Medicine and Society

Movement for Global Mental Health: The crusade and its critique

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The Movement for Global Mental Health (MGMH)[1] aims to improve services for people with mental health problems worldwide, with a focus on low- and middle-income countries (LMIC). The core principles of this movement include scientific evidence and human rights. It is a broad coalition led by psychiatry and its membership now includes over 200 institutions and 10 000 individuals.

The movement is a product of the call for action of the Lancet Global Mental Health Series.[2] The components of the movement include advocacy, human rights, universal healthcare, policy, research and programmes relevant to LMIC.[1] Its main aim is to focus on the post 2015 Millennium Development Goals (MDGs) including mental health. The movement has inspired many field studies and has developed resources.[1] Support for the movement also comes from the WHO and its recent plans and programmes, which include Mental Health Gap Action Programme (mhGAP),[3] Mental Health Evidence and Research (MER) and the Comprehensive Mental Health Action Plan 2013–2020.

The mhGAP[3] recognizes the burden of mental illness, identifies limitations in service delivery, highlights gaps in treatment and services and attempts to bridge the void. Its resources include an intervention guide for common disorders, resources, projects and publications.

The core projects of the WHOs Mental Health Evidence and Research programme are the Mental Health Atlas 2011,[4] which maps mental health resources across countries,[4] the Assessment Instruments for Mental Health Systems (AIMS), which allows for uniformity of assessment of services,[5] and Mental Health in Emergencies.[6]

The major objectives of the WHO's Comprehensive Mental Health Action Plan 2013–20[7] include 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 system, evidence and research in mental health. Its cross-cutting principles include universal health coverage, human rights, evidence-based practice, life-course and multisectoral approaches and the empowerment of people with mental disorders and psychosocial disabilities. The plan aims to restructure, reinvigorate and invest in mental health services.[7] It provides a framework for national governments, development agencies, academia and civil society. It provides broad and objective measurable indicators and targets for key priorities including service coverage, updating mental health policies and laws, reducing rates of suicide, improving data collection to evaluate implementation, progress and impact.

The case to scale up services has the following rationale: (i) to fulfil unmet needs of 450 million people with mental disorders; (ii) to recognize mental disorders as a precursor to reduced resilience in conflict; (iii) to consider mental illness as a barrier to peaceful and inclusive societies; (iv) to improve economic productivity; (v) to make urbanization and development sustainable; and (vi) to ensure justice, equity and human rights.[8] The key indicators proposed are an increase in service coverage for severe mental disorders by 20% by 2020 and a reduction in rates of suicide by 10% by 2020. The MGMH and the WHO agenda aim to include mental health in the post 2015 development agenda and improve and increase delivery of mental health services.

THE CRITIQUE

Although the MGMH seems to be the dominant discourse, various components of its powerful critique include: (i) diagnosis based on symptom counts sans context; (ii) mismatch of tertiary concepts and primary care; (iii) reality of primary healthcare; and (iv) economic and cultural perspectives.

Symptom counts sans context

The absence of pathognomonic symptoms, the use of day-to-day phenomena (e.g. sadness, anxiety, crying, etc.) and the absence of laboratory tests for diagnosing psychiatric disorders mean reliance on clinical symptoms for diagnosis.[9] Symptom counts sans context result in heterogeneous categories. Such heterogeneity extends to clinical symptomatology, aetiology and pathology, variable response to standard treatments and marked variability of clinical outcomes. Consequently, people who receive the label depression can have a variety of contexts: interpersonal difficulties, marital discord, domestic violence, unemployment, financial problems, communal strife, poverty, structural violence, migration and forced displacement. Psychiatric labels and antidepressant use as well as standard mental health solutions fail to communicate or solve complex contextual challenges.

Issues related to severe mental illnesses (e.g. schizophrenia, bipolar disorders and psychotic depression) are also multifaceted. While people with these conditions benefit from psychotropic medication, many patients have variable outcome despite optimal treatment. The persistence of symptoms, distress, impairment, disability and handicap, despite regular treatment, call for explanations that go beyond the simplistic concept of disease. Consequently, patients, their families and the local community simultaneously hold multiple and contradictory models for their illness (e.g. disease, degeneration, deficiency, sin, punishment from god, karma, black magic, etc.).[10] People concurrently and sequentially seek biomedical and non-medical treatments. They visit hospitals for cure and seek healing from temples, mosques and churches and from traditional and faith healers.

Most societies are pluralistic and offer multiple, divergent and contradictory explanations for illnesses. These belief systems

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interact with the trajectory of the person's illness to produce a unique personal understanding, often based on a set of complex and contradictory explanations, which provide succour to overcome challenges including disabling symptoms, persistent deficits, impaired social relations and difficult livelihood issues. People tend to choose explanations that are non-stigmatizing and seem to rationalize their individual concerns, suggest that those are pragmatic responses at coping and call for a diversity of approaches to manage mental illness.[11] MGMH with its biomedical model and logic fails to comprehend the complexity of issues facing people with mental illness.

