention) and a range of professional and civil society groups (Freeman et al, 2015; Caldas de Almeida, 2019). It is clear therefore, that while presence of strong human rights principles in high level frameworks is welcome, and offers a strong basis for distributing power and influence, there is far to go before there are common interpretations of how to translate them into practice.

As mental health becomes a priority in global health, and there are increased resources, it is only through paying attention to the knowledge and experience of local leaders, and people affected by service reform, that the opportunity can be used in a way that increases practical access to rights. The global agenda must be framed in a way that supports achievement of local priorities, for example with broader stakeholder consultation during decision-making processes (for example in normative guidelines development).

The other major means of allowing for alignment to national realities and preferences, for example In the case of guidelines, is local adaptation. This can in principle increase relevance of interventions, and ownership, but the degree of variation from the original document is usually limited, both by the need to adhere to parameters of the scientific basis of the guidelines (as discussed above), and lack of confidence of local actors to change what is perceived as expert guidance. One example of promoting a greater flexibility in local use is the QualityRights programme, designed to support local advocates in skills to evaluate services, and advocate for change (WHO, 2012). When used in India, peer support workers were included in the programme as were felt to add to the impact and ownership (Pathare et al, 2019).

Appropriate application of evidence to support people affected by mental illness can lead to profound improvements in quality of life (Prince et al, 2007). This can only be done well if locally owned services are of a high quality, follow best practice (for example with respect to deinstitutionalisation), and respect peoples' right to choose what kinds of care they access. Achieving the ideal balance of applying best evidence and practice, while incorporating local

circumstances, beliefs and experience, is best done by putting power in the hands of informed local leaders. This has been done by providing short practical training in leadership and advocacy, with examples in a number of locations, for example in India (www.sangath.in/workshops-training/leadership-in-mental-health), in Nigeria (Abdulmalik et al, 2014) and Egypt. Each of these courses targets a variety of actors, including professionals, advocates, and service users, who can design and implement effective reform suitable for the context they know well.

Global agreements and international conventions like the Mental Health Action Plan and the UNCRPD that seek to promote and protect rights are important standards against which local governments can be held to account. Where governments have signed or ratified such agreements, there are often mechanisms in place for reporting against expectations and standards. This may be relatively non-binding, for example with the MHAP, this may be simply reporting progress towards goals. With CRPD, the mechanism is more comprehensive, requiring regular transparent reporting to the UN CRPD Committee, including a parallel report that can be submitted independently by civil society actors. In order to drive change, building the capacity of local actors, especially people affected by legislation, policies, services and social environments, to effectively engage in accountability mechanisms offers the opportunity to translate global frameworks to improved lives and promote genuine inclusion. This has previously happened, for example in the example of HIV (Heywood, 2009), but for this to happen, investment and decision-making authority needs to shift to local and national levels. Increasing confidence in such local leadership by current holders of power will demonstrate a genuine rebalancing of power, so that Global Mental Health can be the global public good it seeks to be.

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