**Global Mental Health Movement: A Qualitative Review of its Cultural Discourse**

**Abstract**

The present article reviews the goals and differing positions on Global Mental Health (GMH) movement worldwide, with a distinct emphasis on the cultural differences in the understanding of the aetiology of mental health issues. The proponents and advocates of GMH support its intentions and primary agenda of scaling up the mental health services, especially in low-income and middle-income countries where the prevalence of mental health disorders is on an exponential rise. However, many cultural psychologists and sociologists highly criticise its attempt to universalize the psychiatric symptoms, as this universalization of clinical symptoms could actually suppress the local voices and might also underscore the significance of culture and other political and psychosocial predictors that may encompass various mental health challenges. Discussing both the thesis and antithesis of GMH movement, this qualitative review article is finally concluded with a conceptual analysis of GMH position and by offering predictions about its future discourse.

***Keywords:*** global mental health; GMH; mental illness; culture and mental health

**Introduction**

The current surge in the prevalence of mental disorders calls for a paramount need to scale up mental health services in an attempt to improve mental health conditions around the globe. The Lancet series on Global mental health (2007) reported that every year up to thirty per cent of the population worldwide have experienced some form of mental disorders and at least two-thirds of these people fail to receive any treatment, especially in low income and middle-income countries (LIMICs). Lancet Global mental health groups aim to design different kinds of interventions across all routine-care systems in a much-required effort to scale up mental health services universally. Such services are also intended to strengthen the human rights of patients having mental issues, along with a careful consideration of the well-being of their family members as well. This scaling up the mental health services worldwide, as Global Mental Health (GMH) groups believe, can only be truly achieved if governments, multilateral agencies, public health organizations, mental health experts and other stakeholders enter the same field and work towards that goal. The movement for Global mental health advocates for human rights in context with mental health, healthcare research in LMICs and universal mental health care policies etc. This movement inspired various other fields to contribute to mental health research, to deliver existing resources to the individuals affected with mental illness and to design effective policies that conserve the rights of this often stigmatized population. However, the outlines proposed by Lancet series of GMH have their own pitfalls, which have been long vocalized by many researchers working in the field of mental health. One such criticism revolves around the fact that universalizing the symptoms and treatments, in reality, suppresses the local voices and undermines the importance of culture and other psychosocial and political factors that play a contributory role in the development, prognosis and treatment of any mental health challenges. Making mental illness context-free or culture-independent serves as an important barrier in the treatment efficacy. Moreover, the emphasis on physical health over mental health, inadequate training, and over-reliance on hard quantitative data over qualitative measurement refrain us from viewing the reality of this overburdened population. Overlooking these ground realities about the policies, presentations and approach of this movement would indeed be problematic unless not addressed immediately.

**Global Mental Health Movement**

Mental health issues make a substantial contribution to the global health burden, as indicated by WHO health statistics (2011). Given the lifestyle approach adopted by individuals worldwide, it is quite evident that there has been an exponential increase in the incidence of mental illnesses across the globe. It is expected that one out of four individuals in the world at some point in their lives are susceptible to mental or neurological disorders. Despite the availability of various effective treatment strategies and rise in the awareness of mental health problems, the ratio of individuals receiving primary mental health care is very low, which is almost 75-80 per cent in LIMICs and 35-40 per cent in high-income nations (WHO, 2011). These unresolved issues have resulted in the emergence of various initiatives to improve the mental health conditions all around the globe. One of such notable initiatives is Global Mental Health (GMH) movement, which attempts to provide an international perspective to the mental health issues worldwide.

It is reported that LIMICs account for less than 2 per cent of the total global mental health resources and thus these indices are the clear indicator of how much scaling is required to be done. Scaling up mental health services is one way to ensure that such services reach LIMICs in a cost-effective fashion. Global mental health (GMH) is a movement, the history of which can be traced back to 2007 when Lancet published “Call for Action” on Global Mental Health. Scientific evidence and human rights are the two fundamental principles that serve as this movement’s strong foundational pillars. GMH movement is built upon the foundation that mental disorders around the globe are mostly linked with poverty, marginalization, social inequality, which resulted in scarce financial and human resources and inefficient allocation of such resources. Thus, this movement believed that scaling up the resources will help in increasing the access to mental health facilities and diminishing the illness-based inequalities (either outcomes or discriminations) between or within countries. Synthesizing the evidence on what treatments are effective for addressing a wide range of mental illnesses is one of the objectives of GMH. GMH believes that it requires building a common platform for mental health experts and societies to work upon the shared goals. Summing it up, the four core foundations of GMH can be traced in (Patel, 2011):

1. Evidence supporting the claims the interrelationships between mental illness and social disadvantages.
2. Associations between physical health issues and mental illness as suggested by DALY (Disability-adjusted-life –year).
3. Effectiveness and cost-efficacy of pharmacological and psychosocial treatments for mental illness in LIMICs.
4. Denial and abuse of basic human rights of such populations. For instance, research from people with mental illness from poor cities has shown that patients are chained to the bed or caged in small cells among other inhumane treatments (Klienman, 2009).