Mismatch between concepts and presentations

Non-mental health professionals usually manage the majority of psychiatric disorders in primary care and the community. However, psychiatric presentations in primary care differ from those seen in specialist settings.[12] They are often milder with sub-syndromal and mixed presentations, associated with psychosocial adversity, which remit spontaneously or respond to placebos and require psychosocial support. Specialist facilities with their referral pathways, on the other hand, manage severe, complex and chronic cases. Mapping tertiary care concepts, categories and treatment guidelines to primary care, or even employing their diluted versions (e.g. DSM-IV PC, ICD-10 PHC), fails to comprehend or capture the issues in general practice.[12] Categories useful in primary care are unacceptable to specialists and unsuitable in their settings and vice versa (e.g. mixed anxiety depression). Lower prevalence of classical presentations (e.g. anxiety and depression) result in high false-positive rates as predictive values depend on prevalence. General practitioners with their understanding of local contexts acknowledge and recognize multiple variants of distress. Family physicians argue against the medicalization of human distress and suggest that psychiatric diagnoses (e.g. common mental disorders) essentially flag normal distress rather than disease. The many differences in patient populations and perspectives suggests a 'category fallacy' when specialist cultures are imposed on primary care. The culture of psychiatry in primary care borrows heavily from specialist approaches and attempts to adapt it to the reality of primary care. The compromise is uneasy, unstable and difficult to apply. The low rates of recognition and treatment of mental illness in primary care across countries despite education and re-training programmes for general practitioners suggest the failure of tertiary care approaches in primary care.[12]

Reality of healthcare

The Alma Ata Declaration on Universal Health Care[13] was a revolutionary declaration of intent. However, subsequent attempts at selective primary healthcare, with its narrowed focus, watered down the ideal. The enormous need against the limited and substandard implementation of the intended programmes in LMIC was highlighted at the 30th anniversary of the Declaration.[14]

WHO's ambitious aim to incorporate the mental health component into primary care in the 1980s had resulted in pilot projects across LMIC.[15] The success of the model programmes resulted in national programmes across LMIC. For example, the programme in India with its broad principles of prevention, diagnosis and treatment of mental illness and promotion of mental health reads like a vision document.[16] However, the complete lack of financial allocation meant failure in implementation.[17] Despite the Bellari experience, the District Mental Health Programme 1988 and the Revised National Mental Health Programme 2003[18] were implemented in a relatively small number of districts and with patchy and variable results.[19]

The complete absence of factoring the complex ground reality with its poor health infrastructure, overburdened systems, physical health priorities, poor discipline and morale of staff, inappropriate training, professional apathy, limited finances and poor utilization doomed the programme to failure.[17] Replacing qualitative and anecdotal evidence with sophisticated quantitative data based on small but heavily funded projects and using advocacy without addressing technical issues related to the transfer of technology required to scale up the project also meant repackaging failed approaches using sleek presentations, without addressing the technical issues related to countrywide implementation. The lack of emphasis on universal healthcare, the failure to strengthen horizontal programmes and improve health infrastructure ruin efforts at piggy-backing mental healthcare in the community.

Cultural critique

Deconstructing MGMH suggests that it is an idea, a field of study and a movement. It conceptualizes mental disorders as global, context-free and universal.[20] Its corollaries include the comparison of the situation in LMIC with high-income countries and to draw attention to comparable burden, inadequacy of services and the ensuing treatment gap. It employs the reductionistic biomedical model which medicalizes problems of living.[20] The model developed in high-income settings is of questionable validity and is exported worldwide, and imposed on LMIC.

The opponents of the MGMH programme argue that emotional distress is a response to sociopolitical as well as economic conditions of conflict, social inequality, chronic poverty and unregulated capitalism and not symptomatic of neuropsychiatric disorders.[20] The universal one-size-fits-all approach results in a category fallacy (i.e. the unwarranted assumption that psychiatric categories and diagnoses have the same meaning when carried over to a new cultural context with its alternative frames or systems of meaning). The weakness of the knowledge base also results in overestimation of likely benefits from scaling up programmes. The generalization of psychiatric approaches based on symptom counts across cultures focuses on diagnosis, takes away from the sociocultural and political context, minimizes social determinants of mental health, diverts attention from normal distress and strengthens hospital-based care while also disempowering alternative and traditional approaches, de-emphasizing healing and recovery and violation of human rights. Critics of MGMH argue that globalization, neoliberalism and capitalism export western biomedical psychiatry and propagate neocolonial cultures where the powerful and hegemonic occident provides a hegemonic description of the Orient.[20]

The privileging of psychiatric and medical approaches also invalidates traditional, religious and community supports, which are considered quackery. It disempowers traditional support systems and delegitimizes all non-medical approaches. Personal, social and economic distress now get medical and psychiatric labels due to approaches that solely count symptoms.[20] Such approaches in high-income countries have reduced the importance and contribution of non-medical treatment and support options, leaving health and hospital services overwhelmed. The sole reliance on medical approaches in LMIC, the demonstration of their lack argues for the treatment gap, which is then used to endorse and promote more medical strategies, plans and programmes.

Psychiatric approaches also under-emphasize the role of public

health strategies to mental health and hence do not focus on issues related to basic needs and social security.[21] The diversity of perspectives about mental health and illness, the multiple pathways to care, traditional and faith healers, indigenous systems of medicine, and community supports and resources and public health solutions in addition to psychiatric and medical approaches in LMIC all suggest the need for a bouquet of services. Psychiatric approaches would then be one of many solutions on offer. There is a need to empower local approaches, invest in local communities and review political pressure for improving community and social services in LMIC. It calls for multifaceted and nuanced understanding of mental illness and its treatment.

The divergence of perspectives, disciplinary straightjackets, partial comprehension of issues and incomplete and imperfect solutions on offer demand humility from all those involved in the care of people with mental illness. Medical and non-medical approaches and public health strategies should all be employed to relieve suffering related to mental distress and illness. It calls for a shared perspective, which should be negotiated with people with mental illness, their families and local communities.

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