GMH incorporates a comparative approach wherein each nations’ status of own progress towards the set targets are compared within and between the nations. Contemporary researches have also indicated that only a limited number of studies are based on LIMICs, which unfortunately range from 3-6 per cent of total mental health research (Read, 2012). This lack of sufficient research blinds us from gaining a fuller and universal representation of mental health conditions. Since the access of health care services to people with such disorders mainly in LIMICs is grossly lacking, their primary aim is to strengthen such facilities. GMH believes that there should be a cost-effective delivery of clinical guidelines to the routine clinical practices (Patel, 2009). For this, they have laid down various panels to describe them in the Lancet series. In short, GMH movement hopes to fill the treatment gaps and to preserve the basic human rights of individuals with mental disorders among various other sub-goals.

**Primary Care, Mental Health Services and Stigma**

World Health Assembly (2013) initiated the Comprehensive Mental Health Action Plan (CMHAP) for 2013-2020, which aimed at integrating mental health care services in United Nations (UN) member states into primary care (Saxena, Funk and Chisholm, 2013). This initiative has resulted in the much-needed changes of the basic community based primary health care systems. This transformation has been achieved by including better diagnosis and interventions for both severe and common mental health issues. CMHAP is also committed to enhance the quality of mental health promotion and prevention among its member states. Likewise, the UK government funded “Programme for Improving Mental Health Care” (PRIME) shares similar goals of enhancing the design, evaluation, and cost-effective methodologies of integrating severe mental illness into common mental disorders (Lund, Tomlinson & Patel, 2016). While these various frameworks of GMH focus on advancing the prognosis, care and treatment of people suffering from mental illness, it has been long established that individuals with mental illness face serious prejudice and discrimination (Thornicroft et al., 2016). Therefore, a strong emphasis on reducing such stigma in their framework is as much needed as the other goals. The Ministries of Health in India among other LMICs in Asia and Africa in collaboration with PRIME is, therefore, contributing towards quality improvement and applying collaborative care principles through rigorous studies, which include larger indigenous samples that address health-related stigma and discrimination among users of mental health services (Patel et al, 2013; Thornicroft et al., 2016). These studies, hopefully, highlight stigmas and discriminations these groups face, and that a proper counselling channel and awareness programme could be designed to normalize mental health issues.

**Universalization of Symptoms**

GMH ensures a standard comprehension of mental health distress and how it can be treated across the globe/world with a specific focus on LIMICs. While earlier the focus of conceptualization of mental illness was based on self, society, and politics, it has now been shifted to a universal approach. This might lead to the basic error of objectivity and generalizability as cultures across the places are highly diverse and what may apply to one culture might not apply to the other (Summerfield, 2008). Some researchers argue that traditional psychiatry runs too much in a straight line, and mainly chained to a quantitative approach. However, a more realistic way to understand illnesses is to see the psychology as outside the body of an individual. The critics of GMH proclaim that understanding psychological pathology (and more precisely humans) is more of a philosophy than a science. Since the approach itself wholly believes in science, the globalized outlook of mental health and its whole pharmaceutical industry is erroneous.

The medicalization of mental illness has resulted in an epidemic of false positive diagnoses (Moncreiff, 2014). Moreover, there has been an increased attribution of the aetiology of mental disorders to physiological causes. This further has escalated the prescriptions of psychotropic drugs among mental health practitioners. The critics of GMH position believe that the more the resources are made available, the more are perceived to be needed, leading to an unending circular process (Summerfield, 2012). The rise of the mental health industry in the west has itself become problematic, rather than being a solution, as even the slightest of the everyday distress are often labelled as one or the other mental illness. In addition, there has been a long dispute among experts on the treatment efficacy of these drugs. This all has somehow resulted in the development of medical imperialism, where in western psychiatry is given overdue emphasis. Moreover, the psychiatric practitioners from the west often believe that individuals from other cultures should understand and accept their medical philosophy, and not the other way around (Summerfield, 2012).

The medicalization has done nothing to lessen the stigmatization faced by such population. For instance, the two-generation usage of antipsychotics has still not improved the overall employment rate among people labelled as schizophrenics (Kirsch et al., 2008). In another instance, it was found that people who were diagnosed with depression did slightly worse than those who were not diagnosed (Goldberg, Privett, Ustun, Simon, & Linden, 1998). This leads to a conclusion that medicalization of mental illness has discarded the other factors that may contribute to such illnesses. The voices of the patients and the general population are to be found often missing and disqualified from the “mental health” discourse (Clark, 2014). Before medicalization and psychopharmacological industry came into the picture, the focus was more on ‘self’. However, the scenario has completely reversed now, and individuals’ dependency from self has moved on to biological factors, leading to diminished control over their symptomatology and disease mongering/psychiatric abuses, especially in North America (Lambo, 1960 as cited in Read, 2012). Drugs have migrated from the realms of serious mental disorder into the area of everyday emotional problems (Moncreff, 2014). For instance, what before was early childhood behavioural problem that fades away as the child enters adulthood is now called the paediatric bipolar disorder. Anyone can have any disorder if they choose to have. GMH use of an invalid approach and lack of appropriate cross-cultural research has made us largely understand symptoms globally. The universality of symptoms has been forced into the local voices, which do no justice to the cultural, political and economic influence on individuals’ makeup. Trying to explain the aetiology of any particular mental illness through the lens of other culture could result in a serious misunderstanding of such illnesses. For example, the large-scale suicides of Indian farmers are largely a result of poor economic setups than disruptions in their actual physiological or psychological makeups (Shiva & Jalees, 2005).

Likewise, another initiative that advocates GMH also seems to carry similar issues in their guidelines that the primary GMH movement carries. The guidelines by WHO Mental Health Gap Action Programme (mhGAP), a WHO’s flagship program on mental health similarly emulates a top-down expensive health care system, which is not affordable and practical for most of the populations residing in LIMICs. The small set of countries that they selected for review might not provide a fuller picture of other LIMICs and, therefore, might not be a representative sample. Likewise, this scaling up ignores blindly the mental disorder affecting children as most of the policies are centred toward mental disabilities affecting the adult population and largely acknowledge how these disabilities affect the activities of daily living of adults.

**Conceptualizing the GMH Framework**

Even though the intentionality behind the scaling up appears out to be optimistic, the primary research challenge requires addressing “how this scaling up should be done.” This is the major question, which the supporters of GMH usually fail to answer. Another setback that GMH itself notes down is that there remains an inevitable uncertainty about the estimates concerning epidemiological demands and treatment coverage, utilization and costs regardless of the availability of the best data. Moreover, even though the target is set, it is of high need to constantly monitor and revise the needs based on the current scenario, and, sadly, there is no significant mention of such strategies in their plan.

Despite the presence of a hierarchical framework addressing global mental health improvement, the targeted goals lack enough transparency and adaptability across different cultures. GMH turns out to be more an advocate of pharmaceutical industries than an actual endorser of mental illnesses. As Clark (2014) pointed out that medicalization of illness produces a restricted view. It is, therefore, necessary to fund more research to fill the missing voids in context with the individually tailored objectives for LIMICs and high-income nation. Anthropologists also appeal the current approach to challenge the imperfections and inadequacies in current mental health care systems/approach. Their approach to medicalize mental disorders is a very faulty approach as even though medical diagnosis validates an individuals’ suffering, it cripples them from within. Individuals seeking treatment then tend to believe in medicines more than their own abilities to fight life challenges or their disabilities.

A large array of challenges awaits to improve the concept of GMH, which include developing innovative treatment plans and primary health care services, strengthening individuals’ accessibility to such services, and quality improvement in addition to developing national health policies and legislation for proper dissemination of such services. A clear, consistent and holistic approach that engulfs all the factors (viz. physiological, social, psychological, spiritual, cultural, economic and political) is the only way to scale up the mental health services and its understanding. For instance, a study on Indian mental patients indicated that the inclusion of psychosocial interventions in pharmacological treatments could actually increase the overall efficacy (Jain & Jadhav, 2009). Moreover, allowing family members to become the active part of the treatment process can provide on-going monitoring and the better standard of care for patients outside hospital settings (Read, 2012).

**Conclusion**

GMH movement has certain roadblocks to struggle with in coming days due its overarching goals. However, such critical analysis, in its actuality, is very essential for a productive judgment over an issue. Both the critics and supporters of GMH position, however, intersect on the same ground that the mental health facilities need to be escalated. Undoubtedly, if a stronger emphasis on all these factors is put forward, then the goals related to mentally healthy society can come into being.

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